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Negotiating infant feeding in private and public  
spaces: a study of women's experiences

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This thesis is submitted in fulfilment of the  
requirements for the degree of Doctor of  
Philosophy

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## Abstract

There is a wealth of literature suggesting that breastfeeding for 6 months offers the ideal balance of nutrients for complete infant growth, and that all infants should be: “exclusively breastfed from birth to six months of age” (WHO 2003). However, although 98 percent of new mothers are capable of breastfeeding, only a minority of infants continue to be breastfed at six months following birth. In addition, breastfeeding rates are socially patterned whereby women living in the most affluent neighbourhoods are three times more likely to breastfeed their infants than women living in the least affluent areas (Bolling et al 2007).

This thesis set out to address a range of research questions in relation to women’s lived experiences of breastfeeding in private and public spaces throughout the first 6 months of motherhood within a sample of mothers from the most and least affluent neighbourhoods. Given that breastfeeding is an embodied health behaviour, the epistemology adopted a position of interpretivism as a means of capturing the meaning and lived experiences of women’s breastfeeding. Breastfeeding women were recruited at 2 days following birth from the most and least affluent areas of Glasgow south and 41 in-depth interviews were conducted over 3 time periods following birth: 4 weeks (n18), 10 weeks (n12) and 26 weeks (n11).

The results from this public policy health service research study suggest that breastfeeding is a learnt skill and women work hard to develop their skills and confidence in order to breastfeed comfortably and discreetly in private and public spaces. Breastfeeding is commonly discussed as a private domestic activity, and home is generally considered the most appropriate place for breastfeeding to take place. However, with the constant flow of visitors a new baby attracts, the boundaries between what are considered private and public space breaks down. As a result, women develop an awareness of appropriate and inappropriate spaces for breastfeeding both at home and outside the home. Women suggest, at times, they feel a greater degree of privacy breastfeeding within public spaces than they do in the private space of their own home.

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## Author's Declaration

I declare that this thesis: "*Negotiating infant feeding in private and public spaces: a study of women's experiences*" is the result of my own work except where explicit reference is made to the contribution of others. Furthermore, this thesis has not been submitted for any other degree at the University of Glasgow or any other institution.

Signature \_\_\_\_\_

## Chapter 1: Introduction

It is believed that up to the mid nineteenth century breastfeeding was the cultural norm in all Western societies. However, the political, scientific and cultural endorsement of infant formula feeding throughout the 20<sup>th</sup> century has had a major impact on breastfeeding rates within the UK. For example, whilst it was estimated that 90 percent of women breastfed in Scotland at the beginning of the 1900s, by 1973 only 15 percent of Scottish women chose to breastfeed their infants.

Since the 1980s breastfeeding has become a public health priority. Over the last 30 years various international, national and local policies have been implemented to increase the uptake and duration of breastfeeding. Breastfeeding is viewed as the optimum way to feed an infant and plays a crucial role in reducing inequalities in health within the UK, as acknowledged in the *Acheson Report* (Acheson 1998). The World Health Organisation (WHO) recommends that all infants should be: “exclusively breastfed from birth to six months of age followed by the gradual introduction of solid foods and continued breastfeeding into the second year and beyond” (WHO 2003). These recommendations are based on a significant body of literature suggesting that breastfeeding for 6 months offers the ideal balance of nutrients for complete infant growth (WHO 2001) as well as offering other non-nutritional health and economic benefits to infants, their mothers and society.

Breastfeeding confers a number of health advantages to the baby and mother, including a reduced risk of gastric, respiratory and ear infections in infants (Howie et al 1990; Wilson et al 1998; Kramer et al 2001; Oddy 2003; Quigley et al 2007; Aniansson, Alm & Andersson et al 1994). In addition, women choosing to breastfeed for 6 months are less likely to suffer from illnesses such as breast and ovarian cancers, and heart disease (Newcomb et al 1994; Beral et al 2002; Bordeleau 2003; Rosenblatt et al 1993; Tung et al 2003; Jordan et al 2010; Schwarz et al 2009). Societies also benefit as a result of women breastfeeding: the health costs of treating babies never breastfed is far greater during the first year of life than for those infants receiving breast milk (Ball & Wright 1999; Bartick & Reinhold 2010).

Despite the benefits associated with breastfeeding, large proportions of women in the UK choose not to breastfeed their infants, or do so for only a short time. This is demonstrated in the Infant Feeding Survey (IFS) (2005) which suggests that, in Scotland, 71 percent of women breastfed their infant at birth. However, only 44 percent of women continue to breastfeed their infants at six weeks; this figure drops to 24 percent at six months following birth (Bolling et al 2007). The Scottish Government is committed to ensuring that each child gets the best possible start in life and this is reflected in local delivery plans that aim to increase the proportion of newborn infants being breastfed by 2010/11.

Breastfeeding is universally endorsed as “best for babies” and a woman’s decision to breastfeed her infant is represented within the literature as a sign of “good and natural mothering” (Carter 1995: 42). However, the likelihood that an infant will receive breast milk is influenced by an array of complex cultural and socio-demographic factors. Such factors include a woman’s age, her level of education, occupational status and the area in which she lives. For example, women living in the most affluent neighbourhoods are 3 times more likely to initiate and continue breastfeeding than women living in the least affluent areas. In addition, inadequate support within a woman’s circle of family and friends and a lack of breastfeeding visibility in public spaces (McIntosh 1985; Dungy et al 2008) have been cited as important factors in determining why women choose not to breastfeed, or give up breastfeeding in the early days and weeks following birth. The prominence of the sexualisation of the breasts has also posed many challenges for women in their attempts to breastfeed in front of others without fear of embarrassment to themselves and others (Stearns 1999).

Breastfeeding is commonly constructed as a private activity (Carter 1995) and, as such, the home is generally viewed as the most appropriate place for breastfeeding to take place. The Breastfeeding etc. (Scotland) Act (2005) was implemented in order to “*safeguard the right of an infant under the age of two years of age to be fed milk in a public place or licensed premises, where the child is otherwise lawfully permitted to be there*”. However, it is widely recognised that many women choose to formula feed their infants due to perceived and actual negative social and cultural attitudes, something that the act aims to tackle within Scotland. Such challenges have often left women

feeling socially constrained by the act of breastfeeding (Guttman and Zimmerman 2000).

This study is an interface between health services research and public policy evaluation. The aim of the study was to fill an existing gap in the literature by taking a prospective approach to exploring women's experiences of negotiating infant feeding in private and public spaces throughout the first six months of motherhood within a sample of mothers from the most and least affluent neighbourhoods. As discussed above, breastfeeding is class related and this study explored the possibility that women's experiences and views of breastfeeding in private and public may differ between affluent and deprived areas. Breastfeeding women were selected for the study from a Glasgow Maternity Unit at 2 days following birth. A specific requirement for inclusion in the study was that women resided in either the 20 percent most or least affluent urban areas of Glasgow South (measured using the Scottish Index for Multiple Deprivation [SIMD] 2006-10). In order to achieve the research aim, five core research questions listed below were addressed:

1. Do social and spatial influences affect women's roles in infant feeding?
2. In which environments do women feel comfortable and relaxed while breastfeeding and why?
3. In what ways do women negotiate their behaviour when breastfeeding their infants in private and public spaces?
4. Is women's breastfeeding behaviour influenced by living in affluent or deprived areas?
5. Does the duration of breastfeeding impact on women's ability to feed in public and private spaces?

The intention of this thesis is not to argue that breastfeeding is a natural skill that all women possess. Similarly, it is not the intention to portray women as passive subjects in their attempts to breastfeed their infant. Rather, the thesis aims to explore women's breastfeeding journey in private and public spaces, highlighting the challenges women face and the strategies they develop in order to maintain their breastfeeding both at home and outside the home. In order to develop this argument further, the thesis will adopt the following structure:

**Chapter 2: *Contemporary breastfeeding: benefits, epidemiology and policy:***

This chapter addresses contemporary breastfeeding practice in Western society. The literature on breastfeeding is extensive and the focus of this chapter is to explore three specific topics. The discussion will begin with the benefits that breastfeeding affords in relation to infants, their mothers and society as a whole. The chapter then moves on to discuss the incidence and prevalence of breastfeeding, identifying differences in socio-economic and geographical variations. In addition, recent statistics highlighting women's choices about breastfeeding in public, including their preferred places to breastfeed, will be explored in light of the Breastfeeding etc. (Scotland) Act (2005). The final section of this chapter reviews breastfeeding policy implementation at a global, national and local level, before exploring the impact such policy has had on the uptake and duration of breastfeeding.

**Chapter 3: *Power, control and regulation: twentieth century political, scientific and cultural influences:***

This chapter reviews the literature in relation to medical, political and cultural practices that have worked to undermine and control women throughout the twentieth century. The chapter is structured in three distinct sections. The first section addresses the medical, political and cultural practices underpinning breastfeeding practices. The chapter then discusses the social meanings ascribed to women's bodies and the impact this has had on breastfeeding rates. The final section moves on to explore the role played by social and spatial factors in influencing women's decision to breastfeed in private and public spaces.

**Chapter 4: *The research design:*** Explores the key methodological and analytical issues encountered within this exploratory study. The chapter is split into three main sections. First, it provides a reflective account of the research process by addressing the epistemological approach underpinning the research design: interpretivism. Second, the research design is explored in relation to the exploratory approach adopted, whereby in-depth interviews were used to explore women's breastfeeding journey over a 6 month time period. The final section of this chapter discusses the approach to data analysis, the aim being to give women a voice while maximising the quality and the transparency of the research process.

**Chapter 5: *Early breastfeeding experiences at home:*** Lays the foundations for understanding the central findings of women's experiences of breastfeeding in the private and public spaces. The early section of the chapter considers the characteristics of the women who were interviewed, before moving on to discuss the main factors influencing their decisions and motivations to initiate breastfeeding. The latter section of this chapter explores the practical, physical and emotional journeys that women embarked upon while breastfeeding and, strategies adopted to overcome the challenges experienced. The formal and informal support the women received is also discussed within this section.

**Chapter 6: *Breastfeeding in the private and public sphere:*** Explores women's experiences of breastfeeding in private and public spaces. The findings reported in this chapter relate to interviews conducted at 4 and 10 weeks following birth and are presented within two main sections. The early section provides an insight into how women experienced breastfeeding in private spaces, both at home and in the homes of family and friends. The second section explores women's experiences of breastfeeding outside the home. Within this section a detailed account is provided about the time that women spent in public spaces with their baby, the type of places they were most likely to frequent and the strategies that women adopted in order to feel comfortable breastfeeding in front of others.

**Chapter 7: *A breastfeeding career: changes over time:*** This final findings chapter explores women's experiences of breastfeeding over the first six months of the infant's life. The findings are presented over three sections. The first section explores changes in feeding methods over time, and factors that influence women's decisions to stop breastfeeding once breastfeeding was fully established. Second, the chapter moves on to explore the practical, physical and emotional changes that women experience breastfeeding over time. Central to the research aim, the final section addresses whether the skills and confidence women develop throughout their breastfeeding journey enable them to breastfeed comfortably in private and public spaces.

**Chapter 8: *Discussion:*** This chapter discusses the key findings of this exploratory study and identifies its contribution to the wider literature. The discussion is organised within two main sections. The first section presents a thematic

discussion of findings related to the research questions and places these within the context of the existing literature. The second section addresses the strengths and limitations of the research design; identifies policy and practice recommendations; contribution to the existing literature and areas for future research.

**Chapter 9: *Conclusion*:** This short final chapter concludes by presenting a summary of the key findings in relation to women's experiences of negotiating infant feeding in private and public spaces throughout the first six months of motherhood.

The proceeding chapter presents a literature review on contemporary breastfeeding practice within Western society. The discussion begins by addressing the benefits of breastfeeding and then moves on to highlight the incidence and prevalence of breastfeeding. The final section reviews policy implementation, and its impact on the uptake and duration of breastfeeding.



## **Chapter 2: Contemporary breastfeeding: benefits, epidemiology and policy**

### **Introduction**

The literature on breastfeeding is extensive and the focus of this chapter is to explore three specific topics. Firstly, the literature surrounding the benefits of breastfeeding will be briefly summarised in relation to the infant, its mother and society as a whole. Secondly, the chapter will address the incidence and prevalence of breastfeeding practice identifying differences in socio-economic and geographical variations. In addition, statistics relating to breastfeeding in public and women's preferred places to breastfeed when in public spaces will also be explored. The final section of the chapter will review breastfeeding policy implementation at a global, national and local level and move on to discuss the impact policy has had on uptake and duration of breastfeeding.

Since the 1980s there has been a policy push to promote, protect and support women in their attempts to breastfeed. The most recent international initiative to be launched aims to "improve - through optimal feeding - the nutritional status, growth and development, health and thus survival of infants and young children" (WHO 2003: 6). This recommendation is based on a significant body of literature suggesting that exclusive breastfeeding for six months offers considerable health benefits to growing infants (WHO 2001). However, within the UK only 76 percent of women initiate breastfeeding and as few as 25 percent of infants continue to receive breast milk at six months of age (Bolling et al 2007). However, it is anticipated that global, national and local strategies will act as a catalyst to increase breastfeeding rates (WHO 2003).

The likelihood that an infant will receive breast milk is influenced by an array of complex cultural factors. For example, socio-demographic factors such as age, level of education, occupational status and geographic factors such as the area in which women live are all predictors of breastfeeding initiation (Bolling et al 2007). In addition, cultural factors are also known to influence the initiation and duration rates of breastfeeding and the space in which breastfeeding is likely to occur. For example, inadequate support from social networks and a lack of

breastfeeding visibility in public spaces impinge on a woman's decision to breastfeed, the length of time a woman breastfeeds, and her ability to breastfeed in public spaces (Dungy et al 2008). Although there is a wealth of literature in relation to breastfeeding, few studies have taken a prospective approach to exploring women's experiences of breastfeeding in private and public spaces.

Before proceeding with this chapter it is important to establish definitions of breastfeeding since these tend to vary within the literature. For the purpose of clarity throughout this thesis, the following terminology and definitions presented in table 1 below will be used. However, there are limitations surrounding the definitions of the incidence, prevalence and duration of breastfeeding. For example, the *incidence of breastfeeding* includes infants that were breastfed on only one occasion, and the *prevalence of breastfeeding* does not convey the number of breastfeeds/bottle feeds an infant receives in any one day, only that the infant is receiving some breast milk.

**Incidence of breastfeeding/breastfed ever/breastfed initially** refers to the proportion of infants who were breastfed initially. This includes all infants who were put to the breast at all, even if this was on only one occasion

**Prevalence of breastfeeding** refers to the proportion of all babies who were wholly or partially breastfed at specific ages

**Duration of breastfeeding** refers to the length of time that mothers who breastfed initially continued to breastfeed, even if they were also giving their infants other milk and solid foods

**Prevalence of exclusive breastfeeding** refers to the proportion of all babies who have only ever been given breast milk up to specific ages and who have never been fed formula milk, solid foods or any other liquids

**Duration of exclusive breastfeeding** refers to the length of time that mothers who initially breastfed exclusively continued to feed exclusively, that is, not giving formula milk, solid foods or any other liquids

**Table 1: Definitions of Breastfeeding**

Source: adapted from Bolling et al (2007) Infant Feeding Survey 2005

## Benefits of breastfeeding

Much of the literature on breastfeeding can be found in the research fields of anthropology, geography, health promotion, midwifery and medicine. Across

these bodies of literature, it has been demonstrated that exclusive breastfeeding for six months offers considerable health benefits (Heinig and Dewey 1996, 1997; WHO 2001). The health impacts of breastfeeding to infants, mothers and society will be discussed briefly.

### ***The health benefits of breastfeeding for growing infants***

Breast milk is considered to contain an ideal balance of nutrients for complete infant growth (WHO 2001). In addition to nutritional benefits, breastfeeding offers non-nutritional advantages. Lutter (1990) found that breastfeeding could save more infant lives and prevent more morbidity than any other public health strategy. It has been suggested that:

“If a new vaccine became available that could prevent a million or more child deaths a year, which was free, safe and administered orally [...], it would become an immediate public health imperative” (Editorial: The Lancet 1994: 1239).

The vaccine described above is breast milk and it is estimated that approximately 98 percent of all new mothers are capable of producing breast milk for infant feeding (WHO 1981).

There is a wealth of literature suggesting that breastfeeding offers infants protection against both short and long-term health conditions (Britton et al 2007). There is convincing evidence from large scale international, national and local studies to suggest that breastfeeding protects infants against short-term infections such as gastroenteritis and respiratory infections during infancy (Howie et al 1990; Wilson et al 1998; Kramer et al 2001; Oddy 2003; Quigley et al 2007) and otitis media, an infection of the middle ear (Aniansson, Alm & Andersson et al 1994). In addition, evidence suggests that breastfeeding protects preterm babies from life threatening conditions such as necrotising enterocolitis (Lucas and Cole 1990).

Infants exclusively breastfed for three months of life have significantly less risk of gastrointestinal illness when compared with formula fed infants (Howie and colleagues 1990) and far fewer doctor visits and hospital admissions for respiratory illness and infections in the first year of life (Oddy 2003; Quigley et al 2007). Necrotising enterocolitis, the most common serious gastrointestinal

disease seen within neonatal intensive care units, was 6-10 times greater in formula fed infants than in infants exclusively fed on breast milk (Lucas and Cole 1990).

However, there has been much debate in the literature about the longevity of the effects that breastfeeding offers infants against diarrhoeal and lower respiratory tract infections. The earlier studies suggest that the protective nature of breastfeeding lasts far longer than the breastfeeding period itself (Howie et al 1990). However, more recent studies found that the protective nature of breastfeeding is likely to wear off once breastfeeding has stopped (Oddy 2003; Quigley et al 2007). Despite disagreement, these findings concur with the WHO (2001) recommendations of exclusive breastfeeding for 6 months, and also provide a convincing argument that prolonged breastfeeding promotes optimum health benefits.

Indeed, many researchers have argued that prolonged breastfeeding during infancy can play a protective role against chronic conditions in later childhood and well into adulthood. For example, several studies provide evidence that breastfeeding during infancy lowers blood pressure (Taittonen et al 1996; Wilson et al 1998; Martin et al 2004; Martin et al 2005); offers protection against the juvenile onset of insulin-dependant diabetes mellitus (Sadauskaite-Kuenhne 2004); reduces the incidence of asthma (Kramer et al 2007; Oddy 2009; Scholtens 2009); enhances neurodevelopment (Crawford 1993; Rogan & Gladen 1993; Der et al 2006; Caspi et al 2007); limits the occurrence of sudden infant death syndrome (McVea et al 2000; Vennemann et al 2009) and offers protection against obesity in later childhood (Von Kries et al 1999; Fewtrell 2004; Koletzko 2009). However, such studies exploring the long-term protective role of breastfeeding acknowledge that independent effects of breastfeeding were difficult to quantify due to influences from confounding socio-economic factors.

There is convincing evidence in the literature that breastfeeding an infant offers numerous health benefits and that these benefits may extend longer than the breastfeeding period itself. In addition, the majority of women suggest that the benefits associated with breastfeeding are what influence their decision to initiate and maintain breastfeeding.

### ***The health benefits of breastfeeding for mothers***

There is a large body of literature to suggest that breastfeeding not only provides infants with the best start in life but that it also has many health benefits for mothers. Large scale international studies suggest that prolonged breastfeeding had a positive effect on pre-menopausal breast cancer (Newcomb et al 1994; Beral et al 2002; Bordeleau 2003), ovarian cancers (Rosenblatt et al 1993; Tung et al 2003; Jordan et al 2010) and cardiovascular disease (Schwarz et al 2009).

However, there is also conflicting evidence within the literature as to whether breastfeeding offers mothers protection against the risks of chronic conditions such as hip fractures (Kreiger et al 1982; Alderman 1986; Cumming & Klineberg 1993; Michaelsson 2001) and maternal weight loss (Greene et al 1988; Ohlin and Rossner 1990; Potter et al 1991; Dewey et al 1993). The evidence linking lactation and health benefits often relies heavily on retrospective data and maternal recall dating back more than 20 years. As a result there is potential for misclassification and bias in the reported duration of breastfeeding.

### ***Societal and economic benefits associated with breastfeeding***

It has been argued that mothers who choose to breastfeed their infants bring considerable economic benefits to the family and society. In terms of reducing costs for the family, breast milk is free and readily available. In addition, by choosing to breastfeed, women can reduce the financial costs to society. The Department of Health has calculated that the NHS could save £35 million each year from the treatment of infants with gastroenteritis (DOH 1996) if breastfed. Although these figures are based on speculative estimates, they illustrate the potential for significant cost savings (Fairbank 2000). Ball and Wright (1999) analysed data from the USA and Scotland and concluded that for each 1000 infants never breastfed, there were 2033 more visits to the general practitioner, 212 more days of hospitalisation and 609 more prescriptions. More recently, Bartick and Reinhold (2010) suggested that if 90 percent of USA families exclusively breastfed for 6 months, a cost saving of \$13 billion and the prevention of 911 infant deaths could be achieved each year.

As well as the economic benefits in terms of health costs, there are also potential economic benefits for employers. Studies examined the experiences of the Los Angeles Department of Water and Power when setting up a “*Lactation Program*”. This programme which enabled women to express and store breast milk in the work place resulted in a number of benefits for the company. Benefits included increased employee loyalty, improved productivity and better recruitment which in turn led to an enhanced positive public image of the organisation. In addition, illness rates of breastfed infants were observed to be substantially lower than in infants fed on formula, directly benefiting both employers and mothers in term of lower health care costs and reduced absenteeism. The absenteeism rate in the *Lactation Program* was found to be seven times lower among the mothers of breastfed infants (Geisel 1994; Gibson 1993; Shalowitz 1993 cited in Galtry 1997).

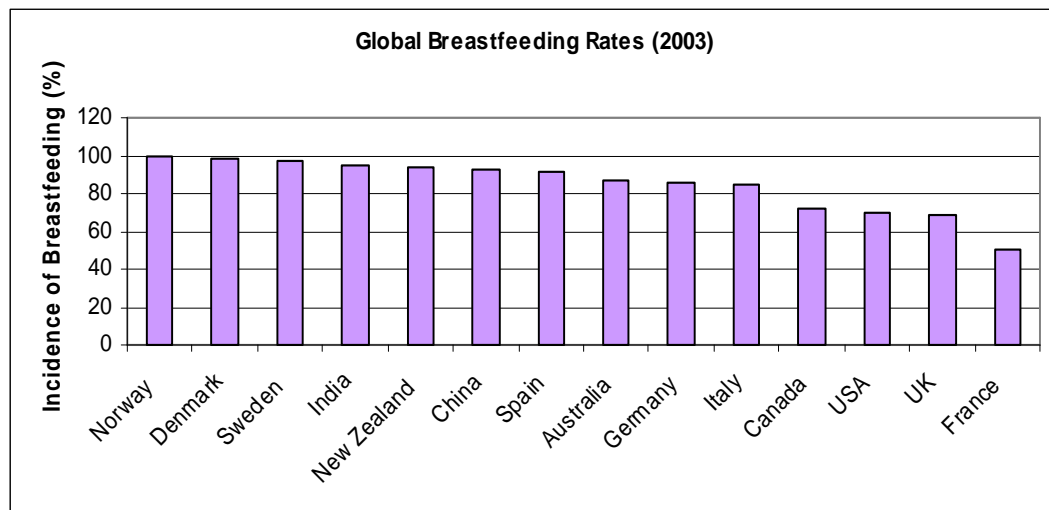
In summary, there is convincing evidence that breastfeeding offers considerable benefits to mothers, their infants and society as a whole. The research suggests that the health benefits that breastfeeding affords are not only associated with the properties of breast milk; breastfeeding also brings about health benefits for both mothers and their infants. In addition, it has been argued that breastfeeding may continue to offer protection long after breastfeeding has stopped. However, although very few women are physically unable to breastfeed current global, national and local breastfeeding rates are far from optimal, particularly amongst women in the least affluent areas (Bolling et al 2007). For example, whilst 80 percent of UK mothers were found to be aware of the health benefits associated with breastfeeding (Bolling et al 2007), knowledge of health benefits does not necessarily encourage the uptake or duration of breastfeeding. This is an issue that will be further explored in the following section.

## **Epidemiology of breastfeeding**

### ***Variations in the incidence of breastfeeding***

Historically, breastfeeding in Western societies was the cultural norm. However, throughout the 19<sup>th</sup> and 20<sup>th</sup> centuries these nations have witnessed a rapid decline in breastfeeding rates. Over the past 30 years various breastfeeding policies have attempted to reverse the global shift to formula feeding by

adopting an encouraging and supportive approach to breastfeeding. However, these policies have brought varying results. At the beginning of the 21<sup>st</sup> century the incidence of breastfeeding rates varied hugely across developing nations. From the histogram in figure 1, it is evident that the highest incidence of breastfeeding is in Scandinavian countries such as Norway, Denmark and Sweden whilst the lowest initiation rates are found in the USA, UK and France (La Leche League, 2003).



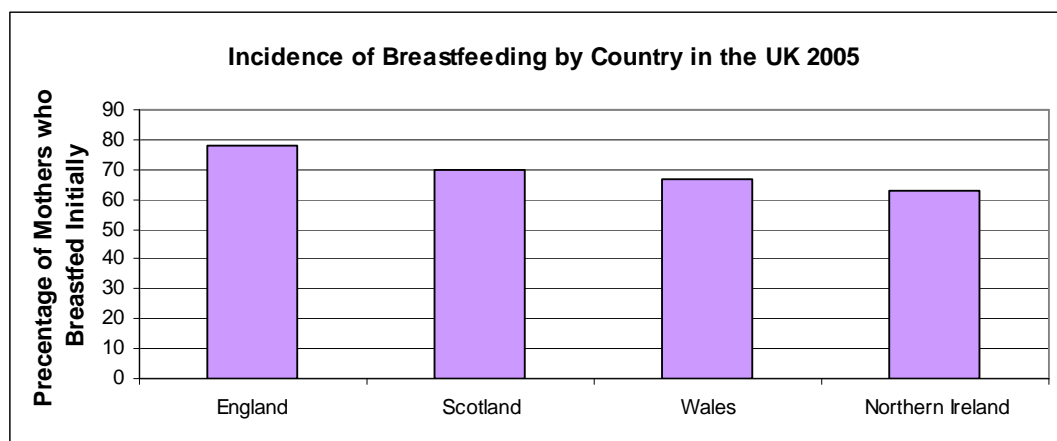
**Figure 1: Global Breastfeeding Rates**  
**Source: La Leche League (2003)**

### ***Incidence of breastfeeding (UK)***

In line with this study's UK context the focus will now turn to UK breastfeeding rates. It is widely reported that in the UK the majority of infants were breastfed until the 1930s, although the shift from breastfeeding to formula feeding can be traced back to the 1850s (Campbell and Jones 1996) (historical and cultural shifts in breastfeeding practices will be discussed further in chapter 3). However, by the 1960s UK breastfeeding rates were at an all-time low in Scotland when compared with the UK as a whole. It is estimated that a third of women never breastfed within the UK whilst approximately 49 percent of women chose to formula feed their infants in Scotland (Campbell and Jones 1996). Since 1975 efforts to monitor breastfeeding rates led the Department of Health, together with the health departments of Wales, Northern Ireland and Scotland to commission a national survey of breastfeeding behaviours to be conducted every five years- the Infant Feeding Survey (IFS).

The most recent 2005 IFS undertaken by the Information Centre for Health and Social Care and the UK Health Department is the seventh to be published (Bolling et al 2007). Information about feeding methods is collected using questionnaires completed by almost 9,500 mothers over 3 time periods during the first 10 months of an infant's life. The aim of the IFS is to present national figures on the incidence, prevalence and duration of breastfeeding practice. In addition, information has been collected on the demographic and geographic variations in breastfeeding rates. Since their inception in 1975 the surveys have continued to evolve. The 2005 IFS witnessed the most significant change thus far and was the first report to provide individual breastfeeding estimates for all four countries in the UK, as well as the UK as a whole. The 2005 IFS for the first time also measured exclusive breastfeeding rates in infants at specific ages. In addition, although the issue of breastfeeding in public has been discussed briefly in previous surveys, the 2005 IFS has set a benchmark by including data from mothers on breastfeeding in public spaces since the introduction of the Breastfeeding etc. (Scotland) Act (2005) (all data on Scottish babies was collected approximately a year following the passing of the law) and compared the experiences of mothers in Scotland with the experiences of mothers in the rest of the UK. The chapter returns to the issue of breastfeeding in public later, following a summary of geographic variation in breastfeeding rates across the UK.

The 2005 IFS provides data on the geographical variations in breastfeeding rates within the countries of the UK, as demonstrated in figure 2 below.

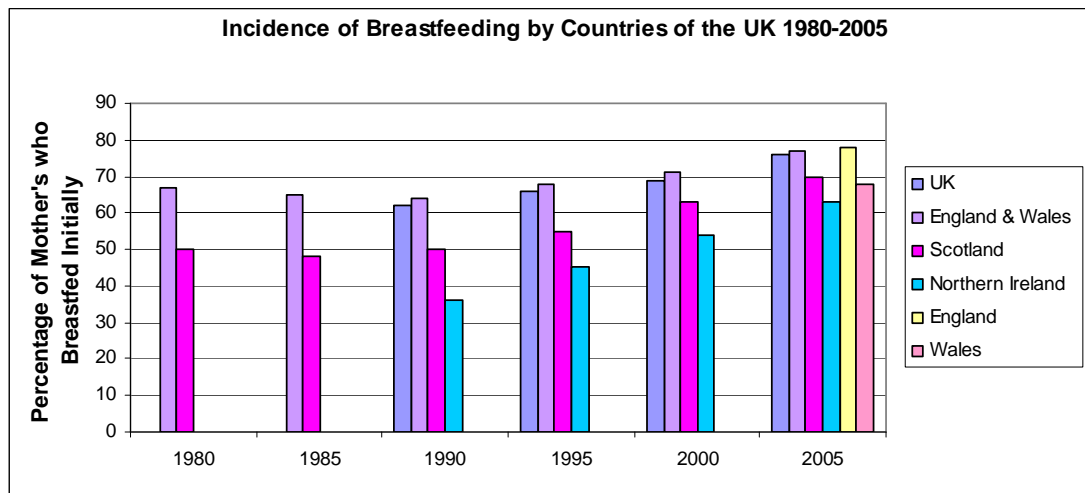


**Figure 2: Incidence of Breastfeeding by Countries in the UK**  
**Source: Infant Feeding Survey 2005**



From the histogram in figure 2 it can be seen that the incidence of breastfeeding varies across the different countries of the UK. In England the incidence of breastfeeding in 2005 was 78 percent while only 63 percent of infants are put to the breast in Northern Ireland. The Scottish figures demonstrate that 70 percent of infants were breastfed at birth (Bolling et al 2007).

The 2005 IFS also provided information on how the incidence of breastfeeding within the UK had changed over the last quarter century. This can be seen in figure 3 below.



**Figure 3: Incidence of Breastfeeding by Countries over Time**

**Source: Infant Feeding Survey 2005: Figures for Northern Ireland were not included in the 1980 & 1985 surveys: figures for England and Wales following devolution were not included until 2005**

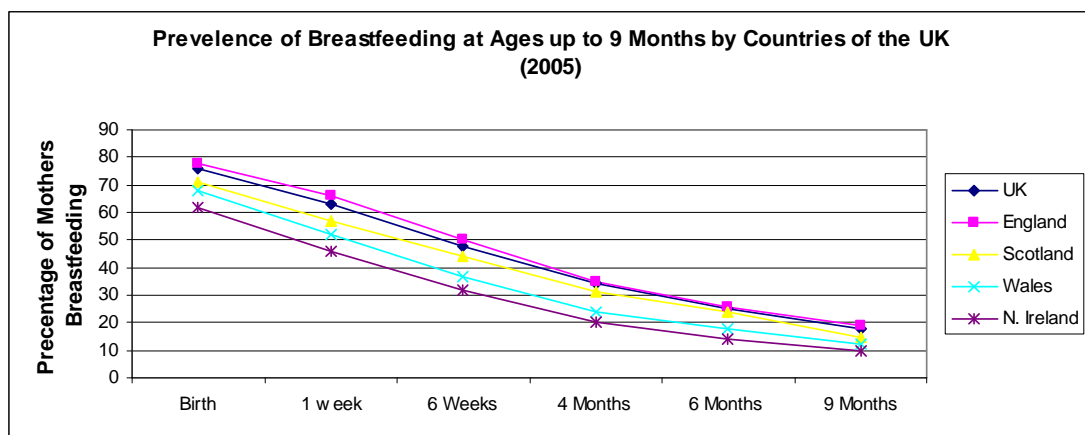
From the histogram in figure 3, there is evidence to suggest that the incidence of breastfeeding has seen significant changes over the past 25 years (Bolling et al 2007). The data indicates that between the years 1980 and 2005 the incidence of breastfeeding in Scotland increased from 50 percent to 70 percent at birth, which is an overall increase in breastfeeding of 20 percent in a 25-year period. England and Wales witnessed an increase in the incidence of breastfeeding of 10 percent over the same time period. Although Northern Ireland had the lowest incidence of breastfeeding, it has also experienced the greatest shift with an increase of 27 percent since the 1990s.

It is important to note that the incidence of breastfeeding rates includes those infants put to the breast on only one occasion. As mothers who delivered within Baby Friendly Hospitals Initiative units are encouraged to breastfeed within the

first half an hour following birth, this reveals little about the duration of breastfeeding. Thus, it is important to look at the prevalence of breastfeeding within the UK.

### ***Prevalence of non exclusive breastfeeding***

The prevalence of breastfeeding refers to the proportion of all babies who were wholly or partially breastfed at specific ages (Bolling et al 2007). Figure 4 below demonstrates the prevalence of breastfeeding rates up to 9 months by country within the UK.

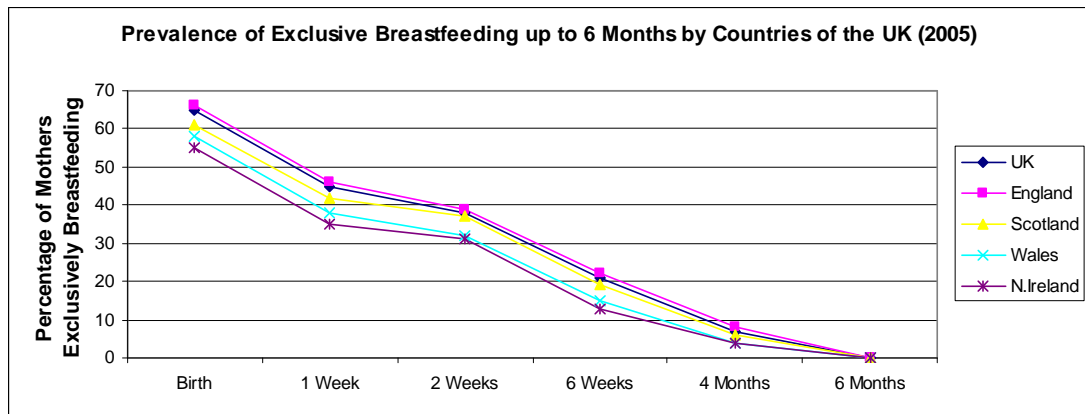


**Figure 4: Prevalence of Breastfeeding up to 9 Months by Country (2005)**  
Source: Infant Feeding Survey 2005

From the line chart in figure 4 there is clear evidence of an even and downward trend in the prevalence of breastfeeding over time in all 4 countries of the UK. At birth between 62-78 percent of infants in the UK were put to the breast, however, one week following birth this figure dropped by an average of 14 percent. At 6 weeks following birth a third of mothers who initially chose to breastfeed had stopped, and by 6 months around 76 percent of mothers had chosen to formula feed their infants. By 9 months only 10-20 percent of mothers continued to breastfeed (Bolling et al 2007).

### ***Prevalence of exclusive breastfeeding***

The WHO (2003) recommends that infants are exclusively breastfed for the first 6 months of life. Exclusive breastfeeding rates are plotted in figure 5.



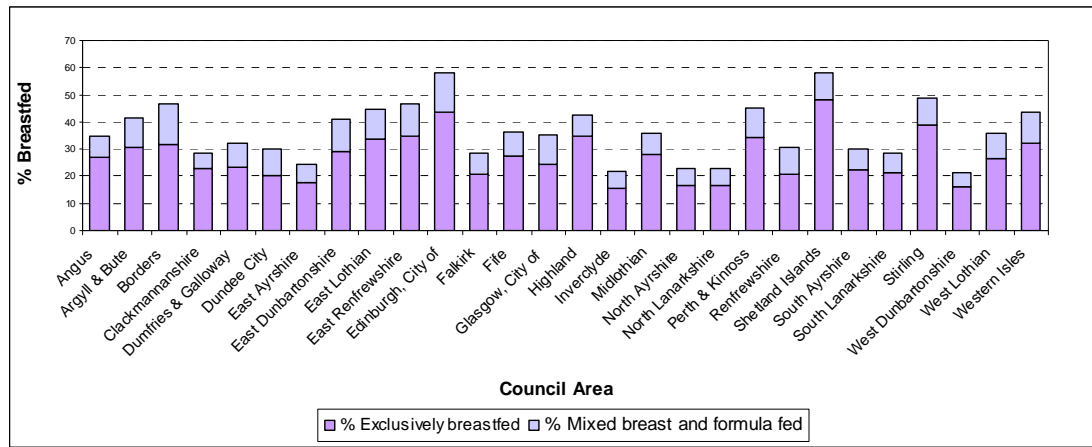
**Figure 5: Prevalence of Exclusive Breastfeeding up to 6 Months following Birth by Countries of the UK**

**Source: Infant Feeding Survey 2005**

It is evident from the line chart in figure 5 that the prevalence of exclusive breastfeeding within all four countries of the UK reduced significantly within the first 2 weeks following birth. At 6 weeks following birth as few as 13-22 percent of infants were being exclusively breastfed; at 5 months this figure dropped to 2-3 percent, while the figures for 6 months is negligible (Bolling et al 2007). What is interesting is that up to 20 percent of women stopped exclusively breastfeeding in the first week, when input from health professionals is at its greatest.

### ***Geographical variation of breastfeeding rates in Scotland***

Data from Information Services Division (ISD) Scotland (2001) found that the prevalence of breastfeeding at 10 days following birth varied from 34 percent in Inverclyde to 62 percent in the City of Edinburgh. The provisional data from 2008 suggests that breastfeeding duration rates at 10 days following birth ranged from 27 percent in Inverclyde to 68 percent in Edinburgh. Within the City of Glasgow 37 percent of infants aged 10 days were breastfed in 2001 increasing to 43 percent in 2008. The figures indicate that the prevalence of breastfeeding in Inverclyde has fallen by 7 percent over the past 5 years, while breastfeeding rates in Glasgow and Edinburgh have increased by 6 percent between 2001 and 2008 (ISD Scotland 2008). Figure 6 moves on to demonstrate the variation in the numbers of women breastfeeding across Scottish council areas at 6-8 weeks following birth.

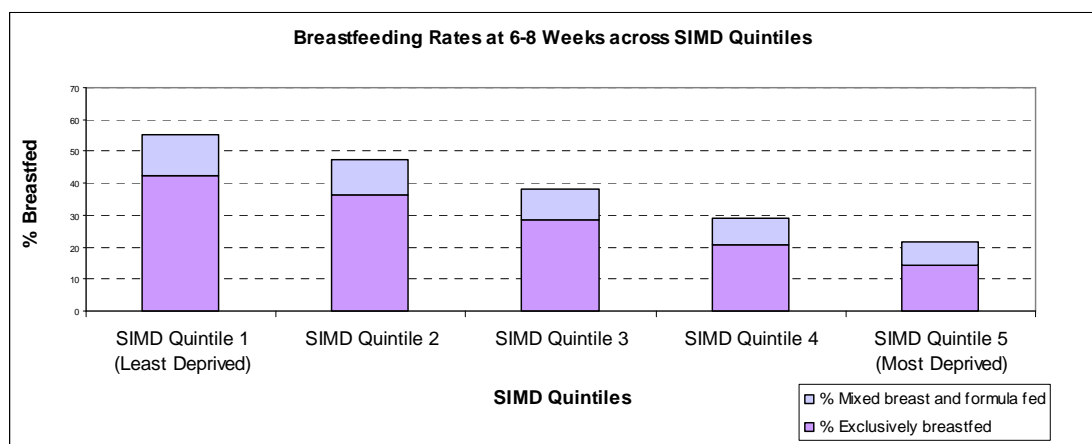


**Figure 6: Breastfeeding Rates at 6-8 weeks by Council Area in 2008**

Source: ISD Scotland CHSP- PS 2009 (Provisional Data)

From figure 6 it can be seen that the City of Edinburgh and the Shetland Islands support the highest duration of breastfeeding at 58 percent. West Dunbartonshire has the lowest breastfeeding rates at 21 percent, closely followed by Inverclyde at 22 percent. Particularly relevant to this research only 35 percent of mothers in the City of Glasgow continue to breastfeed their infants at 6 weeks following birth; this remains well below the Scottish national average of 44 percent at six weeks (ISD Scotland 2009).

Using the Scottish Index of Multiple Deprivation quintiles it is evident that the prevalence of breastfeeding also varies at a neighbourhood level as seen in figure 7 below.



**Figure 7: Breastfeeding Rates at 6-8 Weeks across SIMD Quintiles**

(Review by Scottish Index of Multiple Deprivation (SIMD) in 2008) Source: ISD Scotland CHSP- PS 2009 (Provisional Data)

From figure 7 it can be seen that breastfeeding rates at 6-8 weeks were greater in the most affluent areas at 55 percent and dropped to 21 percent in the least

affluent areas. Similarly, a gap of around 30 percent was noted between exclusive breastfeeding in the most and least affluent areas.

Tappin and colleagues (2001) found that the majority of women in the least affluent areas of Glasgow continue to choose formula feeding for their infants. The Scottish Public Health Observatory (2008) suggested that at 6 to 8 weeks of life in 2004/06 residents of postal code G53 (Priesthill & Househillwood), categorised by the SIMD as the least affluent area, had the lowest breastfeeding rates at 11 percent. On the other hand, residents of postcode G44 (Netherlee), categorised by the SIMD as the most affluent area, had the highest breastfeeding rates at 74.3 percent. As a result, the area women reside in is likely to influence whether or not she is likely to breastfeed. In addition, socio-demographic factors also play a significant role in women's infant feeding choices.

### ***Socio-demographic influences affecting a mother's decision to breastfeed***

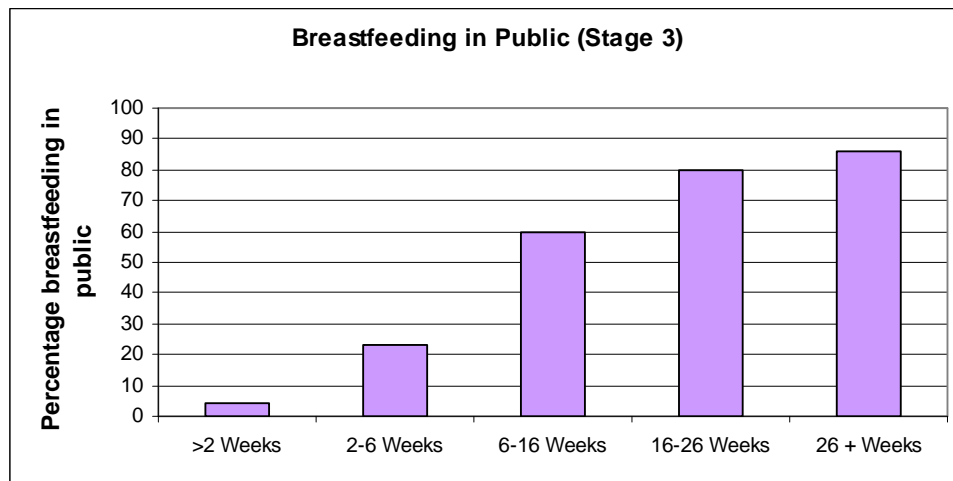
Evidence from the UK IFS indicate that young mothers, mothers in low-income groups and those who ceased full-time education at 16 years or younger were least likely to either start or continue breastfeeding (Bolling et al 2007).

The IFS (2005) reported that 76 percent of UK mothers initially breastfed their infants, with the highest incidences of breastfeeding found among mothers from managerial and professional occupations (88 percent compared with 65 percent of mothers who had never worked). Of mothers with the highest levels of education (beyond 18 years) 91 percent chose to breastfeed compared to those leaving education at 16 years or younger (48 percent). A mother's age also affected the likelihood of breastfeeding. Mothers aged thirty and over accounted for 83 percent of the breastfeeding population, while only 51 percent of mothers aged 20 years or younger chose to initiate breastfeeding. The following chapter will consider the cultural barriers associated with breastfeeding.

### **Statistics on breastfeeding in public places**

There is an argument that greater public acceptability of breastfeeding will augment the rates. In an attempt to push for public acceptability of

breastfeeding, the IFS (2005) measured how many women breastfed in public within the first 10 months following birth. Data were collected at 4-6 months and 8 to 10 months. Based on all women who breastfed initially, 51 percent of UK women breastfed in public spaces and this figure increased to 55 percent amongst Scottish women (Bolling et al 2007). However, the survey found that only a very small proportion of women actually breastfed in public within the first two weeks following birth, and that breastfeeding in public increased with the duration of breastfeeding (Bolling et al 2007), as demonstrated in figure 8 below.



**Figure 8: Percentage of Stage 3 Mother's who had Breastfed in Public**  
**Source: Infant Feeding Survey 2005**

The 2005 IFS noted a marked variation in the prevalence of public breastfeeding associated with demographic factors. Similar to breastfeeding initiation rates, women who chose to breastfeed in public spaces were more likely to have managerial or professional occupations (63 percent) than routine/manual occupations (40 percent). Women educated beyond the age of 18 years were more likely to have breastfed in public (61 percent) when compared with women who left school at 16 or younger (37 percent). In addition, 60 percent of women aged 30 or over who had breastfed initially had done so in public; this figure dropped to 27 percent in women aged 24 or younger (Bolling et al 2007).

Women who had ever breastfed in public were asked about their preferences when feeding in public spaces. Three options were discussed: "special facilities" such as a mother and baby room, breastfeeding where they could find a quiet place to sit, or breastfeeding where they were without seeking a special place in which to sit. The majority of women (82 percent) suggested that they would use

special arrangements and this was equally split between mothers opting to use mother and baby facilities (42 percent) and those who preferred to find a quiet space (40 percent). Only 8 percent of women breastfeeding in public said they would breastfeed where they were without having to go anywhere special. This suggests that women would prefer a discreet location when breastfeeding in public.

However, when addressing the behaviours of women breastfeeding in public, the findings indicate that half of all women breastfeeding initially said they had encountered problems finding a suitable place in which to breastfeed, and 13 percent suggested they had been asked to stop or made to feel uncomfortable while breastfeeding in public. In Scotland this number was reduced to 33 percent of women who had encountered problems finding a suitable place in which to breastfeed and 8 percent who reported they had been asked to stop or made to feel uncomfortable while breastfeeding in public (Bolling et al 2007).

It is clear from the data presented that there are geographical variations in breastfeeding rates across Western countries and countries within the UK. In addition, Scotland provides a good example of geographical variations in breastfeeding rates between the most and least affluent neighbourhoods. Socio-demographic factors play a significant role in influencing breastfeeding rates and breastfeeding in public, with the highest rates found amongst older mothers in managerial or professional occupations who are educated beyond the age of 18 years.

## **Infant feeding policy interventions and their impacts**

The aim of this section is to explore the implementation of infant feeding policy at a global, national and local level. Since the 1980s, there have been a number of international, national and local policies introduced to increase the initiation and duration of breastfeeding. This section aims to highlight such policies before moving on to explore whether they policy have had an impact on the initiation and duration of breastfeeding among women in the UK and, more specifically, in Scotland.

## ***Global policy since the 1980s***

The continuing battle against artificial milk producers has been reflected in the World Health Organisation's (WHO) and United Nations Children's Fund's (UNICEF) efforts over the past thirty years to protect, promote and support breastfeeding (WHO 1989). Health experts including former UNICEF Executive Director James Grant estimated that:

“as many as one million lives a year could be saved by the promotion of breastfeeding while others have estimated that 10 million cases a year of malnutrition and infectious diseases are directly attributable to faulty bottle feeding and as such there is no other public health intervention that offers greater potential for dramatically saving lives” (Grant 1981 cited in Baer 1983: 119).

The 27<sup>th</sup> World Health Assembly in 1974 acknowledged the increasing decline in world breastfeeding rates and attributed such changes to the promotion of manufactured formula milk. At a global level it is suggested that public controversy to the marketing of international formula companies, low breastfeeding rates and the publishing of the health benefits of breastfeeding led the WHO and United Nations Children Fund (UNICEF) to convene a landmark meeting on Infant and Young Child Feeding which resulted in the development of the International Code of Marketing of Breast Milk Substitutes (WHO 1981).

Adopted by the World Health Assembly in 1981, the International Code of Marketing of Breast Milk Substitutes aimed to protect and encourage breastfeeding while endeavouring to regulate the promotion of infant formula milk. However, it took ten years for the European Community to formulate this as a law, and in its inception the use of artificial milk promotion was limited only to infants under the age of 4 months (WHO 1981). Following the launch of the International Code, the World Health Assembly issued a succession of policies designed to increase global breastfeeding rates. Of particular significance was a joint statement published by WHO and UNICEF entitled “Protecting, Promoting and Supporting Breastfeeding: the special role of maternity services” which included the Ten Steps to Successful Breastfeeding listed in Appendix 1 (WHO/UNICEF 1989).

In 1990, the Innocenti Declaration on the protection, promotion and support of breastfeeding was jointly sponsored by WHO/UNICEF. The idea behind the



declaration was to endorse a set of targets to be met by governments in order to achieve cultural change that would facilitate an increase in the initiation and duration of breastfeeding rates. The 32 governments that signed the declaration promised to promote breastfeeding by establishing a national committee and by recommending of the Ten Steps to Successful Breastfeeding within maternity hospitals (De Lathouwer et al 2004). Every facility providing maternity services and care for newborn infants should promote breastfeeding by following the ten steps (see appendix 1).

The Baby Friendly Hospital Initiative (BFHI) was established in 1991 in order to implement the Ten Steps to Successful Breastfeeding while promoting breastfeeding as the “norm” in birthing environments. The Ten Steps were intended “to encourage hospitals and healthcare facilities to adopt practices that fully protect, promote and support breastfeeding” (WHO/UNICEF 1989 iv). The International BFHI is the central aspect of the global strategy and in order for maternity services to receive “Baby Friendly Accreditation” they must fully implement all of the Ten Steps to Successful Breastfeeding. However, Scottish hospitals have been slow to adopt this initiative with only 12 of 45 maternity units in Scotland having full Baby Friendly Accreditation, equating to 27 percent of Scotland’s infants being born in a fully accredited baby friendly hospital (The Baby Friendly Initiative 2009).

The Global Strategy for Infant and Young Child Feeding was developed to build on the previous achievements discussed above. Established jointly by WHO/UNICEF (2003) the Global Strategy was set up to bring to the fore “the impact infant feeding practices have on the nutritional status, growth, development and health, and thus the very survival of infants and young children” (WHO/UNICEF 2003: v). The strategy went further and placed specific importance upon national policies to promote, protect and support infant feeding.

### ***UK policy from 1970s***

The mid 1970s witnessed an all time low in breastfeeding rates throughout the UK. During this time literature surrounding the health benefits associated with breastfeeding was highlighted in medical research. In response to this the UK

Labour government launched the IFS to be conducted and published at five yearly intervals (Martin 1978; Martin & Monk 1982; Martin & White 1988; White et al 1992; Foster et al 1997 Hamlyn et al 2002; Bolling et al 2007). Starting in 1978 the UK Infant Feeding Survey has provided evidence of the incidence and duration rates and provided infant feeding trends in relation to socio-economic and socio-demographic variations. In addition, the surveys have been used to inform breastfeeding policy documents. A number of reports were published such as the *Present day practice in infant feeding* by the Committee on Medical Aspects of Food Policy Infant Feeding Panel (DHSS 1974, 1978, 1980, 1988). Within these documents it was reported that the majority of women in the UK chose to formula feed their infants, whilst women choosing to breastfeed did so only for a short period of time. These reports stressed the importance of breastfeeding shortly after birth, rooming-in (keeping the mother and her infant together) and feeding on demand. They also recommended that all infants should be breastfed for a minimum of two weeks and if possible for the first four to six months of life (DHSS 1974; Martin 1978).

The Joint Breastfeeding Initiative was a government initiative established in 1988 with an aim to reduce the early cessation of breastfeeding in the first six weeks following birth through the establishment of support groups. This initiative encouraged collaboration between health professionals and voluntary breastfeeding support groups in order to promote prolonged breastfeeding (DH 1988). However, Dykes (2006) suggests that the impact of the initiative was limited due to lack of sufficient funding.

The *Good Practice Guidance on Breastfeeding to the NHS* (1996) aimed to guide for all NHS staff on practices to promote the initiation and duration of breastfeeding (DoH 1996). This was followed by the UNICEF Baby Friendly UK Initiative: the community seven point plan (1999) for the promotion, protection and support of breastfeeding in the community. This extends the principles of the ten steps hospital initiative into the community, revised in 2008. Only facilities that implement all of the Seven Steps received Baby Friendly accreditation (see appendix 2).

The *Acheson Report* (1998) acknowledged the role that breastfeeding could play in terms of health gains for both mothers and their infants. Shifting the focus to

adopting breastfeeding as a means of tackling health inequalities led to a commitment to increase breastfeeding rates by 2004 (DH 2000). The *NHS Plan* suggested that increasing breastfeeding rates in the least affluent areas would help reduce morbidity and ensure a healthy start for all children.

The Maternity Care Working Party (2006) document *Modernising Maternity Care* advocated that service providers should demonstrate effective breastfeeding policies and practices that ensures support to all breastfeeding mothers. In recognition of the crucial role infant feeding plays in reducing health inequalities between the most and least affluent groups in terms of infant mortality, obesity and diabetes, the UK NHS Priorities and Planning Framework (PPF) 2003 to 2006 included targets that all Trusts and Strategic Health Authorities increase their breastfeeding initiation rates by two percent annually, concentrating their efforts on women from disadvantaged groups. In order to monitor their achievements, hospital trusts were required to collect infant feeding data from every woman that gives birth under their care (DH 2002).

Guidance from the National Institute for Health and Clinical Excellence (NICE) Maternal and Child Nutrition on breastfeeding was published in a report: *Improving the nutrition of pregnant and breastfeeding mothers and children in low-income households* (2008). Requested by the Department of Health (DH) in order to reduce inequalities in parental and child health, the report recommends exclusive breastfeeding for 6 months in order to achieve the health benefits that breastfeeding can offer mothers and infants. In addition, NICE advocates that all healthcare professionals should possess the skills and knowledge to promote and support breastfeeding and that support should target young women who are less educated and those residing in the least affluent areas.

Finally, *Healthy Lives, Brighter Futures* (DH 2009) suggested that Public Service Delivery (PSA) Agreement 12: *Improve the health and wellbeing of children and young people* (2007) set targets to increase the prevalence of breastfeeding at 6-8 weeks to as high as possible by 2011. The DH will work together with the NHS and the third sector (e.g. National Childbirth Trust) to provide breastfeeding education, advice and support through children's centres and helplines, supported by the *New Antenatal Education and Preparation of Parenthood Program*. In addition, £4 million was to be invested in 2008-2009 to promote

UNICEF Baby Friendly Initiative in areas with the lowest initiation and duration rates of breastfeeding (DH 2009).

### ***Scottish policy from 1980s***

In Scotland, there have been a number of initiatives by a range of agencies to raise awareness of the importance of breastfeeding. Scottish policy has taken an enthusiastic approach to breastfeeding promotion. In 1990 the launch of the Scottish Joint Breastfeeding Initiative (SJBI) funded by the Scottish Office was established to increase breastfeeding rates. In 1994 the first national targets were set in Scotland; they aimed to increase the duration of breastfeeding rates to 50 percent at six weeks of life by 2005 (Scottish Office 1994). However, these targets were not met. Repeated surveys conducted by the Office of National Statistics found that increases in the incidence and duration of breastfeeding rates within Scotland were sluggish. The IFS data found only an 8 percent increase in breastfeeding rates within the 10 year period from 1995 to 2005 at six weeks following birth (Bolling et al 2007).

The Scottish Infant Feeding Advisory Network, previously known as the Scottish Breastfeeding Group (SBG) was set up in 1995 to contribute to policy and development and also to promote good practice and information on breastfeeding practices. A National Breastfeeding Advisor was in post from 1995-2005 to inform and influence policy, and to support and monitor NHS Board activities while encouraging best practice. Although this post was vacant for three years, a new appointee to the role of national Infant Nutrition Co-ordinator took up office in 2008. A key function of the Infant Nutrition Co-ordinator was to develop an infant feeding strategy for Scotland and to support health boards in achieving their targets to increase the proportion of babies exclusively breastfed at 6-8 weeks from 26.6 percent in 2006/07 to 33.3 percent by 2010/11 (Hallam 2008).

The Scottish Social Justice document “*Social Justice: a Scotland where everyone matters*” (Scottish Executive 1999) aimed to reduce child poverty in Scotland in a generation. One area of commitment was that, regardless of family background, all young children should have access to the best possible start in

life. Increasing the proportion of women breastfeeding would contribute to improving the wellbeing of all young children (Scottish Executive 1999).

In 2003, '*An Integrated Strategy for Early Years*' (Scottish Executive 2003) focused on improving service provision for vulnerable and disadvantaged children from pre-birth to five years of age. Within the aims of improving child health, increasing the proportion of women who breastfed was listed as a key priority. In order to achieve this, it was proposed that every family with a newborn infant should have an assessment of their family needs for health care and advice, and continuing support by trained health professionals in the first few weeks of life.

The Breastfeeding Welcome Award (BWA) (2003) was piloted in Glasgow by NHS Greater Glasgow (NHSGG) and Glasgow City Council's (GCC) Culture and Leisure Services (CLS). Premises interested in being considered for the award completed a questionnaire that was then followed up by visits from mothers with breastfeeding experience on two separate occasions. Premises considered to be comfortable received a certificate and Breastfeeding Welcome Stickers were displayed in their windows or doors. Stickers were used to inform the public that it would be appropriate to breastfeed within that particular establishment. The award was developed and accredited by Glasgow City Council CLS venues. Over 650 frontline staff from various venues (including libraries, community centres, museums, art galleries and sport centres) took part in mandatory training (FMR Research 2006). The aims of the award are listed in appendix 3.

The Breastfeeding Welcome Award Audit (2006) reported back on three levels: awareness, impact on attitudes and practice and suggestions on progress. It was concluded that the aims of the award were met to some degree as the BWA was seen to increase mothers' confidence to breastfeed in public spaces (FMR Research 2006).

The Scottish Executive played a vital and unique role in Scotland by encouraging women to breastfeed while promoting a positive public attitude towards breastfeeding in public spaces. The Breastfeeding etc. (Scotland) Act 2005 was implemented in order to safeguard the right of an infant under the age of two years to be fed milk in a public place or licensed premises, where the child is otherwise lawfully permitted to be there. Furthermore, it is widely recognised that some women choose to formula feed their infants due to negative social

and cultural attitudes. The Breastfeeding etc. (Scotland) Act 2005 aimed to tackle and address such negative attitudes and made it an offence to stop mothers' breastfeeding their infants in public. Anyone preventing a mother from feeding would be liable to pay a fine of up to £2,000. The then Deputy Health Minister Rhona Brankin stated "The Scottish Parliament recently passed the Breastfeeding etc. (Scotland) Act which will give more mothers the confidence to feed their children in public" (Scottish Executive 2005).

## **Impact of policy**

Having discussed global, national and local policies in order to promote, protect and support breastfeeding practice it is useful to explore what impact they may have made. The aim of this section is to consider to what extent professional and peer programmes promote the initiation and support the continuation of breastfeeding. This can only be a brief discussion of a complex topic.

Several large systematic reviews have evaluated primary data from international, national and local studies to identify which strategies were most effective at increasing the uptake and duration of breastfeeding. Interventions discussed included breastfeeding support from health professionals, trained lay people; informal small group antenatal health education and peer support programmes (Fairbank et al 2000; Britton et al 2007; McInnes & Chambers 2008). The results suggested that peer support programmes delivered in both antenatal and postnatal periods were effective at increasing both the incidence and duration of breastfeeding in low-income groups and women who had previously expressed a wish to breastfeed (Fairbank et al 2000). Britton and colleagues (2007) also found that lay support was effective in increasing the rates of exclusive, and any breastfeeding. Furthermore, the provision of a combination of professional and lay support together had a positive effect on the duration of any breastfeeding within the first 2 months following birth. However, McInnes & Chambers (2008) concluded that generally speaking new mothers felt that they did not get the breastfeeding support they wanted from health professionals and suggested that the overall lack of staffing in postnatal wards could be attributed to failures in meeting mothers' needs. These findings may explain why so many mothers chose to stop breastfeeding in the days and early weeks following birth (Bolling et al 2007).

Large scale studies conducted at a national and local level suggest an association between improved breastfeeding outcomes and a number of factors related to maternity hospital practice within the Ten Steps to Successful Breastfeeding. Studies examined whether mothers were more likely to start and continue breastfeeding if they delivered in a UNICEF UK Baby Friendly accredited maternity unit. Mothers were found to be more likely to initiate breastfeeding but were no more likely to be breastfeeding a month later than those mothers delivering in units with no Baby Friendly accreditation (Broadfoot et al 2005; Bartington et al 2006). For example, within Glasgow, both maternity units held Baby Friendly Accreditation; however, the accreditation did not ensure success. As the 2009 figures suggested, breastfeeding rates in Glasgow continue to remain well below the expected national average of 50 percent, with only 34 percent of infants being breastfed at six weeks following birth (ISD Scotland 2009). At the time of writing, Glasgow's Princess Royal Maternity Hospital had their Baby Friendly Accreditation suspended (UNICEF 2009). Baby Friendly hospitals are likely to increase the incidence of breastfeeding but not the duration. As such, these studies highlight the importance of support to new mothers after they leave hospital (Broadfoot et al 2005; Bartington et al 2006).

Step two of the *Ten Steps to Successful Breastfeeding* aimed to “train all healthcare staff in the skills necessary to implement this policy”. This condition of the *Ten Steps* is predominately met by training midwives, health visitors and nurses and does not include the training of doctors (Arora & Doherty 2006). These authors assessed the level of breastfeeding knowledge of 77 paediatric trainee doctors in 14 Welsh neonatal units and found that 82 percent had received some breastfeeding training but this was mostly in the form of a single lecture. In addition, only 57 percent of doctors were aware of the Baby Friendly Hospital Initiative (BFHI) (Arora & Doherty 2006).

Tappin and colleagues' (2006) Glasgow study looked at the role of community health visitors in promoting and supporting breastfeeding in Glasgow and found that infants who were breastfed at their first routine health visitor contact after birth (8 to 20 days) were twice as likely to continue to be breastfed at the second visit (3 to 7 weeks) if their health visitor had received training in breastfeeding support in the previous two years. This small study suggests that providing intensive, consistent and positive support by trained health

professionals in breastfeeding may help women to continue breastfeeding for longer.

Hoddinott, Lee & Pill (2006) Scottish qualitative action research study looked at why a complex coaching intervention, which offered health professional-facilitated breastfeeding groups, was more effective at improving breastfeeding rates in some areas rather than others. Breastfeeding rates increased in areas where health visitors and midwives were committed to working together and where professional relationships were stronger. The areas where the intervention was viewed as ineffective included those where there were problematic relationships between midwives and health visitor teams.

Peer support programmes to promote, protect and support breastfeeding mothers, are more common in the least affluent areas. McInnes & Stone established the Easterhouse Breastfeeding Promotion Project (EBPP) in 1994. This peer support programme aimed to encourage and support new mothers, living in an area of social deprivation in North East Glasgow, to start and continue breastfeeding. In addition to setting up the programme McInnes & Stone (2000) conducted an evaluation study to measure the impact of peer breastfeeding support on the prevalence of breastfeeding rates. The findings suggest that a significantly greater proportion of the intervention group initiated breastfeeding at birth; although, there was no significant difference in breastfeeding rates at six weeks following birth. Explanation for the short duration of breastfeeding lay in a lack of support from their social networks, painful breastfeeding and exhaustion. However, the discretionary and delayed nature of support offered by the “Breastfeeding Helpers” (McInnes & Stone 2000: 67) may also have influenced the woman’s decision to stop breastfeeding.

Scott & Mostyn’s (2003) Scottish study employed focus groups as a means of exploring the attitudes and experiences of breastfeeding mothers from the least affluent neighbourhoods in Glasgow. The majority of women recruited to the study had no prior experience of breastfeeding and suggested that they were the first amongst their family and friends to have breastfed. Similar findings were evident in McIntosh’s 1980s study of working class Glaswegian mothers who reported that “there was no tradition of breastfeeding, either currently or historically, within their circle” (1985: 216). In terms of breastfeeding support,



women who have little or no informal breastfeeding support and a low-level exposure to breastfeeding may contribute to the low uptake and duration of breastfeeding. Dykes and Williams (1999) suggest that the most important source of support comes from empathy and approval of a mother's own mother and that a lack of support may lead to early breastfeeding cessation. As a result, peer support programmes must be linked with social network breastfeeding education and promotion in order to maintain breastfeeding duration.

A lack of social network support and lack of exposure to public breastfeeding may explain why women go to great lengths to avoid breastfeeding in public and why the majority preferred to breastfeed away from the public gaze. The impact of the Breastfeeding etc. (Scotland) Act (2005) remains unclear. Although 62 percent of Scottish mothers at stage 2 (4-6 months old) were aware of the introduction of the Act, only 23 percent of mothers in the UK breastfed in public within the first six weeks following birth (Bolling et al 2007).

## **Summary**

This chapter operates at an international, national and local level to provide an epidemiology and policy background in relation to breastfeeding practice. Although this chapter explores the benefits of breastfeeding for infants, their mothers and society, it introduces the concept of breastfeeding in public and private spaces: the main focus of this thesis.

There is a large body of evidence to suggest breastfeeding protects infants against short-term health conditions. Breastfed infants are less likely to be diagnosed with infections affecting the gut and chest than formula fed infants. Similarly, there is a growing body of literature that suggests mothers who breastfeed develop protection against conditions in later life such as cancer and cardiovascular disease. Society also gains from a mother's decision to breastfeed in terms of economic benefits to the NHS and potential economic benefits for employers. Over 80 percent of women in the UK were aware of, and could name, the health benefits of breastfeeding: 87 percent of mothers choosing to breastfeed did so because of the health benefits to the baby. However, these influences did not promote the duration of breastfeeding in private and public spaces.

The epidemiology of breastfeeding suggests that currently the UK has one of the lowest rates of breastfeeding in Western nations and those geographical variations not only exist between countries but also within countries. Socio-economic factors also play a role with the highest incidences of breastfeeding found amongst older mothers, those in managerial or professional occupations and those who were educated beyond the age of 18 years. As a result, it is no surprise that similar socio-demographic findings are evident when looking at women who choose to breastfeed in the public sphere.

In response to the well-documented benefits of breastfeeding and geographical variations in breastfeeding rates, global, national and local policies have been implemented over the last 30 years to promote, protect and support breastfeeding practice. Policy implementation is based almost exclusively on the medical approach to breastfeeding. Whilst such approaches have been successful in terms of increasing the incidence of breastfeeding rates, improved duration rates have been harder to achieve. Peer support programmes go some way to adopt a less medical approach to breastfeeding and provide a woman-centred approach. Although such programmes have increased the initiation of breastfeeding, they have had little impact on breastfeeding duration rates. The Breastfeeding etc. (Scotland) Act (2005) is a welcome new approach to tackling some of the cultural barriers mothers face when breastfeeding in front of others. However, its impact on the duration of breastfeeding rates has not been demonstrated.

As there is evidence to suggest that the majority of infants were breastfed in the UK until the 1930s the next chapter will go on to discuss the historical, social and cultural factors that have impacted on initiation and duration of breastfeeding in private and public spaces over time.

## **Chapter 3: Power, control and regulation: twentieth century political, scientific and cultural influences**

This chapter reviews the literature surrounding influences on twentieth century infant feeding practices in the UK. It will do that by briefly highlighting the political, scientific and cultural factors underpinning infant feeding practices throughout the twentieth century. The chapter then moves on to discuss the social meanings ascribed to women's bodies over time and how these have impacted on women's choices of infant feeding method. The final section explores how social and spatial factors play a significant role in influencing a woman's decision to breastfeed in private and public spaces. In doing so the chapter draws on a range of disciplines including medical history, anthropology, sociology, geography, social policy and feminist theory. However, it is not the intention of the chapter to provide a definitive discussion of breastfeeding throughout the twentieth century rather, particular attention will be paid to several key influences on infant feeding.

### **Twentieth century infant feeding practices**

Until the mid nineteenth century breastfeeding was the cultural norm in all societies (Palmer 1993). Although this statement is literally correct, the historical literature (Jelliffe & Jelliffe 1978; Oakley 1984; Fildes 1986; Apple 1987; Carter 1995; Wainwright 2003; Bryder 2005; Ferguson et al 2006) suggests that the history of breastfeeding is complex, whereby women, unable or choosing not to breastfeed, often experimented with a range of cows' milk mixtures as a substitute for breastfeeding. As Dykes states:

“The global history of infant feeding is very complex, with women supplementing breast milk with a range of alternative, symbolic foods, often from an early age. Practices were highly varied, as influenced by prevailing socio-economic systems, cultural beliefs about the role of women as mothers, and the material conditions of women's lives” (Dykes 2006:26-27).

Carter (1995) suggests that in the early years of the twentieth century the majority of mothers were aware that breastfeeding was best for babies. However, throughout history there have been many reasons why infants were not breastfed and these include poor health or the death of the mother and a

mother's work outside the home. Such issues were seen as the main contributory factors to the short duration of breastfeeding and were firmly linked with infant mortality and poor mothering. Prior to becoming the first Minister of Health in 1919 Newman's publication *Infant Mortality: a social problem* (1906) highlighted the links between epidemic diarrhoea and breast milk substitutes and stated that:

“It is the ignorance and carelessness of mothers which causes a large proportion of infant mortality” (Newman 1906; cited in Carter 1995: 41)

The notion that mothers were ‘ignorant and careless’ was also discussed by the Bureau of Social Research (1927). This report on infant welfare explained that a young mother's failure to breastfeed, because of work outside the home, and a perceived ‘prevailing desire for amusement’, was seen as the main cause of infant mortality (Carter 1995: 41). However, despite the relationship between women's work, early breastfeeding cessation and infant mortality being inconclusive, early infant feeding policies centred on keeping mothers out of the workplace and in the home.

Persistent concerns about rising infant mortality at the beginning of the twentieth century (“15 percent of all infants in England and Wales died in the first year of life” Dunn 2005: 278) and the poor health of the population led to an increasing interest in infant feeding from both a political and medical perspective (Doyal and Pennell 1979; Lewis 1980; Palmer 1993; Carter 1995; Dykes 2006). This interest resulted in a number of events occurring over time which have impacted on the way infants were fed within the UK. Dykes (2006) suggested that up until the twentieth century infant feeding was considered the domain of women. However, this was about to witness significant change.

### ***Political involvement in infant feeding in the early years of the twentieth century***

Political involvement in infant feeding stemmed from the rapid decline in breastfeeding initiation and duration rates in the early years of the twentieth century and increasing concerns about infant mortality (Palmer 1993). Literature exploring infant feeding practices in England during the first two decades of the

twentieth century suggested that the most important single factor affecting the infant mortality rate (IMR) was the way in which babies were fed (Fildes 1998). The Liverpool Medical Officer of Health (1907) calculated that death rates from infant diarrhoea in breastfed infants were 20 per thousand while those infants fed on cow's milk were 440 per thousand (Bryder 2005). Sir James Spence, later Professor of Child Health in Newcastle, 30 years on, argued that increasing breastfeeding rates would help save the lives of 15,000 infants in Britain each year (Spence 1939 cited in Bryder 2005).

In an attempt to reduce infant mortality, infant feeding policies in the early twentieth century operated at two levels. Firstly, they proposed increasing breastfeeding rates and secondly they felt that it was important to ensure the provision of safe formula milk. In terms of increasing breastfeeding rates, policies centred on keeping mothers out of the workplace and emphasised the role of "good and natural mothering" at home under the surveillance of middle class women (Carter 1995: 42). Surveillance of new mothers involved sending lady/health visitors into the homes of working class mothers in order to promote and support the initiation and duration of breastfeeding, while women unable to exclusively breastfeed were advised on the safe preparation and storage of breast milk substitutes (Fildes 1998).

Although breastfeeding was encouraged as the optimum way to feed an infant, the depiction of working class women as both poor and ignorant led UK infant feeding policy to promote the growth of municipal milk depots, and to supply safe breast milk substitutes. By 1907, 15 milk depots had been opened in the UK supplying, at reduced cost, a 'safe' alternative to breast milk for mothers who provided a good reason for abandoning breastfeeding. The Glasgow milk depots opened in 1904 and, within the first 6 months, 314 Glaswegian infants had been provided for (Ferguson et al 2006). The numbers of mother and infant pairs attending the milk depots rose in the early years of the scheme and then fell again when a letter of referral from a general practitioner excusing mothers from breastfeeding was required (Ferguson et al 2006). Further attempts to deter women from attending the depot were evident in that mothers were advised that formula milk would only be administered on the condition that infants were brought in every two weeks to be weighed. This gave health care providers the opportunity to gather information about infants and, more

importantly to offer education on childcare practices (Ferguson et al 2006). Wainwright (2003) argues that the intention behind milk depots was not to reduce a mother's responsibility to breastfeed her infant, rather, breastfeeding was considered a child's "birthright" (MOH report 1915; cited in Wainwright 2003). Oakley (1984) maintains that these depots signified the beginning of surveillance, monitoring and guidance of maternal behaviour through the work of health professionals. In addition to political influences, the twentieth century had also begun to witness the introduction of what would be known as "Scientific Motherhood" (Apple 1987: 97).

### ***Scientific influences undermining breastfeeding practice***

American social historian Rima Apple argued that medical attitudes throughout the twentieth century worked to undermine breastfeeding practice. Apple describes how "scientific motherhood" promoted formula feeding under medical supervision (Apple 1987: 97). Medical supervision inadvertently worked to promote formula feeding on three levels: scheduled breastfeeding, hospital births and a lack of breastfeeding knowledge. Although women had maintained the responsibility for childcare at the turn of the twentieth century, scientific approaches to infant feeding were adopted by male medical practitioners. This exposed a growing need of health professionals to adopt a supervisory role in the regulation of women's bodies and breastfeeding (Apple 1987 and Dykes 2006).

Health visitors played a key role in promoting and supporting mothers with breastfeeding at home while, at the same time, providing information guides (from the Registrar) to all parents. A parental information guide entitled '*Hints Regarding the Management of Children*' recommended that:

"If the mother is able to nurse the child it should have nothing but breast milk for five or six months. It should be put to the breast at regular intervals-every two hours during the day for the first two months, and this interval gradually increased till it is fed about every four hours" (MOH report 1913; cited in Wainwright 2003: 169).

This practice of restricted breastfeeding was central in the work of Dr Frederic Truby King, a New Zealand health reformer and founder of the *Society for the Health of Women and Children* in New Zealand (commonly known as the Plunket Society). Invited to establish a British model of infant welfare at the end of the

First World War, King founded the UK *Mothercraft Training Society* in 1918 with the main aim being to encourage the uptake of breastfeeding and promote the message that ‘breastfeeding mothers made better mothers’ (Bryder 2005). In his book *Feeding and Care of the Baby* (1924) King stressed the importance of breastfeeding and discipline. King’s methods, popular in post-war Britain, advocated strict four hourly feeds with no night feeds in order to prevent the risk of over feeding which he considered to be “more dangerous than under feeding in breastfed infants” (since it was linked to increased risk of diarrhoeal infections) (Wickes 1953: 500). In addition, the idea of feeding by the clock was to allow mothers some free time between breastfeeds and prevent the onset of anxiety (anxiety in mothers was considered at the time to disrupt both the quality and quantity of breast milk). King suggested restricted feeding prevented a mother becoming:

“overworked or worried, simply because she knows that by following the laws of nature, combined with common sense, baby will not do otherwise than thrive” (King 1937; cited in Mander 1996: 3).

The British journal *Mother and Child* claimed that at his death in 1938 King had “hypnotised thousands of mothers into the belief that breastfeeding was the most important factor in infant care” (Bryder 2005: 182), with his slogan “Breast fed is Best fed” (Wickes 1953: 500). However, in advocating the practice of restricted breastfeeding this in turn worked to undermine a woman’s ability to maintain breastfeeding.

Rotch, a professor of childhood disease at Harvard University, published a paper entitled ‘*The management of human breast milk in cases of difficult infantile digestion*’ (1890). In it, Rotch described breastfeeding as a production process whereby the breasts are:

“Beautifully-constructed mills, turning out when demand is made” and breast milk is “a product which has been directly moulded within their walls” (Rotch 1890: 89; cited in Dykes 2006: 28).

Rotch described the female body as a machine and argued that breasts and breast milk were required to be managed in order to maintain the correct quantity and quality of breast milk. Rotch recommended that three components were required in order to maintain breastfeeding. Firstly, a mother should pay particular attention to her diet and, in particular, mothers were recommended

to eat meat in order to increase fat in their breast milk. Secondly, mothers were to avoid any stress and ‘unstable states’ as these were seen as the cause of an imbalance in the properties in breast milk. Finally, a woman’s behaviour was required to be regulated to ensure timely breastfeeds (Rotch 1890 cited in Dykes 2006: 29).

Vincent (1910), a senior physician at the Infants’ Hospital Westminster, London, concurred with Rotch (1890) and King (1924) on timely and restrictive feeding and suggested that in order to avoid a chaotic approach to infant feeding:

“Infants should be given the breast every four hours [...]. It is a serious mistake to allow the infant to take freely of the colostrum when it is plentiful. In anything but a small amount, colostrum seriously disturbs the infant” (Vincent 1910; cited in Dykes 2006: 30).

This practice of prescribed breastfeeding intervals and restricting the amount of time infants spent at the breast had a detrimental effect on a woman’s ability to establish and maintain breastfeeding. As breast milk is produced on a supply on demand basis, restricting any access to the breast impacted on the amount of milk that a mother would produce. This led to the condition commonly known as ‘insufficient milk syndrome’ (IMS) (an issue that will be discussed further in the next section of this chapter). Thus, medical guidance to promote breastfeeding at the beginning of the twentieth century actually increased the likelihood that women would be unable to establish and maintain their milk supply.

The introduction of hospital births at the turn of the twentieth century also provided a space in which the “principles of production, surveillance and time predominated” (Dykes 2006: 31). From the early 1900s up until the 1970s, the majority of European and North American infants were born in hospitals. Hospitalisation for women during childbirth rose from 15 percent in 1927 to 66 percent in 1958 (Carter 1995) and by 2006 approximately 98 percent of births took place in UK hospitals (Dykes 2006). This increase in hospital births raised issues surrounding infection control which in turn contributed to the separation of mothers and their infants during their stay in hospital (Palmer 1993). Hospitalisation of childbirth placed infants in special nurseries while their mothers occupied rooms that were a distance away. Mothers met with their infants every four hours to put them to the breast for 20 minutes then infants were returned to the nursery; those infants not receiving the amount of feed



they required were given additional formula milk (Dykes 2006). However, the harmful practice of separation and topping up infants with formula had a detrimental effect on a woman's ability to breastfeed, often leaving women feeling that their milk supply was inadequate and that formula feeding was their only option.

Harmful breastfeeding practices and the increased use of formula milk in hospitals went a long way to reinforce the notion that not all women were capable of producing enough breast milk for their infants. Emmett Holt, Professor of Diseases of Children at Columbia University, contended that breast milk could be unreliable and reported that 75 percent of New York upper class women were unable, rather than unwilling, to suckle their infants. However, Wolf argues:

“The notion that human lactation is an unreliable body function became a cultural truth that has persisted unabated to the present day” (Wolf 2000: 93).

Apple (1987) suggests that the decline in breastfeeding rates throughout the twentieth century can be attributed to a lack of breastfeeding knowledge amongst medical professionals. Mothers experiencing breastfeeding problems were encouraged to formula feed as doctors and midwives apparently found it easier to suggest weaning than attempting to manage the breastfeeding problem itself (Apple 1987; cited in Dykes 2006). However, this practice may reflect the lack of breastfeeding training health professionals received. As Sedgwich and Fleischner suggested:

“The hours in medical school devoted to artificial feeding stands out in striking contrast to the casual attitude which is so frequently taken in discussing with students the advantages of maternal nursing” (Sedgwich & Fleischner 1913; cited in Apple 1987: 75).

Even those doctors committed to breastfeeding openly supported the convenience and healthfulness of formula feeding (Dykes, 2006; Apple, 1987; Wolf 2000). According to Apple (1987), such endorsements resulted in a downturn in breastfeeding practice and actively promoted the view that formula-fed babies were as healthy as breastfed infants. Dr Williams McKim Marriott took a biochemical approach to paediatric research and in his book

*Infant Nutrition: A textbook of infant feeding for students and practitioners of medicine* Marriott (1930) suggested that:

“With modern knowledge of nutrition, an infant nourished by a prepared formula can be as healthy in every respect as the breastfed infant” (Marriott 1930; cited in Bryder 2005: 181).

Whilst the nineteenth century formula fed baby was viewed as an object of pity, the twentieth century formula fed infant was promoted by medical professionals as ‘healthful’ (Apple 1987).

### ***Medical, political and commercial influences on the use of infant formula***

The medical, political and commercial endorsement of infant formula feeding has had a major impact on breastfeeding rates throughout the twentieth century. As Arneil (1989) reports in 1900, following birth 90 percent of women breastfed in Scotland; by 1945 breastfeeding rates dropped to 50 percent and by 1973 only 15 percent of Scottish mothers chose to breastfeed their infants. Many factors were thought to have led to this dramatic uptake of formula feeding. Factors such as the harmful political and medical practices discussed above were known to have played a significant role in undermining a woman’s confidence to successfully breastfeed. Donnelly and colleagues (2000) argued that free samples of formula milk distributed at health centres and hospitals had also contributed to mothers deciding not to initiate and maintain breastfeeding. In addition, Mead and Newton’s 1960s study found that bottle feeding was considered as both socially and culturally convenient, as it allowed mothers to participate in activities outside the home. Breastfeeding, on the other hand, was considered by middle class women as old fashioned, an activity of the less affluent and a primitive animal-like behaviour (Mead and Newton 1967).

Ever growing multinational formula corporations publicised the convenience of formula feeding using placards, posters and the media, promoting their products as the most desirable way to feed an infant (Sokol 1997 cited in Dykes 2006). Strategic advertising portrayed breastfeeding as:

“Prone to failure, unsophisticated, outmoded and primitive whilst formula feeding was associated with affluence, consumerism and the liberated woman” (Dykes 2006: 32).

Apple (1987) gave an account of how formula feeding could be liberating. She reported that increasing numbers of women chose not to breastfeed and felt constrained when having to stay home to breastfeed. As Apple explained:

“Nursing tied them down, as changes in American society not only altered women’s domestic role but also expanded their activities outside the home” (Apple 1987: 173).

Again, this quote reinforces the notion that breastfeeding only occurs within the privacy of the home and, in order to enter public spaces, women wanted a convenient and safe alternative to breast milk. Advertisements produced by formula milk companies and endorsed by medical staff promoted formula milk as safe, fit for royalty and for the majority of mothers provided the perfect alternative to breastfeeding. As figure 9 below states:

“Twelve royal babies to date have been fed on COW & GATE. Can you do better for your baby... it’s the best that money could buy, and the best possible start in life” (Cow & Gate Advertisement 1940s & 1950s).

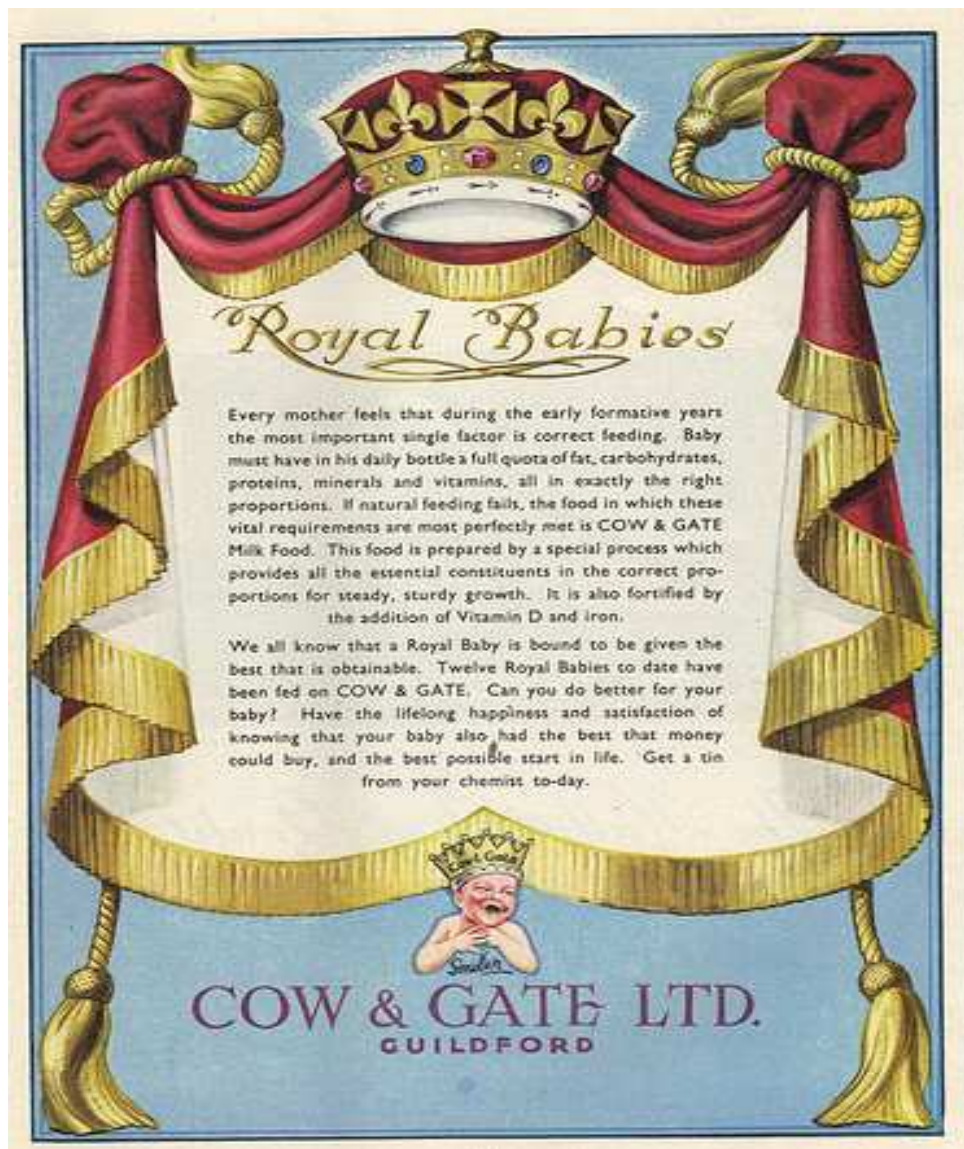


Figure 9: Cow & Gate Advertisement Published Widely in the UK (1940s and 1950s)

The Second World War also paved the way for the acceleration of formula feeding. A “National Dried Milk” produced in bulk, was made available to all nursing mothers in order to improve the health of the nation. National Dried Milk was not only cheap, it was provided free of charge to all mothers facing financial difficulties (Darke 1988). The existence of an abundant and cheap infant formula made formula feeding possible for all. Government investment in formula milk was illustrated by Winston Churchill’s statement:

“There is no finer investment for any community than putting milk into babies” (Winston Churchill 1943; cited in Carter 1995: 55).

As well as the political endorsement, formula companies gained credibility for their products by marketing through hospitals and health care workers, which in

turn boosted their sales. Medical employees were rewarded for their role in promoting formula feeding by receiving lavish gifts and financial incentives (Dykes 2006) and infant feeding specialists such as Truby King had produced their own powder milk. As the multinational formula companies continued to expand they became involved in the design of new maternity units/hospitals. In order to meet their own interests and promote the use of formula milk, the practice of separating mothers from their infants continued, providing an environment where formula feeding became almost a necessity. Such damaging hospital practices made breastfeeding very difficult to maintain (Baer 1982).

Carter (1995) argued that this rise in formula feeding provided women with control over their lives and enabled them to resist the self-monitoring of their bodies. The rise of formula feeding also promoted the breasts as sexual objects, and with that came the notion that breastfeeding would only be acceptable within the privacy of the home, thus removing the need for breastfeeding to take place in public (issues that will be explored further within the next section of this chapter).

As stated earlier, by 1945 almost 50 percent of Scottish women chose to use formula milk when feeding their infants. As depicted in figure 10 below formula feeding had become the cultural norm:



**Figure 10: Daughters of James Ferdinand Irwin USA bottle-feeding their babies  
Family reunion celebration marking the return of Irwin's sons from service in WWII**

Although formula companies were successful and remain very successful in promoting breast milk substitutes, their focus was not on the health of infants or their mothers. As discussed in Chapter 2, infants and their mothers are less likely to get ill or die prematurely if they were breastfed/breastfeeding. As a backlash against the promotion of infant formula feeding and medical control over women's bodies pro-breastfeeding organisations were established in the 1950s to support women in their attempts to breastfeed.

### ***Pro-breastfeeding organisations and the backlash against formula feeding***

The establishment of lay movements to promote natural childbirth and child rearing was viewed as a backlash to the lack of political and medical interest for breastfeeding in the post war period. In opposition to the growth of medical control over childbirth and the growth of infant formula companies, three pro-breastfeeding organisations were established (Carter 1995). The National Childbirth Trust (NCT) was established in the UK in 1956, and it aimed to restore breastfeeding as the norm by empowering women to breastfeed through advice and support (Carter 1995). La Leche League (LLL), American in origin and launched in the UK during the 1970s, developed peer support networks for breastfeeding mothers (run by women who had breastfed or were continuing to breastfeed) within local communities (LLL 2003a). Much later the Breastfeeding Network (BfN) was established in the UK in 1997. The BfN adopted an inclusive approach to breastfeeding support, placing a specific interest in providing outreach and breastfeeding support centres for women living within areas of social deprivation.

Despite the efforts of pro-breastfeeding organisations, in 1975 breastfeeding rates had reached an all time low. However, scientific evidence published at this time promoted the health benefits associated with breastfeeding for both new mothers and their infants. Although breastfeeding had always been linked with the notion of 'good mothering', the influx of breastfeeding literature led the UK government to readdress breastfeeding as a priority policy issue. The following statement from the Department of Health and Social Security suggests that, in order to maintain health infant growth all infants should receive their mothers' milk:

“We are convinced that satisfactory growth and development after birth is more certain when an infant is fed an adequate amount of breast milk, we recommend that all mothers be encouraged to breastfeed their babies for a minimum of two weeks and preferably for the first four to six months of life” (DHSS 1974: 24).

Apple (1987) suggests that within three generations, between the late nineteenth century and mid twentieth century, the majority of American mothers no longer breastfed and babies received formula milk under medical supervision. The UK paints a similar picture and as a result infant feeding practices up until the mid 1970s resulted in a lost tradition of breastfeeding (Arneil 1989).

### ***Breastfeeding: a lost tradition***

When breastfeeding ceased to be the cultural norm, the levels of knowledge and support within communities for breastfeeding mothers were reduced. As only 15 percent of women in Scotland breastfed during the 1970s, the support for breastfeeding within social circles was also lost. This raised issues surrounding the role and purpose of a woman's body. In Western societies it is likely that a new mother may have never seen a woman breastfeed, especially in public (Palmer, 1993). A qualitative study of 69 working class women in Glasgow, Scotland, found that the majority of women interviewed had no prior exposure to breastfeeding (McIntosh 1985). The author noted that there was:

“No tradition of breastfeeding, either currently or historically, within their circle” (McIntosh 1985: 216).

This resulted in 80 percent of mothers choosing to bottle feed due to the “social unacceptability” of breastfeeding. Women in this study suggested that the need to expose their breasts in order to feed their baby was “potentially embarrassing, restricting and social isolating” and as a result women went to great lengths to avoid breastfeeding in public places (McIntosh 1985: 216).

Furthermore, little has appeared to have changed in working class culture since the mid 1980s. Scott & Mostyn's study of a peer support intervention conducted in Glasgow in 2003 found that women in their sample had little or no prior experience of breastfeeding and, with the exception of their husbands they received little breastfeeding support from family or friends. Of this sample of



lower social class women with low educational attainment, the majority of mothers indicated that they had been the first in their family to breastfeed and did not know any friends that had previously breastfed. In addition, their choice to breastfeed had made them different from other women in their social circle. As a result many women talked about a continual pressure from family and friends to bottle feed. Conversely, research conducted in a socio-economically deprived area in the East End of London had found that women who had regularly seen relatives or friends successfully breastfeed were more confident in their decision to breastfeed and were more likely to succeed (Hoddinott & Pill 1999).

Although there has been a ban on the advertising of infant formula since the 1980s and breastfeeding rates are currently increasing (as discussed in chapter 2), the promotion of bottle feeding remain robust within UK culture. This is depicted in figure 11 where a high street retailer sold a feeding bib sized to fit a newborn infant, as part of a three-part set:



Figure 11: Infant Feeding Bib, Next: Christmas 2009.

In summary, breastfeeding throughout the twentieth century was firmly linked with “good and natural mothering” whilst choosing not to breastfeed in the early 1900s was associated with “ignorance and carelessness”. However, this notion of



ignorance and carelessness could more aptly fit medical and political influences, which inadvertently worked to undermine the role of breastfeeding and promoted the use of formula feeding through the supervision and management of women's bodies. By the mid 1900s formula feeding was promoted as healthful. Harmful practices, such as restricted breastfeeding and the promotion of formula milk, encouraged women into believing they were unable to produce the quantity and quality of milk required for healthy infant growth. This highlighted the lost tradition of breastfeeding and brought to the fore issues surrounding the role of the female body.

## **The female body and women's infant feeding choices**

Over the last thirty years, the body has become a major concern of academic study. Much of the contemporary debate on the body stems from the work of feminist theorists such as Oakley (1972) and postmodernist writers (Butler 1990; Grosz 1994; Shildrick 1997). The past decade has also witnessed increasing literature on women's bodies emerging from the study of geography (Longhurst 2001; Mahon-Daly & Andrews 2002). These approaches have witnessed a shift from traditional studies of the body, in terms of the power and sex differences between men and women (Oakley 1972), to the lived experiences of women's bodies in their everyday lives. This section will discuss the social meanings ascribed to women's bodies and how in turn this has influenced and impacted on women's infant feeding decisions.

Historically, ideas about women's bodies have played a considerable role in either challenging or maintaining power relationships between men and women, which feminists have described as patriarchal, whereby women are located lower on hierarchies of power in all aspects of their social, political and personal life. The control of female bodies has been linked to the growth of a male dominated medical system (as discussed above), and the sexual appropriation of women's bodies (Weitz 2003).

Throughout history perceptions of women's bodies have varied according to social status. While working class and poorer women were seen as robust, their middle-class counterparts were often viewed as physically and emotionally frail as a result of their affluence. These frailties were used by medical practitioners

as justification for restricting women's rights to maintain a career and participate in education. The president of the Oregon State Medical Society, Van Dyke claimed:

"That hard study killed sexual desire in women, took away their beauty, and brought on hysteria [...]. Educated women, he added, would not be able to bear children with ease because study arrested the development of the pelvis at the same time it increased the size of the child's brain and therefore its head. The result was extensive suffering in childbirth by educated women" (Van Dyke 1905 cited in Weitz 2003: 6).

Attempts to rid middle class women of such perceived extensive suffering during childbirth led doctors to perform radical surgery to remove the ovaries and uteruses of women displaying signs of rebelliousness or depression as a result of their restricted roles in society (Weitz 2003).

However, it was not until the development of second wave feminism in the 1960s that practical attempts were made to tackle these and other issues of inequality experienced by women. One of the first issues tackled by the feminist movement was the introduction of the contraceptive pill (Hooks 2000). The 'pill' paved the way for the sexual liberation of women, allowing women for the first time to take control of their reproductive body. Adrienne Rich argued that as women took control of their bodies, a new social change emerged.

"The repossession by women of our bodies will bring far more essential change to human society than seizing of the means of production by workers...We need to imagine a world in which every woman is the presiding genius of her own body" (Rich 1979: 285-286).

Women's liberation set out to challenge the sexist ideology that female worth rested solely on their physical appearances, looking good for men and their biological capacity to produce offspring. Promoting a notion of self-love of the body saw feminists strip their bodies of restrictive clothing, worn for male pleasure and work, replacing them with comfortable clothing. For many middle class women, embracing their newfound liberation meant abandoning their make-up, uncomfortable dresses and crippling high heel shoes. However, this came at a price when the media opted to portray feminist actions as "just plain old ugly" (Hooks 2000: 32).

However, as the feminist movement continued to take hold, a backlash emerged (Faludi 1991). One area where this was particularly evident was the increasing pressure on women to control their appearance and body shape. Orbach (1989) and Chernin (1983) argued that the natural size and shape of women's bodies are undermined by patriarchal forces (Shilling 1993: 56). This was evident in the overwhelming images of "the ideal woman with messages that love, acceptance and approval from men were dependant on the right appearance" (Baumslag & Michels 1995: 7). At the beginning of the twenty-first century the fashion industry denied mature adulthood by promoting the infantilisation of women's bodies as narrow-hipped slim women: an image that seemed more appropriate to that of a teenage girl than a fully developed breasted woman (Weitz 2003).

As well as women's bodies, a woman's breasts have also had their own particular place in patriarchal cultures. Women reported that their level of attractiveness was regularly judged by the size and shape of their breasts. As Young states:

"For many women, if not all, breasts are an important component of the body self-image; a woman may love them or dislike them, but she is rarely neutral" (Young 2003: 152).

Although breasts are viewed in Western culture as the most visible sign of sexuality, a woman's breasts are often perceived as belonging to others; they belonged to a partner, husband or infant rather than women themselves (Young 1990).

### ***The multidimensional nature of the female breasts***

Women's breasts have been characterised as multidimensional, having both sexual and nurturing functions (Stearns 1999). However, the emergence of a body-obsessed sexualised culture in Western society played a significant role in contributing to the dwindling rates of women using their breasts to feed their infants. Yet this was not true for all societies since there are cultures where breastfeeding an infant is a normal activity and breasts are not seen as sexual objects. As Dettwyler (1995) states:

"In most cultures around the world, breasts hold no sexual connotations for either men or women. Sexual behaviour does not involve the breasts, which are perceived as existing for the sole purpose of feeding children" (Dettwyler 1995: 175).

However, the dominant value in Western society is that breasts are to be looked at and enjoyed by grown men and not babies (Carter 1995). Indeed, this is evident in Bacon & Wylie's survey in 1976 examining the attitudes of 200 mothers in Newcastle, England. The authors found that for some mothers, "the idea of suckling a baby was repugnant, embarrassing and a few regarded breastfeeding as primitive" (Bacon & Wylie 1976: 309).

Carter's (1995) retrospective study (1920-1980) focused on working class women also from Newcastle, England, and their experiences of breastfeeding. This study suggested a powerful link between good mothering and breastfeeding where being a good mother was associated with the desire and the ability to [breast] feed 'naturally'. However, given the strong cultural preference for the sexualisation of breasts within Western societies, women who choose to breastfeed merge the boundaries of the good maternal body and woman as sexual objects. Stearns' (1999) qualitative study examined the breastfeeding experiences of 51 USA women and argued that:

"The sexual aspects of women and the maternal aspects of women are expected to be independent of each other. Thus, breastfeeding raises questions about the appropriate uses of women's bodies, for sexual or nurturing purposes" (Stearns 1999: 309).

The idea that the nurturing and sexual nature of breasts as two separate entities, that never cross paths, could be regarded as naive. It is well documented in the medical and cultural literature that the very nature of breastfeeding can lead to sexual responses. During the 'let down' reflex (which allows the milk to flow from the breasts) oxytocin levels are raised. The rise in oxytocin levels is also evident during sexual activity (Riordan & Auerbach 1999: 103) and as a result, oxytocin has been labelled a 'love hormone' (Bartlett 2005). Masters and Johnson's (1985) study of sexuality in the 1960s suggests "women often become sexually aroused during nursing" (Masters & Johnson 1985: 136). However, Stearns (1999) suggests that the characterisation of a good maternal body as non-sexual is taken very seriously in law and culture and, as a result, few women are likely to report experiences of breastfeeding and sexual feelings. Bartlett (2005) argues that breastfeeding should be accepted as potentially sexual, rather than simply just about nutrition. Attempts to break down the barriers between the sexual body, breastfeeding and good mothering are depicted in the following photograph of the model Lucy Lawless; most

famous for creating the role of Xena Warrior Princess in the series Hercules. The poster below was an attempt to restore a national breastfeeding culture in New Zealand and was released as part of World Breastfeeding Week in 2002.

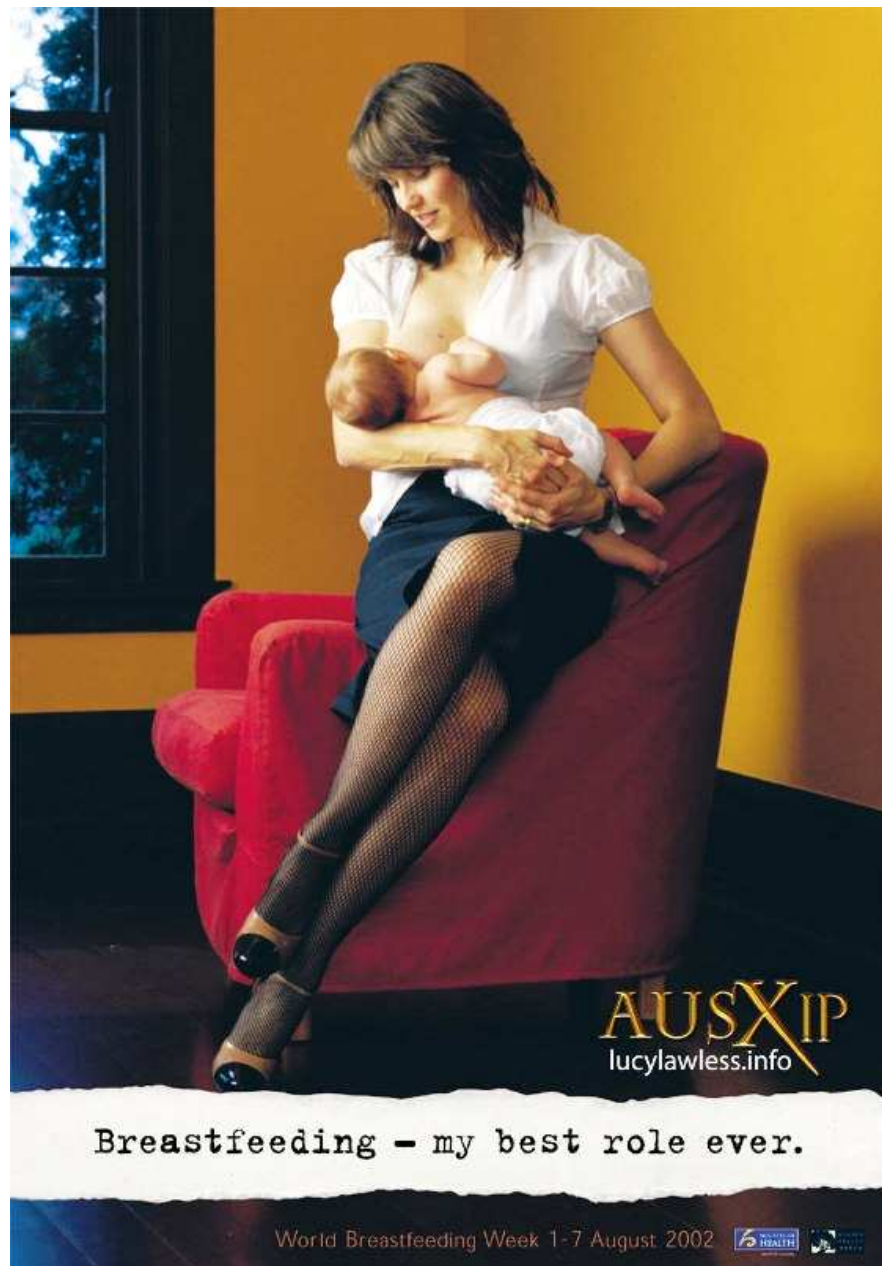


Figure 12: Photograph of Lucy Lawless (WHA World Breastfeeding poster 2002)

It is obvious that this is a staged photograph that deliberately mixes the visual cues of the sexualised body and the maternal body. Lawless is wearing a white puff-sleeved shirt, a short black skirt, fishnet stockings and stiletto heels. She sits perched on the arm of a chair, cross legged, staring adoringly at her baby boy as she breastfeeds (Shaw 2004).

Displaying posters of breastfeeding women that combine the act of breastfeeding with sexy images of women's bodies was found to be contentious. Young suggests that breastfeeding and "breasts are a scandal because they shatter the border between motherhood and sexuality" (1998: 132-133). Furthermore, Shaw (2004) found that the distribution of Lawless' poster to secondary schools, child-care centres, community groups and health care providers provoked controversy. For example, one health organisation suggested that placing Lucy's poster on the walls of their facilities would make people feel uncomfortable in the building and may deter them from seeking further healthcare.

A final point to be raised about Lucy's photograph relates to the quote "Breastfeeding - my best role ever". This fits in neatly to Butler's (1990, 1993, 1997) theory of "performativity of gender". Butler argues that "the acts by which gender is constituted bear similarities to performance acts within theatrical context" (Butler 1990: 272). Similarly, Bartlett (2002) found the notion of performativity particularly appropriate in relation to its ability to portray "breastfeeding as quite specific to each act, rather than assuming homogeneous experiences between women or even for one woman over time and place" (2002: 113). This analogy of performativity displaces the notion of breastfeeding as a natural bodily activity and recognises that, in choosing to breastfeed, women may develop a greater understanding about the capabilities and the way they feel about their bodies.

### ***Breastfeeding and the female body***

Mahon-Daly & Andrews' (2002) qualitative study in North London adopted a post-medical geography perspective to investigate the extent to which the practise and performance of breastfeeding is liminal. In the liminal period women may move into a "new world" by experiencing "a new natural state and activity" of their breastfeeding body (Mahon-Daly & Andrews 2002: 65).

Three stages of liminal experiences were proposed by Mahon-Daly & Andrews. First, there was a postnatal period, where women's breastfeeding bodies were viewed as being in a "liminal physical state". Here women's breastfeeding bodies are said to be held in a transitional period (in that they are physically

different, with different functions) before returning to a perceived “normal bodily state”. A common issue for women within this period was the potential conflict between their breasts as sexual or nutritional objects. For many breastfeeding women in their study, breasts were viewed as off limits during sexual activity. As a result, women remained in a liminal physical period as long as breastfeeding continued. Secondly, Mahon-Daly & Andrews (2002) proposed that the emotional experiences of breastfeeding are captured for life. Breastfeeding women developed a new awareness and understanding of their bodies and demonstrated this by sharing their new found knowledge with others. Thirdly, the breastfeeding event itself is often considered as a liminal activity (Mahon-Daly & Andrews 2002: 65). That is, breastfeeding takes place in social spaces and women move in and out of these spaces to avoid causing embarrassment to themselves and others. Women found themselves negotiating places which they deemed as appropriate or inappropriate for their breastfeeding body (an issue that will be explored further in the final section of this chapter).

### ***The embodied experience of breastfeeding***

The embodied experiences of breastfeeding relate to both physical and emotional impacts of breastfeeding (Bartlett 2002; Schmied & Lupton 2001; Bailey & Pain 2001; Kelleher 2006). Schmied & Lupton’s (2001) qualitative study explored the embodied experience of twenty-five first-time middle class breastfeeding parents from Sydney, Australia. Using data up to six months following birth, women in this study viewed their breastfeeding as a crucial part of their maternal identity that promoted a positive relationship with their infant and enhanced their feelings of being a good mother. Mothers in this study also talked about the practical aspects of breastfeeding in two contrasting ways: some found the experience pleasurable and intimate, while others found it unpleasant and disruptive. A third of women described breastfeeding as ‘wonderful’ and related this to bonding, closeness and ‘being at one’ with their infant. However, only a minority of women enjoyed such positive experiences, particularly in the initial weeks following birth. In contrast, two-thirds of women discussed the demands of frequent feeding and constant proximity to their baby as restrictive, while others found themselves crying with pain at each breastfeed (Schmied & Lupton 2001).

Similarly, Kelleher interviewed 52 women from the USA and Canada and found that women face numerous physical challenges associated with breastfeeding during the first month following birth. The author argues that “many women were surprised by the level, intensity and duration of discomfort and pain” they experienced (2006: 2730). This pain ranged from mild and short lasting to being unbearable at times and led several women in the study to question their ability to persevere with breastfeeding. In addition, frequent breastfeeding also left women feeling physically constrained and exhausted. Bartlett (2000) recalls her own personal experience of breastfeeding as:

“Nights sitting up in the dark breastfeeding through the pain of - bad positioning? unfamiliarity? soft nipples? - chanting to myself ‘big strong nipple, big strong nipple’ with tears quietly streaming down my cheeks, thinking ‘this is the pits. It cannot get any worse’” (Bartlett 2000: 180).

Bottorff (1990) argues that the belief of breastfeeding as ‘gift giving’ and a sign of ‘good mothering’ was what motivated many women to persist with breastfeeding. Within Kelleher’s study 90 percent of mothers continued to breastfeed at one month following birth. Similarly Schmied & Lupton’s (2001) study reported that, despite the major challenges breastfeeding women faced, 18 of the 25 mothers continued to breastfeed at 6 months following birth. However, many women reported feeling physically and emotionally unprepared by the challenges that breastfeeding presented.

Bailey & Pain’s (2001) qualitative study of 11 first-time mothers from Newcastle, England, found that mothers attending breastfeeding workshops, and reading baby care manuals and health promotion leaflets, presented women with an “image of breastfeeding as natural”. However, this failed to prepare many women for their actual breastfeeding experiences (Bailey & Pain 2001: 311). As discussed previously, breastfeeding is a learned skill that demands that first time mothers learn about their body in ways that are very different from their previous experiences. In addition, mothers often perceive that the quantity and quality of the milk they produced may be inadequate for healthy infant growth (Hill and Aldag 1991).



### ***The perception of the unreliable breastfeeding body***

Insufficient Milk Syndrome (IMS) is a broad term used within the breastfeeding literature to explain a mother's inability, or perceived inability, to produce adequate amounts of breast milk (Peters 1997). As discussed previously, 98 percent of mothers are capable of producing breast milk for their infants and, as such, IMS is considered to be a belief rather than a medical condition for many women. For example, Earle (2000) suggests that the oppression of women's bodies in Western societies throughout the twentieth century lead women to believe that they are unsuited to breastfeeding. This in part may stem from the historical and medical ideology of a female body as being weak, defective and deeply untrustworthy (Oakley 1984; Martin 1987; Carter 1995; Shildrick 1997; Blum 1999), and/or the notion of the multidimensional representation of the breasts as sexual rather than maternal. However, rather than instinctively acknowledging that, with support, women are capable of providing adequate milk for their infants, women are socialised to substantiate the notion of the unreliable body through the ritual of weighing their babies, which is then reinforced by midwives and health visitors. Infant growth is seen as verification of what Oakley (1984) refers to as: "uneasy balance between a dependence on medical authority and the needs to trust one's own knowledge of one's body" (1984: 283). The production and maintenance of milk is an important happening for breastfeeding mothers but is often reflected in negative terms in the case of IMS or the leaking body.

### ***Women, breastfeeding and the leaky body***

Grosz (1994) introduced the notion of disgust and repulsion in relation to human bodily fluids in general but argues that bodily fluids associated with women's reproductive functions are viewed to be more dangerous and more disgusting than those emitted by men. Grosz theorised that "women's corporeality is inscribed as a mode of seepage" and this in turn has led to a social definition of women's bodies (particularly maternal bodies) as "liquid, sites of pollution" (1994: 203). Aligned with this, Kitzinger (2005) contends that women are "educated to be secretive and ashamed" of their leaky bodies. Breast milk, Kitzinger argues, is regarded as:

“disgusting’, ‘revolting’ and ‘threatening’, a ‘social disgrace’ which must be hidden, it’s an “unclean secretion which streams out freely and at times is socially inconvenient” (Kitzinger 2005: 40).

This conceptualisation was recognised by women and in Mahon-Daly & Andrews’ (2002) study, their sample did not feel in control of their leaky bodies, and felt slightly ashamed of their perceived dirtiness when escaped milk became visible. This notion of dirtiness was reinforced when women noted that formula feeding mothers were far more likely to be offered help and receive assistance when their babies had vomited, when compared with mothers who were breastfeeding.

Similarly, Earle & Robson (2004) argued that any evidence of leaking breast milk would render a woman as lacking control of her bodily functions, reinforcing that breastfeeding should only take place in private and not within public places. Bartlett (2002) suggests that:

“lactating breasts when taken outside the home are capable of disrupting the borders of morality, discretion, taste and politics, breasts are capable of transforming legislation, citizenship, and cities themselves” (Bartlett 2002: 111).

As such, breastfeeding bodies are deemed to require management or at least be subject to a certain level of surveillance.

### ***Under surveillance: managing the breastfeeding body***

McKinley and Hyde (1996) suggest a woman’s body is socially constructed as a sexual object to be scrutinised. As a result of this construction, women have been socialised to view their bodies as if they were outside observers. There is an expectation that women will:

“internalise cultural body standards so that the standards appear to originate from the self and believe that achieving these standards is possible even in the face of considerable evidence to the contrary” (McKinley & Hyde 1996: 183).

McKinley (1995) discusses this experience in terms of objectified body consciousness (OBC). Bartky (1988) and Spitzack (1990) suggest that three dimensions of OBC are important in a woman’s bodily experiences: beliefs about

appearance; control of the internalisation of cultural body standards and body surveillance.

Within the concept of OBC, a woman's body was constructed as an object of male desire and exists to receive the gaze of the male (Spitzack 1990). Constant self-surveillance, seeing themselves as others see them, was a necessary part of ensuring that women comply with cultural body standards and avoid negative judgements. This concept of the women's gaze upon their bodies was illustrated by Shildrick (1997) who argued:

“The gaze now cast over the subject body is that of the subject herself. What is demanded of her is that she should police her own body, and report in intricate detail its failure to meet standards of normalcy; that she should render herself, in effect transparent. At the same time the capillary processes of power reach even deeper into the body, multiplying here not desire but the norms of function/dysfunction. As with confession, everything must be told, not by coercive extraction, but ‘freely’ offered up to scrutiny” (Shildrick 1997: 49).

This notion of self-surveillance was particularly relevant to breastfeeding women, as breastfeeding around others has the ability to highlight challenges. Such challenges may stem from the cultural preference to see breasts as sexual objects. Many women were expected to monitor and resist the male gaze by withdrawing to a private space or negotiating their behaviour in the public spaces in order to achieve discretion while breastfeeding (Carter 1995).

### ***Summary: social meanings ascribed to women's bodies***

The historical literature suggests that the social meanings ascribed to women's bodies affected the way in which women live. In Western cultures the female body has been portrayed as uncontrolled, unclean, and inadequate; as a result, women's bodies have been required to be managed and self-monitored. This notion of monitoring and self-surveillance was particularly evident amongst women who chose to breastfeed in a society that objectifies breasts as sexual objects rather than providers of infant nutrition.

## Breastfeeding in private and public spaces

The theoretical concepts of private and public spaces have been debated across many disciplines within the literature while being subject to various interpretations. It is argued that the private/public distinction is gendered and that this stems from inequalities of power between men and women and women's traditional confinement to home based domesticity. This notion of private and public distinction has restricted women to the private space of the home, away from the male dominated public spaces. The final section of this chapter will explore how social and spatial factors have impacted on women's decisions to initiate and continue breastfeeding in the public and private spaces within Western societies.

### *The private/public distinction*

The origin of private and public can be traced back to Aristotle's distinction between the *oikos* and *polis* (Arendt 1958). The former related to the home where the master (male) of the home ruled (Mahajan 2009). As Habermas stated:

“The reproduction of life, the labour of the slaves, and the service of the women went on under the aegis of the master's domination” (1989: 3).

The *polis* symbolised the public political domain where only those deemed as citizens would collectively gather to engage in decision making processes for the common good (Mahajan 2009). As such, the concepts of private and public appear to be related to individuals. However, when modern liberals talked about the notion of private space they discuss it in terms of the space occupied by individuals rather than the individuals themselves. They refer to private space (mainly in terms of the home) as excluding all external agencies, in order to promote a level of liberty and freedom to do as one would please within their own space. At first the distinction between public and private space appears to be self-evident. Public refers to society, the community, and the common good: things that are shared and common to all. Conversely, the term private signifies something that is a closed, intimate, a somewhat more exclusive arena shared by family and friends (Landes 1998). Butler and Parr (1999) contend that public

space can be anything from the city, the street outside, the park, a maternity unit, restaurant or café while private space relates to the domestic space of the home.

Furthermore, it is well established in the geographical, anthropological, sociological, political and feminist literature that gender has a profound impact on an individual's perceptions and experiences of everyday spaces (Johnson et al 2000; Rosaldo 1974; Bartlett 2002; Watson & Doyal 1999). As briefly mentioned above, women's historical lack of power relative to men (Rosaldo 1974) was reflected in the way space was used, organised and controlled by men (Ardener, 1993). The concept of public and private space needs to be understood in terms of traditional patriarchal social relations (Walby 1990). As Dominelli has described:

“defining womanhood in terms of domestic labour confines women to the private arena, while men dominate the public one where knowledge, power and authority prevail, keeping the two spheres separate is essential in maintaining relations of subordination and domination of women” (Dominelli 1991: 267 in Carter 1995).

Johnson (2000) suggests that the design of cities and homes in the early 20<sup>th</sup> century were based on expectations that, within the family unit, the man would leave the house for employment in the inner city whilst women tended to the home and childcare. Moreover, Watson & Doyal (1999) suggests that the city continues to be designed by men for men, while the home is seen as a female space. However, within middle class homes each member of the household would hold claim to their own space with the exception of the women. This reflects the idea that women's spaces are often shared spaces, either a site of labour (the kitchen) or a sexual sleeping area (bedroom) where men continue to dominate. The phrase “a man's home is his castle” reinforces the traditional associations of patriarchal expression within the home (Duncan 1996: 131). The suburban home was represented as a warm home to which men returned after a hard day at work in the city while women were restricted in the suburbs; the home was suited to nurturing, passive and subordinate mothers. Virginia Woolf's innovative essay *A Room of One's Own* (1929) provided a set of arguments about bringing women's non-domestic work into the private sphere. Woolf suggests that £500 a year and a space away from the oppressive private world of home

and family was indispensable in order for women to attain intellectual independence and economic freedom from the patriarchal nature of society.

However, maintaining this dichotomous notion of the public and private is problematic. As Weintraub and Kumar suggest:

“The enormous bodies of discourse that use ‘public’ and ‘private’ as organising categories are not always informed by a careful consideration of the meanings and implications of the concepts themselves...the public/private distinction is not unitary, but protean. It comprises, not a single paired opposition, but a complex family of them, neither mutually reducible nor wholly unrelated” (Weintraub and Kumar 1997: xii).

The boundaries between public and private spaces are not static but rather change over time and are bound within cultural attitudes. With this in mind, Massey (1994) argued that space was a social construct developed through various practices within the negotiation of meanings both at interpersonal and societal level and was inherently political. As such, the meaning of space was inherently volatile and subject to renegotiation or “social contests” (Massey 1994: 5).

Bartlett (2002) notes contemporary women now spend far more time within the public sphere than in the family home, prior to, and following, motherhood. A woman working outside the home was a comparatively rare event in the late 1920s while in 2008 it was estimated that the majority of women (70 percent) were employed outside the home. For women, having a dependent child had a substantial impact on employment. For example, 57 percent of women with a child 5 years or younger were in employment, although 38 percent of women with dependant children returned to work part-time (Office for National Statistics 2008). This high rate of mothers in paid employment following the birth of a child may reflect the financial constraints that women face during their 39 weeks of maternity leave. At the time of writing, women who are receiving statutory maternity leave receive 90 percent of their average income for the first 6 weeks following birth but no more than £123.06 for the remaining 33 weeks of their maternity leave (Directgov 2010). However, current proposals by a committee of the European Parliament aim to extend maternity leave across Europe to 20 weeks at full pay (BBC News 2010). Such proposals may

promote the initiation and duration of breastfeeding and increase the numbers of women breastfeeding in public spaces.

However, women's place in public space is not just associated with work. For example, McIntyre and colleagues (1999) acknowledge that even those mothers who choose to, or are required to, 'stay at home' with their children were no longer limited to the domestic sphere.

"mothers with small babies are often seen in public places such as shopping centres and restaurants indicating that they now spend considerable time outside of the home" (McIntyre et al 1999: 132 cited in Bartlett 2002).

Consequently women's use of, and claim to, public space has steadily increased. However, although women have increased access to public space, they were not free to do as they please within public spaces. Gaining insight into the way gender has become embedded in public and private space is useful in understanding the experiences of breastfeeding women.

### ***Women breastfeeding in public spaces***

Mahon-Daly & Andrews (2002) discuss spatial divides of the private and public in relation to breastfeeding experiences. A central point of their argument is the extent to which the practice and performance of breastfeeding is liminal. The concept of liminality is used in this study as a means of understanding and interpreting human behaviour in private and public spaces. This theory suggests that breastfeeding takes place in private and public spaces and women negotiate their breastfeeding behaviour in such spaces to avoid upsetting or causing embarrassment to themselves or others. Many women in this study were aware that there are places which are more or less appropriate for breastfeeding and women therefore seek liminal private spaces in which to feed their infants.

This constriction of spatial freedom that breastfeeding women can experience has been explored by geographers (Bailey & Pain 2001; Mahon-Daly & Andrews 2002) and others (McIntosh 1985; Whelan & Lupton 1998; Stearns 1999; Guttman & Zimmerman 2000; Paz Galupo & Ayers 2002). These studies suggest that "public space is a social environment in which the actual practice of

breastfeeding is at best socially constrained” (Guttman & Zimmerman 2000: 1471).

Whelan and Lupton’s (1998) study of low income women in England suggested that many women viewed everyday activities such as shopping, visiting family and friends and walking in the park as being out of bounds with a breastfeeding baby, mainly because they lacked the confidence required to breastfeed in public places. The majority of women in this study were embarrassed about the thought of public breastfeeding and often went to great lengths to avoid having to do so. In addition, Stearns’ (1999) study found that women planned their day in order to avoid breastfeeding in public. Women reported they would breastfeed their infants prior to going out and would time their trips out in order to be home for the next feed. However, as infants are known to feed frequently, particularly in the early days, this meant that women were limited to spending only very short periods in public spaces (Stearns 1999). Pollak and colleagues’ Canadian study found most mothers who discontinued breastfeeding before 4 months “remained housebound or restricted in their movements while breastfeeding to avoid the social stigma of breastfeeding in public” (Pollak et al 1995 cited in Sheeshka et al 2001:31).

Britton’s (2000) qualitative study investigated the early and long-term breastfeeding experiences of 51 women from Sunderland, England. Women in this study suggested that many of the public places they frequented prior to birth, such as shopping areas, were no longer comfortable space when out with a breastfed infant. As a result women in this study also tended to restrict their time out of the home and planned their trips out around what they described as the ‘safe refuge’ of the mother and baby rooms.

The space related constraints placed on women in their attempts to breastfeed were explored by Paz Galupo & Ayer’s (2002) qualitative study conducted in the USA with 30 mothers from differing social backgrounds who had breastfed for at least one year. The authors found that mothers negotiated the boundaries of breastfeeding in private and public spaces on a daily basis. It was apparent to participants that others may interpret the simple act of nursing as inappropriate due to the sexual nature of the breast. As a result, women in this study altered their breastfeeding behaviour for the sole purpose of not offending others and to



avoid embarrassment, making others and themselves feel more comfortable in public space. In addition, women also adopted strategies in order to minimize breastfeeding in public spaces. For example, some of the women in this study chose to breastfeed in secrecy or privacy whilst in public spaces, often feeding in toilets, parked cars or under the cover of blankets.

Similarly, the women in Stearns' (1999) study chose to breastfeed in department store dressing rooms, parked cars and even stayed home in order to avoid public breastfeeding. Stearns suggests that:

“The actual labor of breastfeeding is increased because women must constantly negotiate and manage the act of breastfeeding in every sector of society-in public and in the home” (1999: 322).

There are few studies which address the use of the car as an extension of private space. Marsh and Collett (1986) suggested that the 49 Ford was described as “a living room on wheels” in the Ford brochure in 1949 (1986:11). Pearce (1999) also demonstrated how the car has the ability to act as a private dwelling. She suggests that owners of a car have the ability to control who enters it, much in the same way as homeowners' control who visits their home. As a result the car has become a “home from home”; a place to perform business, romance and other activities deemed as private.

### ***Attitudes of others: breastfeeding in public spaces***

Research addressing public attitudes towards breastfeeding practice reports the prevalence of negative attitudes. In McIntyre's study, telephone interviews were conducted with 93 managers in South Australia, 66 of who were restaurant managers, and a further 27 managed shopping centres. This study demonstrates that 66 percent of restaurant managers and 52 percent of shopping centre managers discouraged breastfeeding anywhere in their facility, encouraging a mother to move to a more secluded area (McIntyre 1999). Similarly, a 1993 survey of 734 restaurants conducted by midwives in the UK and Channel Islands found that 79 percent of restaurants would allow breastfeeding at tables as long as there were no complaints from other customers (RCM 1994).

Guttman & Zimmerman's (2000) qualitative study of 154 USA multi-ethnic women from low-income families found that, of the women who had never

breastfed, one third responded negatively to women breastfeeding in public. Some of the younger mothers in the study suggested that while they tended to believe that their community viewed breastfeeding as the optimal way to feed an infant and that their decision to breastfeed reflected the choice of a good mother, they also reported that their friends and peers usually disapproved of breastfeeding, and characterized it as something “nasty or disgusting” (Guttman & Zimmerman 2000: 1466). Half of the women in the sample believed that others displayed negative reactions to the women they saw breastfeeding in public, while only 5 percent perceived a positive reaction. For example, one breastfeeding woman in this study recalled how she had seen a mother breastfeed on a train and thought this was ‘fine’ but went on to suggest that others may find it disgusting and that most of her friends choose to formula feed because “nobody wants to whip their breasts out in public” (Guttman & Zimmerman 2000: 1466).

Similarly, Sittlington and colleagues conducted a quantitative survey with 200 expectant mothers in Belfast and found that the majority of women agreed with the statement that ‘women should not breastfeed in public places’ irrespective of their intention regarding feeding method (2007: 568). Greene and colleagues’ (2003) study found that the vast majority of teenagers (96 percent) supported breastfeeding only when it takes place in the home.

The belief that breastfeeding should only occur in the home was discussed as being particularly relevant for mothers breastfeeding an older child. The World Health Organization (WHO) recommends that children are breastfed for two years and beyond, although children in many Western cultures are not usually fed this long. This may reflect the notion “that for most Westerners, an older child at the breast is considered an offensive sight” (Giles 2003: 207-208). Stearns (1999) notes that the motivation to feed an older child is often publicly scrutinized, supported by an unfounded argument that breastfeeding beyond infancy is not nutritionally necessary. Women in Giles’ (2003) study indicated that they often retreated to the privacy of their home to breastfeed and faced mounting pressure from others to discontinue breastfeeding as their child grew. Stearns (1999) argues that one way in which women resist this continual pressure to stop extended breastfeeding while avoiding negative reactions from others was to develop code words or breastfeed only in the privacy of their own home.

Women encouraged their children to use code words such as ‘milky’ in order that their breastfeeding remained concealed from others and thus avoid negative reaction. In addition, many women created rules with their children that breastfeeding would only take place in the privacy of the home.

The above studies demonstrate that women have faced many challenges in their attempts to breastfeed in private and public spaces. However, new legislation protecting a women’s right to breastfeeding in public spaces may have a positive impact. In an attempt to combat the social stigma of breastfeeding in public spaces, legislation was implemented in the State of California and across 13 other USA states between 1994 and 1999 (Baldwin and Friedman 1998). In addition, Scotland also introduced the Breastfeeding etc. (Scotland) Act (2005). It is important to note that there has never actually been a law against breastfeeding in public; however, some typically claimed that it violated statutes against indecent exposure and obscenity (Baumslag & Michels 1995). As a result, legislation states that breastfeeding a child in public is a legal behaviour and should not to be confused with public nudity. Prior to breastfeeding legislation the literature suggests that women were influenced in their choice to breastfeed, or not, by their perceptions that breastfeeding in public was unacceptable (McIntosh 1985; McIntyre et al 1999). This was demonstrated in Australia in 1999 where the Queensland Young Liberals prepared a notion for the state convention proposing “on-the-spot fines” for women caught breastfeeding in public areas other than designated parenting rooms (Saunders 1999; cited in Bartlett 2002: 116).

The question of where it may be appropriate to breastfeed is a very real dilemma for women. As discussed in the previous chapter the Infant Feeding Survey (IFS) (2005) gathered information on breastfeeding in public following the introduction of the Breastfeeding etc. (Scotland) Act (2005). The results found that few mothers breastfed in public in the first 6 weeks following birth. For example, approximately 4 percent of mothers had breastfed in public space in the first 2 weeks following birth, and approximately 20 percent had breastfed in the first 6 weeks. In addition, women who breastfed in public were more likely to be older, more educated, and classified as being in the managerial/professional socio-economic group (Bolling et al 2007: 297-298).

## ***Breastfeeding at home***

Finding a comfortable place to breastfeed at home is also an issue for many women. Women's reported experiences of breastfeeding at home are few in the literature; the work of Carter (1995) & Britton (2000; 2009) are welcome exceptions. These studies suggest that even within the private confines of a woman's own home, breastfeeding may not be a neutral activity. Visits from family or friends can turn the home from a private and intimate space into a public space. In order to feel comfortable breastfeeding at home, women may have to negotiate where, and in front of whom, they choose to breastfeed. Many of the women in these studies suggested that breastfeeding at home posed particular challenges, and they found themselves retreating to the bedroom or using clothing or a blanket in order to remain discreet and minimise embarrassment to themselves and others. For those women who claimed their homes were spaces where they could breastfeed comfortably, they nevertheless chose to negotiate their behaviour in light of the sexualised breast (Carter 1995; Britton 2000; 2009). The following image in figure 13 is of a woman breastfeeding in private at home in the USA (1950):



**Figure 13: Mother Nursing Baby (1950) Hilda Kassell, New York City  
Library of Congress, Prints & Photographs Division: Gottscho-Schleisner Collection  
(Library of Congress)**

McIntosh's (1985) qualitative study of low-income women in Glasgow examined feeding practices of 80 first-time mothers from three antenatal clinics and suggested that women's perceived lack of privacy within their homes had an influence on them choosing to formula feed. Furthermore, the majority of mothers (80 percent) acknowledged that their decision to use formula milk was directly related to the social unacceptability of breastfeeding (McIntosh 1985).

### ***Breastfeeding and discretion***

When discussing breastfeeding in front of others both at home and in public space, women have stressed the importance of negotiating their behaviour in order to minimise the visibility of their breast. For the women in Stearns' (1999) study achieving this was difficult, particularly in the early days. Breastfeeding is a learned activity for both mother and baby. "Trying to get a baby positioned correctly on the breast while simultaneously hiding all parts of the breast is not always easy for the new mother" (Stearns 1999: 312).

Marchand & Morrow (1994) also reported that privacy and modesty were fundamental for women. For mothers choosing to formula feed, avoiding potential embarrassment was deemed more important than any nutritional gains of breastfeeding. Scott and colleagues' (1997) Australian study suggested that both mothers and fathers considered public breastfeeding as generally acceptable; however, male university students thought it was only appropriate some of the time, while adolescent girls tended to disapprove altogether. No groups were in support of 'immodest' breastfeeding in public (Sheeshka et al 2001). Sears & Sears (2000) states that:

"Nursing at the mall, the museum, or your mother-in-law's house is going to require a different approach....in most social situations, most people are more comfortable when mothers nurse discreetly. Good manners suggest that you should take the feelings of others into account" (Sears & Sears 2000; cited in Saha 2002: 66).

Sears' breastfeeding advice manual *The "Breastfeeding book"*, Sears (2000), devotes several pages to what type of clothing women can wear in order to breastfeed discreetly when outside the home. Saha (2002), when analysing selected works of advice literature written by health professionals, reports that:

“Other breastfeeding literature also looks optimistically at the development of special dresses where baby is hidden during nursing, as well as the use of blankets and/or sheets to cover up the child while he or she is breastfeeding, and at the use of breast pumps, which allow for the breast milk to be given by bottle - a far more acceptable way to feed babies in public” (Saha 2002: 66).

The rise in baby friendly clothing and the use of breast pumps in order to express breast milk allowed women the opportunity not to breastfeed in public spaces or breastfeed discreetly. Discretion in public was something which was particularly important to breastfeeding women and something that women work very hard to achieve.

Breastfeeding occurs within a specific context of time and place (Dodgson et al, 2002a). Breastfeeding is not only a biological process, but an activity which is heavily culturalised (Dettwyler, 1995). Therefore, to understand the inherent complexities of successfully promoting and supporting breastfeeding, women's breastfeeding experiences must be examined within their specific context. This requires taking a broader ecological view of breastfeeding experiences that places breastfeeding within their cultural and social environments (Dodgson et al 2002a).

## **Summary**

This chapter has highlighted factors that have worked to undermine breastfeeding practices during the twentieth century and into the twenty first century. The first section began by addressing how scientific, medical and political influences undermined the role of breastfeeding and influenced the use of breast milk substitutes for infant feeding. This occurred at a number of levels. At a policy level rising levels of infant mortality in the early years of the 1900s led to the introduction of public policies that aimed to supervise women in their roles as mothers through the establishment of milk depots throughout the UK supplying reduced cost formula milk. Although it was not the intention of the milk depot to reduce breastfeeding amongst mothers, it was evident that this did occur.

Scientific and medical practices at the turn of the twentieth century promoted the harmful practice of restricted breastfeeding and concluded that women's

bodies required management in order to ensure the right quantity and quality of breast milk was produced. In addition, the promotion and endorsement of formula milk by medical professionals as 'healthful', free access to 'National Dried Milk' for all nursing mothers on low income and huge media campaigns, all contributed to breastfeeding rates of 15 percent in Scotland during the 1970s. This in turn created a lost tradition of breastfeeding and raised issues surrounding the role, purpose and control of a woman's body.

The social meanings ascribed to women's bodies played a significant role in influencing a woman's feeding decisions. Traditionally, control over women's bodies has been linked to patriarchal relationships. The scientific approach to infant feeding also witnessed medical professionals (dominated by men) managing and supervising women's bodies. In addition, the sexual appropriation of women's bodies came to the fore during the 1920s and led to the notion that women's breasts were linked with attractiveness and were objects of sexual desire, rather than nutritional objects. The concept of a multidimensional breast for both nutritional and sexual purposes was viewed as culturally unacceptable. In addition, the female body has been portrayed as uncontrolled, unclean, and inadequate and requires managing and self-monitoring.

Breastfeeding presents many challenges for women in both private and public spaces. In public spaces women find themselves aware of appropriate and inappropriate spaces to breastfeed and negotiate their behaviour in an attempt to breastfeed discreetly. Although breastfeeding is very often discussed as a private domestic event, breastfeeding at home in front of family members is considered to be potentially embarrassing; this made the home, at times, a public and problematic breastfeeding space. Furthermore, despite the recent introduction of the Breastfeeding etc. (Scotland) Act (2005), very few infants were breastfed in public spaces within the first 6 weeks following birth, and of those mothers breastfeeding for more than 8-10 months only 55 percent had breastfed their infants in public.

## Chapter 4: The research design

The literature reviewed in the previous two chapters addressed the medical, policy and cultural aspects of breastfeeding. The aims of this chapter are to explore key methodological and analytical issues encountered within this exploratory study of women's experiences of breastfeeding within the private and public sphere. The chapter is split into four main sections. First, it begins with a summary of the researcher's background and the motivations behind this thesis. The second provides a reflective account of the choice of particular research methods used. The third section provides the reader with a detailed account of the setting, access, ethics, recruitment and the sample. The final section discusses the data management techniques and the analytical strategy.

### Finding a focus

The researcher's interest in breastfeeding in private and public spaces can be traced back to her work as a nurse during the 1980s and 1990s within a paediatric cardiac unit. During this time, very few newborn infants admitted to the unit were breastfed or given expressed breast milk when unable to feed from their mother. For the new mother, the idealised maternal role anticipated by a woman is often changed when her newborn becomes hospitalised, and she becomes dependent on the medical and nursing team in order to obtain information and make contact with her baby (Fenwick, Barclay, & Schmied 2001). Women in the unit would often ask nursing staff what they could do for their baby during this difficult time. Within the researcher's role as a paediatric nurse, tasks such as bottle feeding (where appropriate), eye care and nappy changing were discussed. However, it never seemed appropriate to suggest breastfeeding/expressing breast milk with new mothers, mainly because this was seen, in the researcher's view, as the role of the midwife.

However, this issue remained at the forefront of the researchers' mind and was the driving force behind the following dissertations: *Postnatal feeding choices of women in Glasgow* (Anderson 2005), and *Infant feeding support for new mothers in Glasgow* (Anderson 2006). The findings that emerged from these small scale qualitative studies inspired the researcher to develop an understanding of



women's breastfeeding experiences within the private and public spaces, providing the catalyst for the current research.

Although the researcher has no personal experience of motherhood or breastfeeding, it would be incorrect to state that she is objective, value-free or neutral within this thesis. The researcher does advocate that breastfeeding is best and that women should be supported in their attempts to breastfeed by the broader community. However, the aim of this thesis is not to explore how the researcher or broader community feel about breastfeeding practice, nor to look at how many women choose to, or choose not to breastfeed. Rather, it is designed to explore how women from affluent and deprived neighbourhoods negotiate their behaviour in order to breastfeed in front of others both at home and when out with their baby, from birth through to six months following birth.

## **Research design**

A research design is “an action plan for getting from here to there, where ‘here’ is the initial set of questions and ‘there’ is a set of answers” (Yin 1994: 19). In this study the central topic for exploration was breastfeeding in private and public spaces. However, an important first step in the research process was to narrow the focus of the study. Mason suggests that the researcher needs to be very specific in pinning down the focus of the study:

“Identifying a general interest or topic in this way is fairly straightforward, it is much more of a challenge to design an effective project with a clear, relevant and intellectually worthwhile focus to explore your topic” (Mason 2002: 13).

With this in mind, careful considerations were given to the aims and research questions at an early stage. It was important to acknowledge that decisions made in the early stages would have significant implications for the way in which data would be collected and analysed.

## ***Aims of the study***

The purpose of this study was to explore women's experiences of negotiating infant feeding in private and public spaces throughout the first six months of

motherhood within a sample of mothers from the most and least affluent neighbourhoods.

## ***Research questions***

The five main research questions of this thesis are as follows:

1. Do social and spatial influences affect women's role in infant feeding?
2. In which environments do women feel comfortable and relaxed while breastfeeding and why?
3. In what ways do women negotiate their behaviour when breastfeeding their infants in private and public spaces?
4. Does the duration of breastfeeding impact on women's ability to feed in private and public spaces?
5. Is women's breastfeeding behaviour influenced by living in the most or least affluent areas?

Having developed the aims and research questions early, considerations were also given to epistemology in the research design. Bryman (1988) and Silverman (2005) have both argued that research methods are not neutral techniques but reflect both our view of the world and our conception of knowledge. Therefore, making the connection between epistemology and the research design was initially a crucial step, particularly when narrowing down the focus of the research.

## **Philosophical considerations**

Epistemology refers to “the nature and production of knowledge and how it can be acquired” (Ritchie and Lewis 2003: 23). Within social research there are two contrasting epistemological approaches: objectivism and constructionism (Crotty 2009). Objectivism, found in the positivism paradigm, proposes that only those occurrences that can be observed through the senses, defined by Sarantakos (1998) as “Reality”, can be accepted as knowledge. Reality, from a positivist perspective, is said to be independent of human consciousness, objective and measurable, and organised by natural and unchangeable laws. The particular strengths of positivism within the social sciences are to be found in investigating trends found amongst large groups, offering greater insight into the ‘how many’

of social entities. However, positivism fails to elucidate the 'feelings' or 'subjective experiences' of individuals (Atkinson 1990). For example, a positivist approach can tell us much about the incidence and prevalence of breastfeeding. However, in order to understand women's experiences of breastfeeding in private and public spaces, a constructionism position was adopted within this research. Constructionism challenges objectivism and acknowledges that:

"All knowledge, and therefore all meaningful reality as such, is contingent upon human practices, being constructed in and out of interaction between human beings and their world, and developed and transmitted within an essentially social context" (Crotty 2009: 42).

In other words, constructionism claims that meanings are constructed by people as they engage with the world they are interpreting. Here, social reality places an emphasis on experience, meaning and understanding, and is committed to seeing the social world from the point of view of the research participant. The aim of this study is to "engage in research that probes for deeper understanding rather than examining surface features" (Johnson 1995: 4).

This view links neatly with Immanuel Kant's (1724-1804) early writings of interpretivism: a theoretical perspective grounded in the belief that knowledge of the world can be gained through means other than direct observation. Kant proposed that perception relates not only to the senses but to people's interpretations of what their senses tell them. Furthermore, he suggests that knowledge of the world is based on an 'understanding' which arises from thinking about what happens to us as individuals, and not just simply from having had particular experiences (Ritchie and Lewis 2003: 6). The underlining assumption within interpretivism is that the world is complex, and multiple realities exist from the lived experiences of those who live it. Blaikie (2000) argues that interpretivists' interests lie in understanding how people produce and reproduce their social world through their actions and suggests that:

"Everyday reality consists of the meanings and interpretations given by the social actors to their actions, other people's actions, social situations, and natural and humanly created objects" (2000: 115).

This suggests that interpretivism promotes the uniqueness of each particular situation while pursuing contextual depth (Kelliher 2005). The need to engage in

an interpretive understanding of human behaviour was crucial in this study which explored the lived experiences of breastfeeding women in differing private and public spaces. The interpretivist approach facilitated the exploration of the meanings that women assigned to the action of breastfeeding, and, more importantly, acknowledged their perceptions of others in each social situation. An understanding of women's experiences was achieved through semi-structured interviews and by asking open-ended questions, techniques that will be explored further in this chapter.

Talking interactively and, importantly, gaining access to women's lived experiences has provided an opportunity to explore and gain a greater understanding of the meanings women assigned to their breastfeeding experiences. As Denzin has stated:

"Interpretative interactionism attempts to make the meanings that circulate people in the world of lived experiences accessible to the reader. It endeavours to capture and represent the voices, emotions and actions of those studied" (Denzin 2001: 1).

However, philosophical debates have suggested that purism about the particular epistemological approach adopted may undermine the researcher's ability to choose and implement the most appropriate research design (Bryman 1988; Silverman 1993). In addition, qualitative research methods have been criticised for a lack of transparency in the way the research is carried out and how conclusions are reached (Bryman 1999). In order to avoid such criticisms, this chapter provides a reflective account of each stage of the research design, the influence of the researcher in the process and the reliability of knowledge that was produced as a result. Mason suggests that:

"Reflexivity in this sense means thinking critically about what you are doing and why, confronting and often challenging your own assumptions, and recognising the extent to which your thoughts, actions and decisions shape how you research and what you see. This is of course is a very difficult process, not at least if it involves recognising and dealing with elements in your own assumptions which you would rather not face, but it is also a highly creative and sometimes exhilarating one" (Mason 2002:5).

The researcher's undertaking to be reflexive indicates a desire to be both transparent and critical about the decisions undertaken during the research process, and to explore the assumptions informing such decisions and the

implications for the research findings (Mason 2002). As such, reflexivity also entails a consideration of the effects of the experience of fieldwork on the researcher and the participants. In the spirit of critical reflection, such considerations have been particularly important in the context of this study, particularly in relation to the researcher's commitment to ground the study in women's experiences of infant feeding. Hearing women's accounts, acknowledging their subjective views, minimising hierarchical relationships and recognising the role of the researcher within the research process was crucial (Morris et al 1998). Holland and Ramazanoglu argued:

"If we locate the researcher as an actor in the research process, we open the way to recognition of the power relations within which the researcher is located. Each researcher brings particular values and particular self identities to the research and has lived through particular experiences. While these values, identities and experiences do not rigidly determine particular points of view, they do give researchers variable stand points in relation to subjects of research" (Holland and Ramazanoglu 1994: 131).

The reflexive approach adopted within the methodology will be evidenced throughout this chapter.

## **Value of a qualitative approach in breastfeeding research**

A qualitative approach was adopted in this research as a means of exploring women's lived experiences of breastfeeding over time in private and public spaces in contrasting areas of affluence. Mason suggests that qualitative research is a "highly rewarding activity" where the researcher engages with and becomes immersed within the topic area:

"Through qualitative research we can explore a wide array of dimensions of the social world, including the texture and weave of everyday life, the understandings, experiences and imaginings of our research participants, the way that social processes, institutions, discourses or relationships work, and the significance of the meanings that they generate. We can do all of this qualitatively by using methodologies that celebrate richness, depth, nuance, context, multi-dimensionality and complexity" (Mason 2002: 1).

However, there is a notable lack of research that exposes the relationship between socio-cultural and personal experiences of breastfeeding behaviour, the day-to-day context in which breastfeeding occurs and the meanings that are

associated with women's experiences (Miller, Bonas & Dixon-Woods 2007; Maclean 1989). Within this research design it would have been difficult to understand the sensitive nature and meanings applied to breastfeeding experiences or answer the research questions without directly asking mothers to report unconstrained and freely from their own frame of reference. Having selected a qualitative interpretative approach as the optimum way to develop a detailed and rich understanding of women's lived experiences of breastfeeding in the private and public spaces the focus will now turn to particular methodology surrounding data collection.

Focus groups have frequently been used in breastfeeding qualitative studies (Dykes et al 2003, Stewart-Knox et al 2003; Scott & Mostyn 2003) to gain insight into the understandings and meanings that people assign to their actions. However, they may prevent women providing detailed accounts of their own behaviour and experiences, particularly given the sensitive nature of enquiry. Another qualitative approach to data collection involves participant observation which entails the researcher immersing herself in the research setting, so she can experience and observe a range of women's breastfeeding behaviours in various social settings. However, participant observation alone would be impractical in determining women's lived experiences, given that much of their time is spent within the home setting.

The term qualitative interviewing is used to refer to in-depth interviewing and is often described as a form of everyday conversation (Burgess 1982; 1984: Loftland and Loftland 1995) or "conversations with a purpose" (Burgess 1984: 102). In-depth interviews give women a voice and an opportunity to express their view of the world. Interviewing generates information that would be difficult to achieve through focus groups or participant observations (Hammersley & Atkinson 1995). It is also worth noting that although interviews provide data in the form of verbal accounts, non-verbal accounts of actual behaviour can be recorded too.

Semi-structured interview schedules are a useful way to explore specific topics arising from the research questions. The use of topic guides within this research had three main advantages. Firstly, they enabled women to tell their own story in their own way. Secondly, they offered flexibility which was crucial as it

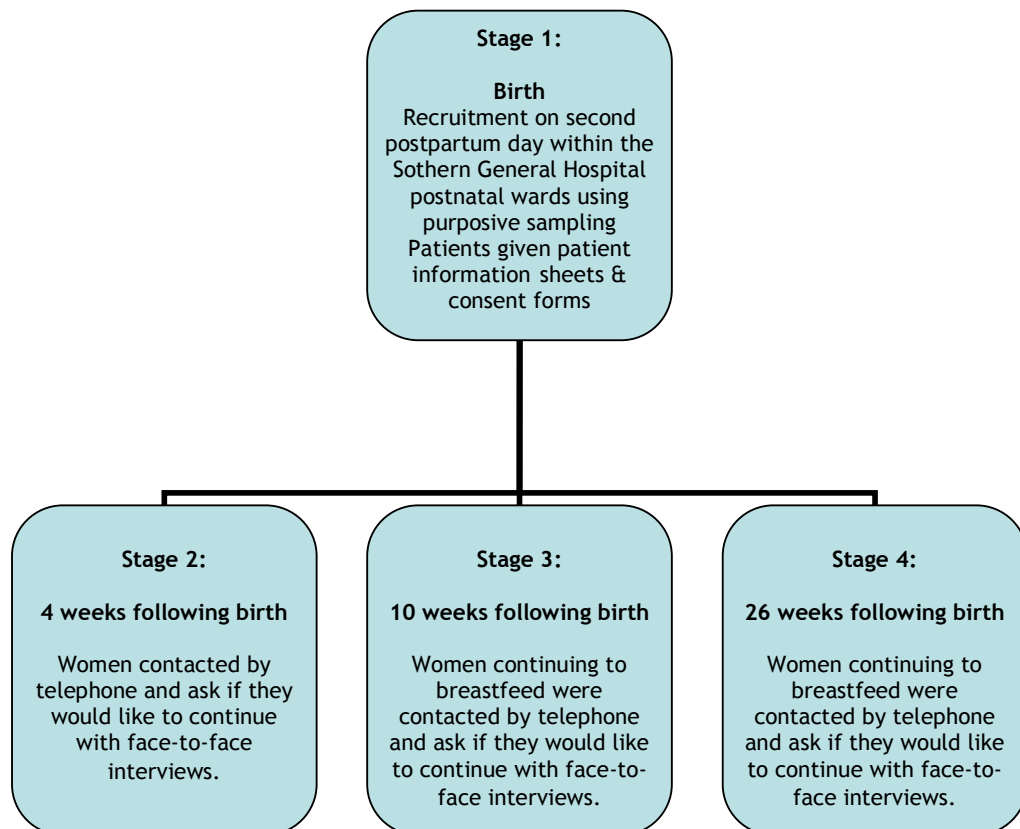
allowed responses to be fully explored and also to allow the researcher to be responsive to relevant issues raised spontaneously by the interviewee. Using a topic guide also allowed the researcher to use a range of probes and other techniques to achieve depth within the responses. As such, further questioning by the researcher followed an initial response to obtain a deeper and fuller understanding of the woman's meaning (Ritchie & Lewis 2003). For example, within this study the researcher used semi-structured interviews to ask participants about their breastfeeding experiences. Following a participant's response the researcher then went on to explore factors that underpin such responses: these include the reasons, feelings, opinions and the beliefs behind the responses (Ritchie & Lewis 2003).

## **Staged approach to interviewing breastfeeding women**

A staged approach to interviewing was adopted within this study in order to achieve a prospective account of women's breastfeeding experiences over a six month period. A staged approach was implemented in order to enable the researcher to capture women's experiences of breastfeeding at specific times throughout their breastfeeding journey. Breastfeeding over the months is not straight-forward and there are known changes in women's experiences throughout early parenthood. For example, research suggests that towards the end of the first month it was anticipated that breastfeeding women would have gained some experience of breastfeeding in front of others at home and possibly within public places. In addition, it was likely that many mothers may have given up breastfeeding within this initial period and, as such, challenging experiences would have been captured in the early interview. Later, at 10 weeks following birth, the breastfeeding behaviours of mothers may have changed. As women become more established in their breastfeeding practice, their views about breastfeeding in private and public places as an established breast feeder may alter; also, as time progressed women may have felt more able to identify where they felt most and least comfortable while breastfeeding. Therefore, semi-structured longitudinal interviews were adopted as a means of exploring women's breastfeeding journeys over time at 4, 10 and 26 weeks following birth.

The final interviews undertaken at 26 weeks sought to gather information on women's experiences of breastfeeding as their infant continued to grow; the

impact breastfeeding had on their lives and how their experiences of breastfeeding in private and public spaces changed over time. Issues of returning to paid employment were explored at this time in order to highlight challenges associated with breastfeeding and/or expressing milk on return to work. A staged approach to recruitment was adopted within this thesis and is outlined in figure 14 below:



**Figure 14: Staged Approach to Recruitment**

## **Qualitative interviewing: experiences of new mothers**

The in-depth interactive interviews reflect shared experiences in which the researcher and the interviewee came together to share a conversation of intimacy in which participants feel comfortable telling their stories (Ramos, 1989). The nature of such in-depth interviews distinguishes them from quantitative research, in which distance and control are highly valued. At the beginning of each in-depth interview, participants may not be aware of what information they may divulge. However, Larossa et al (1981) suggest that in a comfortable atmosphere such as the home, when trust develops, participants



are more likely to reveal information that they otherwise may not (Corbin & Morse 2003).

A woman's home was considered the optimum location in which to conduct interviews, as meeting in other locations such as a local café may have had implications relating to openly discussing sensitive issues. Furthermore, as the women were breastfeeding, interviewing outside the privacy of their own home may have led participants to feed their baby in what they may consider an uncomfortable space. In addition, new mothers may find it particularly challenging to be in a specific location, at a specific time, particularly in the early weeks following birth.

Furthermore, in examining the experience of undertaking sensitive health research it is important to first consider what qualitative researchers actually do. Entering a woman's life and home, sometimes in times of crisis and stress, and asking them to talk in detail about their experiences, requires an element of trust and a rapport between both the researcher and the participant. For the researcher, Dickenson-Swift et al (2007) have captured this fundamental element of respect by suggesting:

“It is so much more than just signing a form to say that they are willing to offer you information, they are actually allowing you [researcher] into their lives, they are telling you personal information that might be quite hard, so you need to demonstrate a certain degree of discretion, of respect, of appreciation for what they are doing, because the reality is that it is more than just words, it's more than just what you are going to analyse, it's their life, their experience and you need to make sure you are aware of that” (2007: 330).

Oakley (1981) suggests that feminist critiques have exposed inherent inequalities within qualitative methodology. This is mainly discussed with regards to the interviewer as a collector of information, opposed to the giver of information. Oakley recommends that “sisterhood can provide a vehicle for overcoming such inequalities between the interviewer and interviewee (provided of course that both are women)” (Cornwell 1984: 12-13). Sisterhood was viewed as a commonality that women share, and as a result of this commonality, participants may be more open and responsive during the interview process. However, Oakley, in her discussions of ‘sisterhood’ omits to mention that

differing roles, social class and educational background may also influence the relationship between the interviewer and interviewee (Cornwell 1984).

Hoddinott (1997) discussed the influence of the researcher's professional background on qualitative interviews, a consideration that was also made by the researcher in this research. Hoddinott (1997) argued that her interview techniques improved when she declared she was a general practitioner and concluded that in future she would make her professional background clear to all participants. Richards & Emslie (2000) compared the interview process in two qualitative studies, and found that participants asked health-related questions of Richards when she introduced herself as a non-practicing GP, whereas participants tended to talk to Emslie (introduced as a researcher) about broader, non-health-related topics. The researcher in this thesis opted not to inform participants of her previous role as a paediatric nurse in order to avoid any pre-conception that participants may have about the researcher in relation to breastfeeding practice. Furthermore, as the researcher was exploring cultural issues of breastfeeding, exposing her nursing background may have elicited more medical responses. The researcher in this study did share information about herself during the interview process, but only when women asked. Such questions related mainly to the researcher's interest in the study and her maternal status, questions which she was happy to answer. Oakley argues "an attitude of refusing to answer questions or offer any kind of personal feedback was not helpful in terms of the traditional goal of promoting rapport" (Oakley 1981: 49).

The women participating in this research were informed by the researcher at recruitment within the Maternity Hospital that she was from an academic institution, and currently undertaking a PhD research project. Here the academic researcher may be viewed by participants as having a certain degree of authority. Cornwell (1984) argues that when this is the case the interviewee will provide the account they think is acceptable. However, it is also possible that the researcher was viewed as a mature woman with no children (the majority of mothers asked the researcher if she was a mother). The researcher felt this was advantageous when asking further probing questions rather than mothers assuming that she may have readily understood (Hammersley and Atkinson 1995). Finch (1984) suggests women interviewees talk about personal

areas of their lives denoting a high level of trust in the researcher, and indicated that they expect the researcher to understand their experiences simply because she is a woman.

Having addressed the qualitative approach adopted within the research, and provided a transparent account of the researcher's role, the next section of the chapter moves on to discuss the what, how and why of the fieldwork.

## **Conducting fieldwork**

An important part of fieldwork is to provide a documented and reflexive "chain of evidence" of the decisions made during the research process (Yin 1981: 63). In order to achieve this goal it is important for the researcher to provide a discussion on what was done, how it was done and why. As such, this section will provide the reader with a detailed account of what happened in the field in terms of participant criteria, setting, sample, access, recruitment and ethics.

### ***Participant criteria***

Qualitative research usually involves some sort of sampling for two reasons. The first relates to practical and resource-based issues. It is unlikely that the researcher could gain insight into the breastfeeding experiences of all new mothers. The second reason relates to narrowing the focus, gaining depth, nuance and understanding. Purposive sampling was employed in this research as a means of enabling the researcher to meet her specific needs of the study aims and to address the research questions Denzin and Lincoln suggest:

Many qualitative researchers employ...purposive, and not random, sampling methods. They seek out groups, settings and individuals where...the processes being studied are most likely to occur (Denzin and Lincoln 2000: 370).

This research aimed to explore whether women's experiences of breastfeeding differed by the area in which women live. As such, a purposive sampling strategy was used to identify women who were continuing to breastfeed at two days following birth within the SGH. In addition, only breastfeeding women living in the 20 percent most and least affluent areas were approached about participating in the research.

***Area-based sampling tools: identifying diversity of place***

Following on from the discussion in Chapter 2, infant feeding practices are socially patterned. In the UK and other industrial countries, women choosing to breastfeed are likely to be older, highly educated and have higher occupational status. In addition, the area women reside is also an indicator of the likelihood that they will initiate and continue to breastfeed; the lowest rates of breastfeeding are observed amongst the least affluent neighbourhoods (Bolling et al 2007). As breastfeeding patterns differ by social class this research aimed to identify whether living in the most/least affluent neighbourhoods had any bearing on a woman's experience of breastfeeding in private and public spaces. In order to gain an insight and understanding of women's experiences of breastfeeding at home and outside the home, within the most and least affluent areas, an area-based sampling tool was employed.

Area deprivation was measured using the Scottish Index for Multiple Deprivation (SIMD) 2006 (Scottish Executive 2006). The SIMD is the latest Scottish Government tool which utilises the 2001 census output to provide a measure of social and material deprivation within data zones. There are 6,505 data zones in Scotland (average population size of 769 people), ranked from the most deprived (1) to the least deprived (6,505). Rankings are made up of seven individual domains: current income, employment, health, education, housing, geographical access to services and crime (Scottish Government 2010). Although the SIMD cannot determine "how much" more deprived one data zone is to another, it does suggest that as the ranks increase the level of deprivation is reduced. However, as an area-based measure, it is important to note that the index does not claim to identify deprived individuals. As such, not all deprived people live in areas identified as having multiple deprivations; equally, not all those living in the deprived areas are deprived (Scottish Executive 2006).

Using an area-based measure (SIMD) to identify women living in the 20 percent most and least deprived areas did not allow any meaningful explanations or comparisons between the breastfeeding experiences of women. This is not surprising as others have come across similar issues. For example, Macintyre and colleagues (2002) discuss the contextual (place) versus compositional (individual) debate as to whether living in a particular area is likely to impact on health

related behaviours independent of the people who reside in the area. This study concluded that both place and individual characteristics matter but individual characteristics seem to matter most. Similarly, Pickett and Pearl note: “where you lives matters for health, although probably not as much as who you are” (Pickett and Pearl 2001 cited in Macintyre et al 2002: 128). The individual characteristics of the sample of women living in the most and least affluent neighbourhoods, who voluntarily agreed to participate in this study, will be discussed in chapter 5.

## ***Setting***

The research was carried out in the city of Glasgow on the West coast of Scotland. Glasgow was chosen as an ideal site for this research as it is an area with low rates of breastfeeding, and with significant contrast between affluent and deprived areas in terms of health inequalities.

Glasgow was in the process of changing from 3 to 2 maternity units during this research: the Princess Royal Maternity Hospital and the Southern General Maternity Unit (SGH) currently support approximately 12,300 births each year (NHS GG&C 2010) of which 5,500 births occur in the SGH. At the time of writing only the SGH has maintained their Baby Friendly Hospital (BFHI) award in protecting, promoting and supporting breastfeeding practices. The potential benefit in choosing to recruit from the SGH was that exclusive breastfeeding rates at 6-7 days were significantly higher (47 percent) when compared with breastfeeding rates at the Princess Royal (34 percent) (Birth Choice UK 2005). In addition, the SGH served a population that varied in terms of their socio-economic status and ethnic backgrounds. Furthermore, as the researcher had conducted a study within the SGH a year earlier, she was known to the Maternity Manager and ward staff which may have eased the process of access.

## ***Gaining access to recruit breastfeeding women to this study***

Using the same method as the researchers’ previous study, the approach to access began with a telephone call to the maternity manager outlining the details of the study. Following this initial call, a letter (see appendix 4) and information pack was sent to the maternity manager containing: the research

proposal (see appendix 5), proposed participant information sheet (see appendix 6), participants' questionnaire sheet (see appendix 7), interview schedules (see appendix 8) and consent form (see appendix 9). A further telephone call with the Maternity Manager highlighted two main issues. Firstly, the most appropriate postnatal day in which to recruit women to the study was discussed. Secondly, it was agreed that the researcher would meet with Ward Managers and maternity staff to discuss appropriate times for recruitment to take place. It was agreed with all concerned that the second postnatal day was the most appropriate time for recruitment as many women are discharged on this day. It was also agreed that approaching women mid-morning would be most appropriate for midwives as this was after the doctors' rounds. This time was also deemed a quiet period for women, prior to partners visiting. Following a telephone conversation, the Maternity Manager stated that she would be happy to allow access into the wards in order to recruit participants and indicated this in writing to South Glasgow and Clyde Local Research Ethics committee (LREC).

### ***Ethical considerations***

Ethical approval for conducting this research was obtained from Glasgow and Clyde Local Research Ethics committee (LREC) by submitting a research ethics application in July 2007. Following the authorisation of the application, the researcher met with the 10 board members of the ethical committee on the 31<sup>st</sup> of July 2007. The ethics committee and the NHS Research and Development Directorate granted approval, and an honorary contract was awarded to the researcher on the 15<sup>th</sup> of August 2007 (see appendix 10). Notification of the study was also sent to the National Research Register.

Social science codes of ethics for professional and academic associations follow the conventional format for moral principles. By the 1980s, each of the major scholarly associations had adopted its own code of ethics. Within the British Sociological Association (BSA) code of ethics, issues of anonymity, privacy and confidentiality are highlighted as important when conducting research (BSA 2002). At all stages in this research, consideration and assurance towards anonymity, privacy and confidentiality were respected. The initial questionnaire asked for some personal details such as name, date of birth, address, postcode, telephone number and baby's date of birth. Information in relation to age of

leaving full-time education, occupation, feeding method and parity were also taken at this time. Any information identifying participants was only to be seen by the researcher and treated in the strictest of confidence. No personal details were passed to anyone else, nor were names used or mentioned in any subsequent reports. Women in the study are referred to as respondents (for example R1-R26). All personal details obtained would be destroyed at the end of the research. No reward was offered to participants taking part in the study.

The use of qualitative in-depth interviews at home and asking women about personal and, sometimes private activities, as a means of data collection does raise a number of ethical issues. As the nature of this research may be viewed as an intrinsically sensitive area, the researcher attempted to be prepared in a number of ways. As women consented to participate they were willing to discuss the research themes, however, at the start of each interview, women were reminded about the confidential nature of the research.

When conducting interviews in a woman's home, Stake suggests that researchers are "guests in the private spaces of the world" (1998: 105). As such, the researcher must possess a strong ethical stance and be well mannered to avoid any harm to participants. However, there are also implications for the researcher while interviewing in a woman's home. A security strategy was adopted to maintain the researcher's safety. During all of the interviews the University Department PhD secretary was aware of the whereabouts of the researcher and the times that she entered and left a woman's home. This was achieved using the researcher's mobile phone. The office secretary was informed to contact the head of department if the researcher failed to contact her, or could not be reached at the times given. At no point during the research did the researcher encounter or perceive any threats.

### ***Informed consent***

Social science research insists that participants have a right to be informed about the nature and the consequences of research in which they are involved. Respect for human freedom includes two necessary conditions. Firstly, participants must agree voluntarily to participate; secondly, their agreement must be based on full and open information. The declaration of Helsinki states

that subjects must be told the duration, methods, possible risks and the purpose and the aim of the research. Women were informed that they could withdraw from the study at any time without explanation.

### ***Recruitment***

When access to the wards had been secured, physical presence on the ward offered no guarantees that the women the researcher would like to speak with would be accessible (Silverman 2005). This was in the hands of the ‘gatekeepers’ (ward sisters) and the preference of women themselves. Throughout the recruitment on the wards the researcher was dependent on ward sisters and midwives identifying women who were continuing to breastfeed and their postcode data. Without such information recruitment of participants could not proceed. Whilst Hammersley and Atkinson (1995) warn of potential conflict of interests between the researcher and the gatekeepers, the researcher’s experience within the SGH was a very positive one, particularly in light of the time pressure ward sisters and maternity staff face. The researcher felt she developed a good rapport with all ward staff; they included her in their personal conversations and often asked her to join them for their morning tea/coffee break. In part, the positive experience may reflect the researcher’s previous work on the postnatal wards as several midwives remembered her.

Recruitment was conducted over a six month period from September 2007 to February 2008 within both post-natal wards of the SGH. A two wave approach to recruitment was established. The first wave took place over a two-week period in September 2007; 15 participants were recruited at this time, followed by the second wave in a 3-week period between January and February 2008 with 11 participants being recruited.

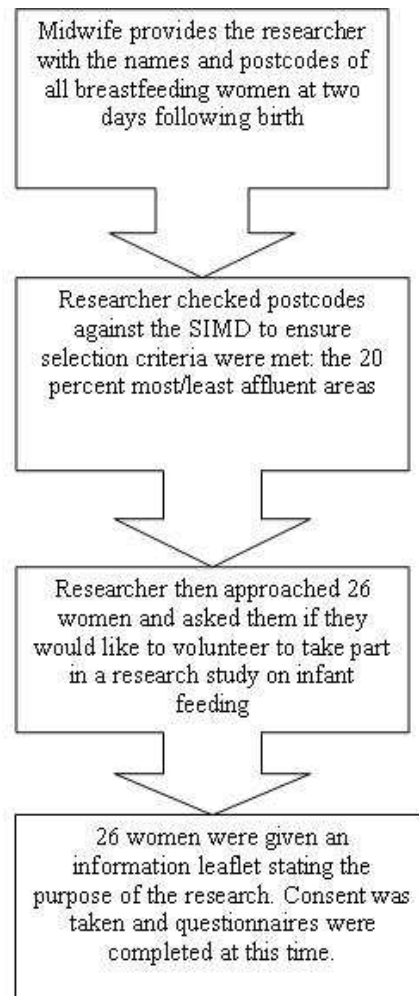
A two wave approach to the research was thought to be advantageous as a small sample of new mothers could be recruited each time, thereby allowing the researcher adequate time to commence and facilitate follow up interviews of each woman at 4, 10 and 26 weeks following birth. Furthermore, using a waved approach provided the researcher with an opportunity to identify particular strengths and weaknesses within the research methods during the early stages and enabled time for reflection and to make any required changes. The second



wave of recruitment commenced following the completion of the 10 week (stage 3) interviews by which time the researcher could estimate the number of women maintaining breastfeeding and create an appropriate overall sample size.

The researcher collected information daily on breastfeeding mothers from both wards within the SGH maternity unit and the postcodes were entered in to the Scottish Neighbourhood Statistic (SNS) website in order to determine levels of affluence. This was accessed by two means: direct access to a computer on the postnatal ward (as previously arranged) or by telephoning the University Department PhD secretary and asking her to input the postcode into the website and feedback the SIMD status.

Women fitting the research criteria consisted of mother's breastfeeding their infants at two days following birth from the 20 percent most and least affluent areas in South Glasgow. These women were then approached by the researcher and asked if they would be interested in volunteering to take part in a PhD research study about infant feeding in private and public spaces. All women approached volunteered to take part. Women were then invited to read through the patient information sheet and ask any questions they may have had before completing the consent form and questionnaire. The questionnaire asked for basic contact details, such as the woman's name, date of birth, address, postcode, telephone number, date of delivery, feeding method, parity, age at leaving full-time education and occupation. The researcher returned to the women after a short time to collect the completed questionnaires and consent forms, and to answer any questions. All completed forms were returned to the researcher directly, usually within a two hour period. Figure 15 below outlines the recruitment process.



**Figure 15: Recruitment Process**

From the sample of women initially approached for recruitment, all of the women approached agreed to take part. The high participation rate may have reflected both the day and the time of day that recruitment took place. As discussed above, women were approached during a quiet time (10am) just prior to visits from husbands and partners. Furthermore, women were very interested in the topic area, were enthusiastic about taking part and reported enjoying discussing it with the researcher. In addition, the researcher was onsite to answer any questions and inform the women that the researcher herself would conduct all interviews. On collection of completed consent forms and questionnaires women were thanked and informed that the researcher would contact them within three weeks to arrange a convenient interview time.

In participating in the research many of the women may have been entering unfamiliar territory. They may not have participated in research before and, perhaps more significantly, may have rarely shared personal and sensitive

information with strangers other than possibly health professionals. Consequently, initial contact with mothers in hospital was viewed as very important in setting the tone of the research experience, meeting the researcher and discussing any issues relating to the research. This also meant that all participants had met the researcher prior to the first interview and were expecting to be contacted.

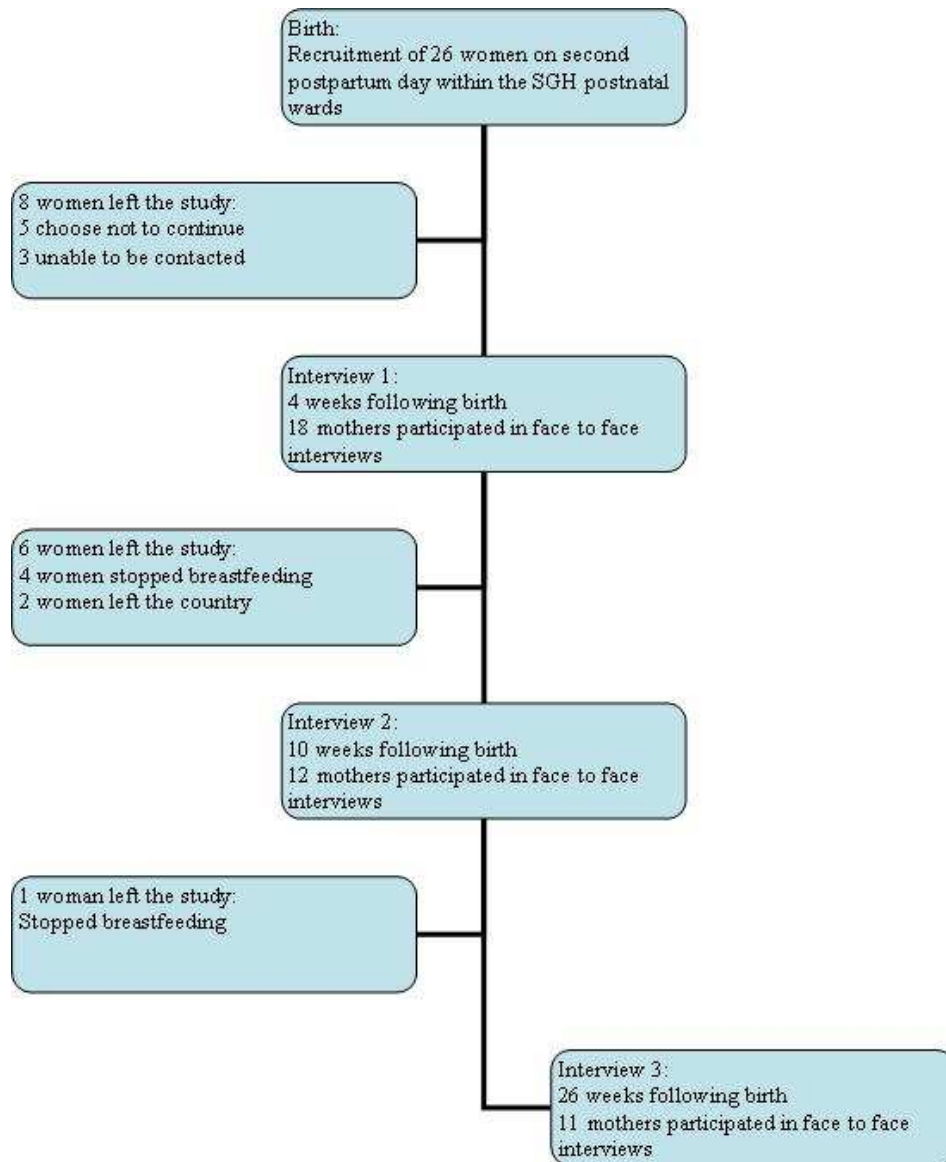
### ***The sample***

The aim of this qualitative research was to gain an insight in to the experiences of a small group of breastfeeding women from both the most and least affluent areas of Glasgow South. In order to achieve a sample of women to participate at each stage of the interview process, all volunteering women were recruited for interviews at two days following birth within 2 postnatal wards. The sample consisted of 26 participants; this number was seen as a manageable amount in terms of the time restraints placed on the researcher, but also when taking into account drop-out rates of participants. Of the mothers volunteering to participate, 16 had given birth to their first baby while 10 of the mothers had other children. The majority (17) of the women were Scottish; 6 were Asian, 2 women were Eastern European and 1 woman was South American. Mothers were aged between 18-43 years; the average age was 30 years; 14 mothers lived in the 20 percent least affluent areas while 12 lived in the most affluent areas.

It was the intention of the researcher at stage 1 to personally introduce the study to all women fitting the study criteria. All of the women approached at recruitment agreed and consented to take part in all four stages of the study. Women were then contacted by telephone 1 week prior to each interview to arrange a suitable time and location for the interviews. Following each interview, women who had chosen to stop breastfeeding were subsequently dropped from participating in future interview[s]. This staged approach to interviewing crucially enabled the researcher to gain a present account of women's breastfeeding experiences throughout their breastfeeding journey.

### ***The interview process***

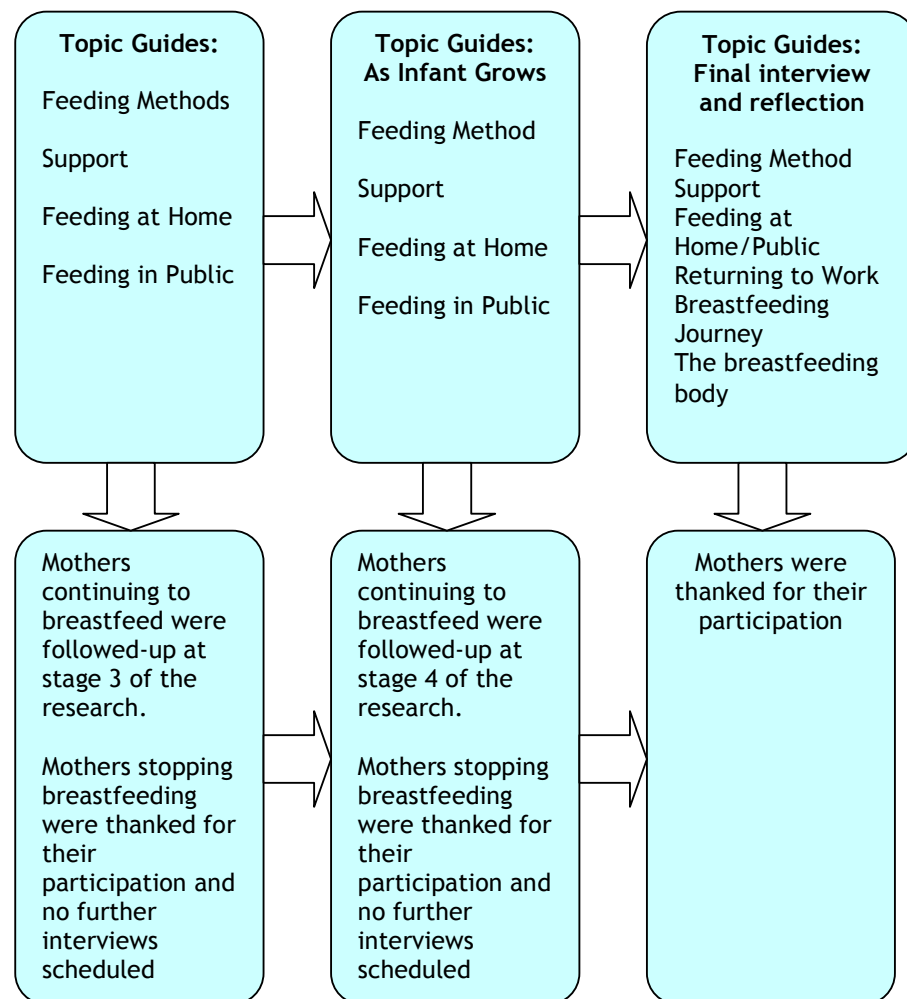
All women recruited were contacted by telephone at three weeks following birth and asked if they would like to continue with the research. From the initial sample of 26 women, 18 agreed to continue in the study. Of the 8 women not continuing in the study, the researcher was unable to contact 2 of the women. In addition, one woman arranged a time and date to be interviewed, but was not at home when the researcher arrived. Further attempts to contact this woman were unsuccessful. A further 4 women contacted chose not to continue with the study and for one woman who agreed to take part; her busy time schedule did not allow the interview to take place. Although women were not asked for a reason, one woman did state that she did not want to continue as she had breastfed for less than 48 hours. From the 18 women interviewed at 4 weeks, 2 left the country and were unable to be contacted for further interviews and 4 women stopped breastfeeding. At the 10-week interviews only one woman was excluded from the study when she stopped breastfeeding; the remaining 11 women continued to the end of the study. The interview process is demonstrated below in figure 16:



**Figure 16: Flow Chart of Participation Interviews**

All of the interviews were conducted within the women's homes. In her role as an interviewer the researcher, a mature white woman, arrived on women's doorsteps, smart but casually dressed, with a Dictaphone and topic guide in hand. Immediately prior to each interview commencing, the purpose and topic guides of the interview were discussed with women, even if this meant repeating information as the interview progressed. During the pre-interview stage there was also lots of informal discussion about how well the women looked following birth, how much the baby had grown since the last meeting and also day-to-day chat about the weather. In the majority of homes, the researcher was offered tea/coffee; this seemed to develop a degree of comfort and trust.

In order to answer the research questions, the researcher had a number of topics she wished to cover. A starting point for all three interviews with each woman was to ask “can you tell me how you’re currently feeding your baby”. The intention of this open-ended question was to allow for least interruption by the researcher while allowing the women to structure their own accounts and agendas. There were no questions in a standardised form. Rather, the interviews were designed to have a fluid and flexible structure allowing the researcher to further explore any unexpected themes. Figure 17 below details the staged approach to the interview process and outlines the themes included in the topic guide.



**Figure 17: Topic Guides**

Each topic guide had 4-7 specific sections: choice of feeding method, changing feeding method, support, feeding at home and in public, breastfeeding journey and breastfeeding and the body (see appendix 8). The interviews did not always

follow the precise order of the schedule but were guided by the direction taken by the interviewees as they talked about their experiences. As such, the schedule became almost like a checklist to ensure all topics were covered.

The staged approach adopted within this research allowed the researcher not only to explore the topic guide but also to develop questions for follow up interviews, which made use of information collected from earlier interviews with them and other women. For example, one woman in the first interview mentioned problems with leaking milk in public; this was then asked at future interviews. Furthermore, following transcription, any information that could withstand further exploration was also discussed with women at follow up interviews.

A total of forty-one interviews were conducted, all within women's homes. The majority of interviews were conducted in private. On one occasion a participant's husband was present and, although the participant appeared comfortable with that, the researcher was considerably less comfortable particularly when discussing issues surrounding support. However, the researcher did not feel this had any impact on the data collected or the experience of interviewing this woman.

Interviewing women at home with a new baby, and in some cases toddlers too, came with many distractions - particularly when the baby reached the six-month stage and demanded their mother's attention. One woman had a friend baby-sit during the interview for fear that she would be distracted by her infant and be unable to concentrate. Following a similar approach adopted by Hoddinott & Pill (2000), the researcher in the current study encouraged women to choose the time and place of the interview. The majority of interviews took place in the morning within their home. Only on one occasion did the researcher have to reschedule an interview.

The women participating in this research showed great commitment to the study and shared their experiences with considerable openness. When asking women to take part in this study the researcher was asking mothers to give up hours of their time spread over a 6-month period. However, there was evidence to suggest that new mothers enjoyed the research process. When telephoning participants to arrange continuing interviews some mothers would state that

they were expecting the researcher's call; women also remarked that throughout the interview process they had been looking forward to the next interview and had been thinking about things they intended to discuss.

Overall the researcher found the interview process to be a very positive and enjoyable experience, if somewhat nerve-racking in the very early days. Similar to Booth & Booth (1994), the researcher at times felt tired from the strain of the interview process, particularly when listening to the sensitive and emotional experiences of women on their breastfeeding journey.

Interviews conducted for this research at times had the potential to mirror therapeutic interviews (Duncombe & Jessop 2002; Hutchinson & Wilson 1994), as they provided a space for women to talk about their experiences to someone who really wanted to listen. Similar to Finch's (1984) study, the researcher was pleasantly surprised at the ease and enthusiasm that women showed when talking to her, and how warmly they welcomed her into their homes, particularly as the researcher interviewed the majority of women on more than one occasion. However, this ease and enthusiasm that the researcher experienced could stem from the fact that women, particularly in the early weeks of motherhood, may be subjected to questioning from doctors, midwives and health visitors about private aspects of their lives and, therefore, participants did not find this unusual (Finch 1984).

The map in figure 18 provides a visual display of the geographical area in which the research interviews were conducted. Information is provided on the areas in which the 18 participants interviewed resided: the most/least affluent neighbourhoods defined by the SIMD. The most affluent areas are shaded green while the least affluent areas are shaded pink. The breastfeeding rates for each data zone area at 6 to 8 weeks following birth were provided by Scottish Neighbourhood Statistics (SNS 2007) and can be identified by the circle size: the smallest circle suggests that breastfeeding rates in the SIMD data zone is less than 20 percent increasing to the largest circle of breastfeeding rates between 67-100 percent.



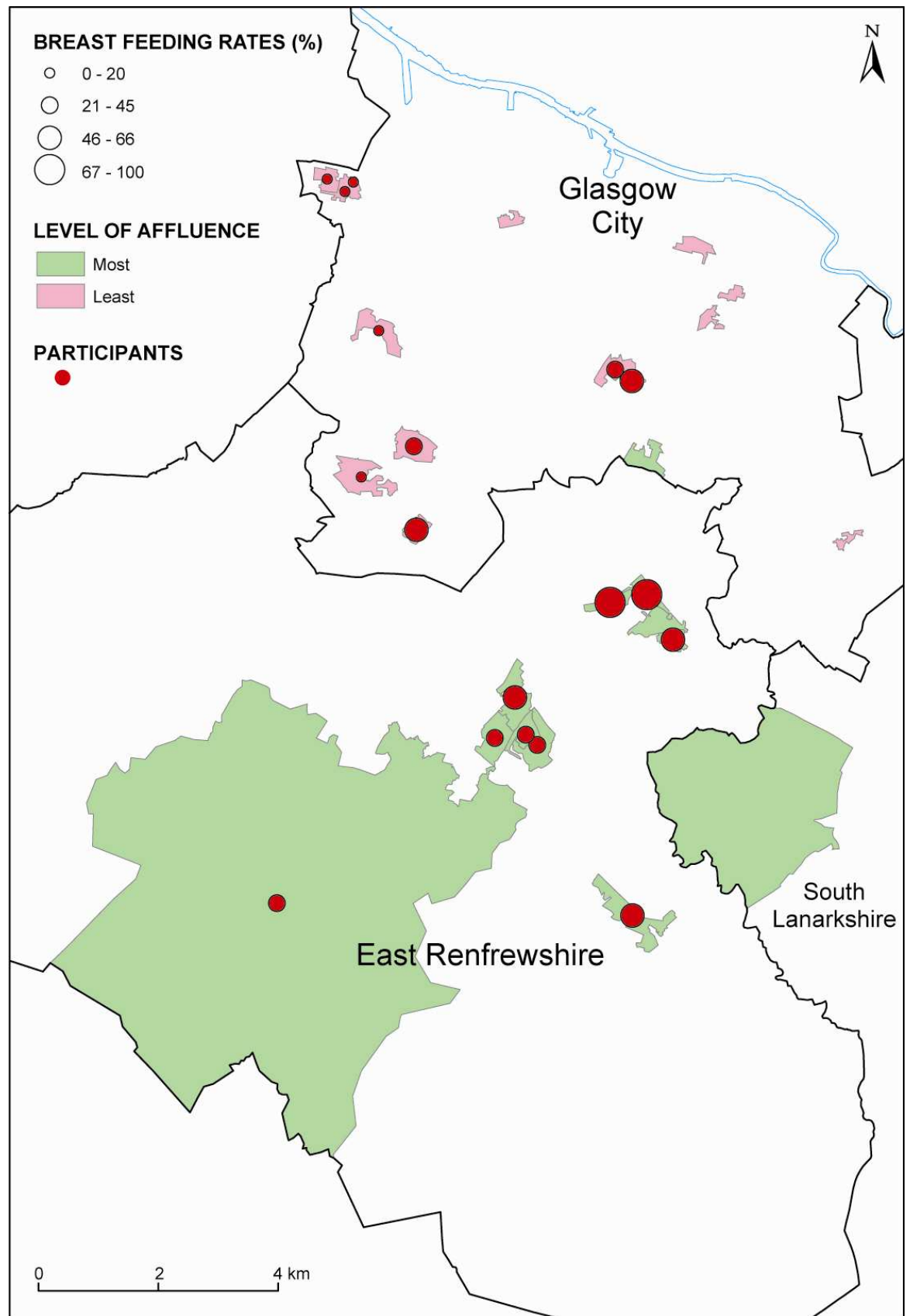


Figure 18: Map of the Recruitment Areas

## Qualitative approach to data

“Analysis is a challenging and exciting stage of the qualitative research process. It requires a mix of creativity and systematic searching, a blend of inspiration and diligent detection. And although there will be a stage dedicated to analysis, the pathways to forming ideas to pursue, phenomena to capture, theories to test begin right at the start of a research study and ends while writing up the results” (Spencer, Ritchie and O’Connor 2003: 199).

The aim of this section involves constructing and presenting an argument for the qualitative data collected during the research process. However, sorting out the material collected covers a wide range of activities including the management, coding and analysis of the data. In addition, it is also important to ensure that the chosen analytical strategy is consistent with the epistemological approach adopted (Silverman 2005). All of this can be seen as an overwhelming task when faced with hours of semi-structured interview transcripts. As such, it is important to begin analysing early using a strategic and consistent manner; this reflects the notion of qualitative data being “voluminous, messy and unwieldy” (Miles 1979 cited in Ritchie and Lewis 2003: 202). It is the task of the researcher to provide consistency and structure to the data set while maintaining the original story.

### ***Data management***

All of the semi-structured interviews were recorded using a digital Dictaphone; women were allocated an identification code for data protection and any reference to individuals removed from documents (this ensured anonymity for the participants). The same technique was applied to each of the recordings. Each taped recording was transcribed verbatim into a Word document and saved in Rich Text Format (RTF). Transcribing the data in full allowed the researcher to gain a greater understanding and familiarity of the data, while enhancing the accuracy of the transcripts. All data were entered into a Computer Assisted Qualitative Data Analysis (CAQDAS) package, ATLAS.ti, designed to support analysis of qualitative data (Muhr 2004).

## Data coding

Due to the semi-structured nature of the interviews, the topic guide provided an initial framework for the analysis of the data. To allow for an in-depth analysis, all the qualitative data obtained from interviews and any comments made were analysed thematically in keeping with the exploratory nature of this research (Green and Thornwood 2004). In addition, iterative readings and discussions of the transcripts by the researcher and her two supervisors facilitated the development and refinement of the final coding frame. Figure 19 demonstrates the use of Atlas ti and the interpretive and reflective coding frame.

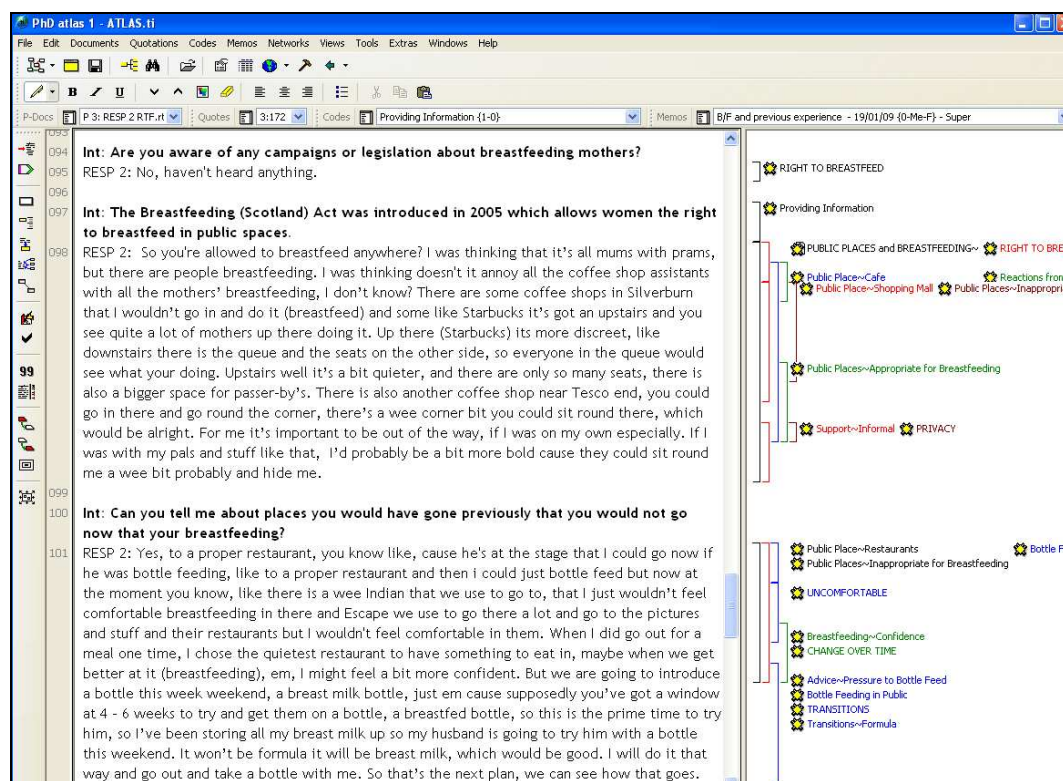


Figure 19: Coded Text

## Data analysis

Mason (2002) refers to three broad approaches to recognising and reading the collected data: literally, interpretively and reflexively. Literal reading means reading data in its literal form, with content, structure, style and layout. Within interview scripts this would involve the words and language used in the sequence of interaction, the form and structure of dialogue and the literal content. Participating in literal reading suggests documenting a literal objective account of the data. However, it has been suggested that purely literal reading is not

possible, just as purely objective description is impossible, because the social world is already interpreted and because what we see is shaped by how we see it (Mason 2002). Literal codes are the most basic types of code in that they simply refer to factual data such as occupational status or level of affluence; such data were included in the family identifier for each transcript.

Within this research interpretative and reflective readings provided the most advantageous approach to data analysis. Interpretative reading allowed the meanings, interpretation and understanding of the women's social world to be explored, while the researcher held an awareness of what is going on outside the interview context. For example, in the data presented above interpretive codes were those where the researcher was inferring a particular meaning from the data - Advice-*'pressure to bottle feed'* was used to code the needs of others to bottle/share feeding. Reflective readings were also adopted within this study in relation to the researcher's role in the interview process, and field notes were gathered, and the interpreted. The researcher reflected on her role in the process of constructing data in the code - *'providing information'*. Here, the researcher crosses the boundaries between seeking information and advising on current breastfeeding policy.

Within qualitative data analysis, coding is also used as a method of development of categories from emerging themes from the literature reviewed and emergent themes from the interviews. The themes were then categorised and subthemes created; this framework was then used to code all the transcriptions before returning to the first read, to ensure that no potential themes had been excluded. This pattern building was then used to develop a structure for writing up the findings and extracting key quotes relating to each theme. ATLAS ti software program was used throughout the research to maximise transparency.

Verification of the findings was also facilitated by the prolonged engagement with participants during the interviews. It was hoped that the prolonged engagement with the women in the study helped to build a trusting relationship in which information was shared, while enabling observation of a wider variety of circumstances (Cricco-Lizza 2004).

A commitment to methodological awareness is essential and demonstrates that the procedures and evidence gathered led to the conclusions presented. Lincoln

& Guba (1995) provide a criterion of trustworthiness to establish and assess the quality of qualitative research, and these perspectives are discussed subsequently.

## **Trustworthiness**

Qualitative research is not experimental in nature and therefore not easily replicable: the path one researcher would take is not necessarily that which would be adopted by another. Yet making clear what was done, how it was done and why, enhances the readers' trust in the analysis and provides helpful guidance for other researchers who may be entering the field with similar data of their own (Seale 1999; Silverman 2005).

Within the qualitative research paradigm, Lincoln & Guba discuss "trustworthiness" as key to appraising that the findings presented are "worth paying attention to" (1985: 290). Guba (1981) proposed four criteria that should be considered in order to achieve trustworthiness within qualitative research: "credibility", "transferability", "dependability" and "confirmability".

### ***Credibility***

Credibility is an evaluation of whether or not the research findings represent an understanding and interpretation of the data drawn from the participants' original data (Lincoln and Guba 1985: 296). Hammersley suggests that "an account is valid or true if it represents accurately those features of the phenomena that it intended to describe" (1992: 69). Within this study credibility was achieved on two levels. First, semi-structured questionnaires were adopted. This ensured that a core set of data were reliably collected whilst also allowing for additional issues to be explored depending on the interests and knowledge of the respondents. This flexible tool enabled the women's voices to be heard, while at the same time, minimised the possibility of the researcher imposing her agenda on the interview. Second, the researcher's supervisors provided feedback on the transcripts.

## ***Transferability***

Transferability is the degree to which the findings of the research can apply or transfer beyond the bounds of the study. However, the main aim of this research was to achieve a descriptive account of women's experiences of breastfeeding in private and public spaces, while achieving contextual uniqueness within a sample of breastfeeding women. As Guba and Lincoln (1985) suggest, whether findings hold in some other context, or even in the same context at some other time, is not the goal. Rather achieving what Geertz (1973a) calls "thick description", a rich account of women's experiences allowing others to make judgements about the possible transferability to other settings.

## ***Dependability and confirmability***

Dependability is an audit by peers of the quality of the integrated processes of data collection, data analysis and theory generation. Auditing is also useful in establishing confirmability; how well the findings are supported by the data collected. As discussed above, iterative readings and discussions of the transcripts by the researcher and her two supervisors contributed to the refinement of the final coding frame. Verification of the findings was facilitated by prolonged engagement with participants during the interview process.

Seale (1999) also argues that good practice can be achieved through aspects of reflexivity at each stage of the research process. He identifies a "methodological awareness" within qualitative research that requires the researcher to demonstrate to the reader that the analytical process that led to her conclusions was systematic and transparent. As such, the author aimed to demonstrate reflexivity in her methods by "showing the audience of research studies as much as is possible of the procedures that led to a particular set of conclusions" (Seale 1999: 158). A more detailed account of the reflective approach adopted within this study was discussed earlier in this chapter.

## **Risk assessment**

The risk attached to the research was mainly due to the unpredictable and decreasing breastfeeding rates within the data collection period. As this

research aimed to recruit from the 20 percent most/least affluent neighbourhoods, there was a significant risk that few women within the study would continue to breastfeed for the duration of the study, particularly those women from the least affluent neighbourhoods. Steps were taken to limit such risks, such as the staged approach discussed above. Other potential strategies that were considered included recruitment of established breastfeeding women from local breastfeeding support groups, although this would not have captured women's early breastfeeding experiences in private and public spaces.

## Summary

The aim of this chapter was to provide a detailed account of the research design employed within this thesis. The chapter began with a brief discussion of the author's motivations behind the research, the aims and objectives of the research and the philosophical underpinnings that informed the research design. The chapter then moved on to discuss the fieldwork issues of access, recruitment, ethics and the proposed research setting. The focus then turned to the means by which data were collected and analysed.

There have undoubtedly been challenges in designing an effective project with a clear and relevant focus on exploring experiences of breastfeeding in private and public spheres. In the early stages, difficulties in articulating the nature of the research were overcome with the completion of the research proposal and presenting the proposal to peers and an academic audience. Applying for ethical consent was a useful exercise to ensure focus and transparency. Furthermore, a considerable amount of time was spent thinking about, and talking about, the research design, and discussing with others the problems and the pitfalls that may have arisen.

This chapter concludes the introductory section of the thesis. Chapters 5-7 present the analysis of the data generated in this study. The chapters have been organised and written thematically, and, combined, offer a detailed journey of how women from affluent and deprived neighbourhoods negotiate their behaviour in order to breastfeed in front of others both at home and when out with their baby, from birth through to six months following birth.

## Chapter 5: Early breastfeeding experiences at home

The aim of this chapter is to explore women's approaches to, and understanding and experiences of, establishing breastfeeding in the early days and weeks following birth. This findings chapter will consist of two sections. The early section will consider the characteristics of the interviewees before moving on to discuss the main factors influencing women's decisions when initiating breastfeeding. The second section of the chapter will consider the practical, physical and emotional journeys that women embarked upon, having decided to breastfeed. In addition, the strategies women adopted to overcome breastfeeding challenges will be explored, and whether the formal and informal support women received had any bearing on their breastfeeding experiences. Within the following three findings chapters identifiers for all participants are provided within the footnote. Women participating in the study were coded (R1-26), the 3 time periods in which interviews took place (4 weeks = 1, 10 weeks = 11, and 26 weeks = 111) and feeding methods at each time period were recorded as (Breastfeeding = B/F or Formula Feeding = F/F).

### The characteristics of participants

As discussed in chapter 4, a purposive sampling approach was adopted to select a heterogeneous group of breastfeeding women from the most and least affluent areas of Glasgow South at two days following birth. A total of 18 women were included in the study. This number was smaller than originally planned because of three factors: the higher than anticipated continued participation in the project over time; the achieved spread of women from contrasting SIMD areas and the continuation of breastfeeding amongst the sample of women.

The characteristics of the interviewees will be discussed in relation to a range of socio-demographic factors, such as, family living arrangements, women's educational, occupational, ethnic origin, the age of the woman giving birth and parity. These factors are summarised in table 2 below.

Respondent Codes: R1

Interviews: 4weeks, 1; 10 weeks, 11; 26 weeks 111

Infant Feeding: Breastfeeding, B/F; Formula Feeding, F/F



	Most Affluent Area	Least Affluent Area
<b>Sample Size</b>	<b>10</b>	<b>8</b>
<b>Tenure</b>		
Owner	7	6
Social Renter	0	2
Private Renter	2	0
Shared Living	1	0
<b>Place of Birth</b>		
Scotland	7	6
South America	1	0
Eastern Europe	0	2
Asia	2	0
<b>Age of Women</b>		
<20	1	0
20-24	1	2
25-29	3	2
30-34	4	1
35+	1	3
<b>(Average age)</b>	<b>30</b>	<b>29</b>
<b>Mother's Age at Leaving F/T Education (Average age)</b>	<b>20</b>	<b>19</b>
<b>Occupation Status</b>		
Professional & Managerial	5	2
Manual	1	1
Non Manual	0	1
Housewife	3	4
Student	1	0
<b>Parity</b>		
First baby	7	4
Second baby	3	4
<b>Return to Work prior to 6 Months</b>	<b>3</b>	<b>0</b>

**Table 2: Characteristics of Women in the Sample**

Table 2 provides key socio-demographic characteristics of the 18 women taking part in the study. The majority of women interviewed were homeowners (n 13), born in Scotland (n 13) and had an average age of 29/30 years. In addition, the

Respondent Codes: R1

Interviews: 4weeks, 1; 10 weeks, 11; 26 weeks 111

Infant Feeding: Breastfeeding, B/F; Formula Feeding, F/F

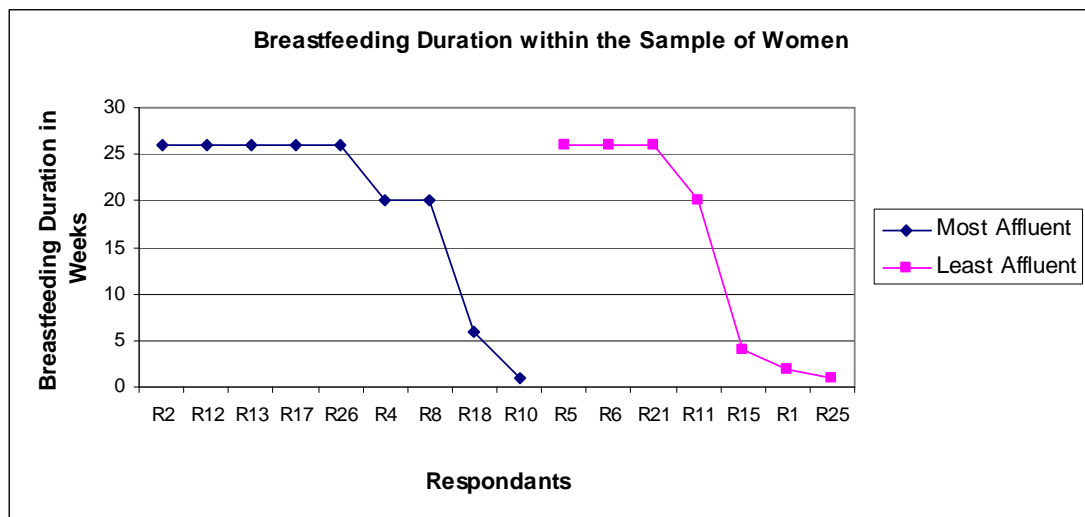
majority of women had continued in education beyond 18 years; the average age of women leaving full-time education was 20 years. The occupational status of the majority of women sat within 2 of the 5 categories: 7 of the women were currently in employment and worked in professional and managerial roles while a further 7 women described themselves as housewives. Only 3 women planned to return to work within the first 6 months of motherhood. The majority of women recruited to the study were first-time mothers (n 11) whilst 7 women had previous experience of breastfeeding. At an individual level, there was no evidence that the sample derived from deprived data zones were of lower socio-economic group than that from more affluent data zones.

It is widely acknowledged that there are striking differences in breastfeeding initiation and continuation rates by educational attainment, occupation, the level of affluence, and the age at which women give birth. In the UK, older mothers and women with higher educational attainment living in the most affluent areas are more likely to initiate and continue breastfeeding than younger women, or women living in the least affluent areas.

This sample represents what might have been expected in terms of the more affluent characteristics found amongst breastfeeding women. For example, when comparing the results found in table 2 with the UK Infant Feeding Survey (2005), there is evidence to show that 70 percent of women aged 29 years plus, will initiate breastfeeding. Similarly, nationally, 87 percent of women in the UK leaving full-time education and after the age of 18 and, 84 percent of women employed in managerial and professional occupations were more likely to initiate breastfeeding. Previous breastfeeding experience is also a strong predictor of future feeding intention. It is estimated that between 75 and 98 percent of Scottish women who have previously breastfed go on to breastfeed subsequent children. Furthermore, women returning to work after 6 months, or not at all, were more likely to continue to breastfeed for 6 months and beyond (Bolling et al 2007). As a result, the evidence shows that the sample of women interviewed within this study were more likely to initiate and continue breastfeeding because of their socio-demographic characteristics and previous breastfeeding experience.

There are undoubtedly fundamental tensions that exist between the research design and the SIMD which was used as a tool to measure area deprivation. It was the intention of this research to recruit women living in the most and least affluent areas of Glasgow South identified by the SIMD. However, as discussed previously in chapter 4, although the SIMD can identify areas that are most deprived, it does not claim that all individuals living in an area of deprivation are deprived.

As previously discussed above, all women in the sample were breastfeeding at 2 days following birth. The breastfeeding duration of women in the sample over the six-month period following birth living in the most and least affluent areas is illustrated in Figure 20 below:



**Figure 20: Breastfeeding Duration within the Sample**

\* Respondents 10 and 16 were unable to be interviewed following 4 weeks as such breastfeeding continuation rates of these women are unknown.

From figure 21 it is clear to see that 2 women stopped breastfeeding within the first two days following, whilst a further 2 women stopped breastfeeding within four weeks following birth. At 6 weeks following birth only 1 woman stopped breastfeeding, however, a further 2 women were unable to be contacted (both were out of their local area for an extended period; breastfeeding duration for these women were omitted from figure 21). At 20 weeks following birth, 3 women stopped breastfeeding, while at 6 months following birth, 8 women continued to breastfeed their infants. There is no noteworthy difference in breastfeeding duration during the first 6 months between women residing in the

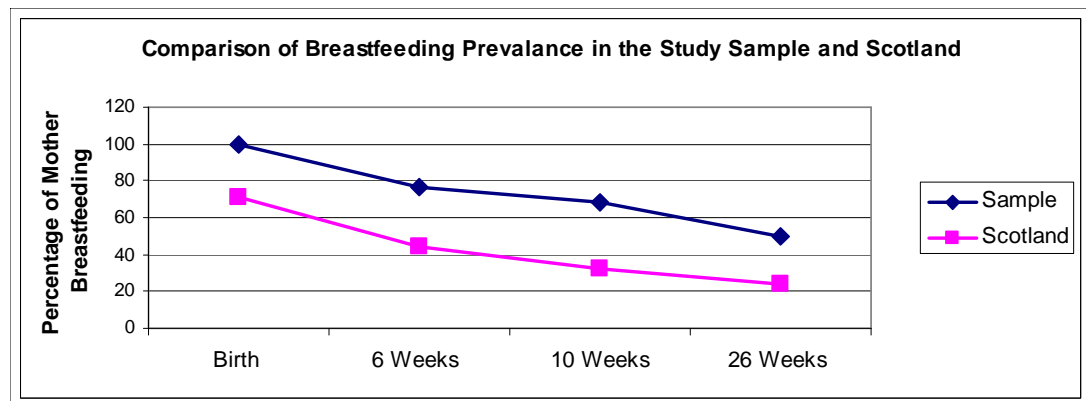
Respondent Codes: R1

Interviews: 4weeks, 1; 10 weeks, 11; 26 weeks 111

Infant Feeding: Breastfeeding, B/F; Formula Feeding, F/F

most and least affluent areas. As sampling did not allow for any meaningful explanation or comparison of affluence and deprivation such issues will not receive any further exploration, unless experiences are patterned based on the area from which women were sampled.

Having discussed breastfeeding continuation rates within the sample, figure 21 shows the breastfeeding rates across the sample, and Scotland as a whole.



**Figure 21: Comparison of Breastfeeding Rates between the Sample and Scotland**  
**Source:** Data taken from the study sample: The Infant Feeding Study (2007) and ISD (2004).

Figure 22 demonstrates a clear gap between the breastfeeding rates within this small sample and breastfeeding rates in Scotland of around 29 percent. There is no doubt that women taking part in this study were more affluent than the Scottish average and therefore more likely to have had higher breastfeeding rates at all time points. However, what is interesting is that the cessation of breastfeeding over time within the sample reflects the cessation rates of the population of breastfeeding women in Scotland. Early cessation rate within the sample of women was in line with the general population of Scottish women. Of the 70 percent of women who initiate breastfeeding in Scotland, only 24 percent continued to breastfeed at 26 weeks (a drop out of 46 percent). Similarly, within the sample, 50 percent of women stopped breastfeeding before 6 months. However, whilst national surveys of infant feeding give a good overall picture of breastfeeding trends, they do not provide an explanation of women's motivations to initiate and continue breastfeeding. However, before addressing factors influencing breastfeeding, it seems important to present the themes and subthemes of the analysis.

Respondent Codes: R1

Interviews: 4weeks, 1; 10 weeks, 11; 26 weeks 111

Infant Feeding: Breastfeeding, B/F; Formula Feeding, F/F

Chapters 5-7 have been organised and written thematically, and combined they offer a detailed exploration of women's experiences of breastfeeding in private and public spaces – the central concern of this thesis. Thematic analysis was conducted on the interview transcripts and each was transcribed and read by the author and coding begun. The analysis revealed four major themes, each with a number of subthemes (see Table 3 below). They reflected women's experiences of breastfeeding in private and public spaces over time, and as such did not separate out as discrete entities, but rather were overlapping and interrelated. However, they are presented as separate entities to facilitate discussion.

Themes	Subthemes
<b>Chapter 5</b> <b>Early breastfeeding experiences</b>	<b>Influences:</b> Prior knowledge, pressure to breastfeed, negative/positive advice <b>Challenges:</b> Felt unprepared, physical, emotional and practical challenges, restrictive <b>Strategies:</b> Short-term goals, bottle feeding <b>Support:</b> Good support, unsupportive/conflicting information <b>Sources of support:</b> Health professionals, family and friends, internet, groups, peer support
<b>Chapter 6</b> <b>Breastfeeding at home</b>	<b>Home:</b> Private/public, comfortable space, achieving privacy, ownership of space <b>Breastfeeding with others:</b> Family, friends, strangers <b>Subgroups of others:</b> Gender, age, familiarity, prior experience of breastfeeding <b>Discretion:</b> Challenging, seek privacy, clothing, self-surveillance, invisible breastfeeding, avoiding embarrassment to self and others <b>Reactions of others:</b> <b>Actual:</b> Supportive, negative comments, privacy <b>Perceived:</b> Uncomfortable, awkward
<b>Breastfeeding outside the home</b>	<b>Withdrawal:</b> Exhaustion, frequent feeding, lack of confidence <b>Preparation:</b> Short trips out of the home, time trips out between feeds, seeking out appropriate spaces, developing skills and confidence <b>Venturing out of the home:</b> Appropriate/inappropriate places for breastfeeding, planning trips out around feeding areas, self surveillance, avoiding embarrassment to self and others <b>Crude categories of public and private:</b> Privacy outside the home, criteria of breastfeeding facilities, appropriate/inappropriate spaces for breastfeeding
<b>Chapter 7</b> <b>A breastfeeding career</b>	<b>Transition to formula:</b> Gradual process, optimum time <b>Influences:</b> Work, reaching breastfeeding goals, personal freedom, regaining ownership of their body, uncomfortable breastfeeding older child in public, pressure to stop from family and friends, women required a socially acceptable reasons to stop breastfeeding <b>Breastfeeding journey:</b> Physical challenges subsided, building skills and confidence, practically easier, convenient, short less frequent feeds, pleasurable connection, changing attitudes of others <b>The private and public continuum:</b> Breastfeeding in private and public space over time, confidence building, breastfeeding in private and public space, retreat to private space

**Table 3: Themes of Analysis**

Chapter 5: *Early breastfeeding experiences*: this chapter explores the main factors influencing women's decisions and motivations when initiating breastfeeding. Secondly, it discusses the physical, emotional and practical challenges women experience in the early days and weeks following birth with

Respondent Codes: R1

Interviews: 4weeks, 1; 10 weeks, 11; 26 weeks 111

Infant Feeding: Breastfeeding, B/F; Formula Feeding, F/F

breastfeeding. The later section of this chapter explores strategies adopted and the support received when faced with breastfeeding challenges.

Chapter 6: *Breastfeeding at home and outside the home*: the early section of this chapter provides an insight into how comfortable women feel breastfeeding in their own home and in the homes of family and friends. The discussion then moves on to explore the art of discretion, women's experiences of breastfeeding with others, and the reactions they received from others while breastfeeding.

Chapter 7: *A breastfeeding career: changes over time*: this chapter explores women's experiences of breastfeeding during the first 6 months of motherhood. The first section highlights changes in feeding methods, and factors that influenced a woman decision to stop breastfeeding, once breastfeeding is fully established. The chapter moves on discuss whether the skills and confidence women developed throughout their breastfeeding journey then enables them to breastfeed comfortably in private and public spaces.

## **Factors influencing breastfeeding**

Breastfeeding is discussed as the optimal method of infant feeding in terms of the multitude of benefits it provides to both women and their infants. At four weeks following birth all 18 women participating in face-to-face interviews were asked about factors that had influenced their decision to initiate breastfeeding. The majority of women talked about having made their decision about infant feeding methods prior to any contact with health professionals, using phrases such as "it had always been in my mind to breastfeed"; "I never really felt like I had two options" and "for me it was always going to be breastfeeding".

Women growing up in countries outside Scotland talked about their decision to breastfeed their baby as a "normal thing", and a "duty of the mother". This was evident in the narrative of this Eastern European woman who was breastfeeding for the first time:

"In (Country) it's always this way, they are not asking you if you will be breastfeeding or formula feeding, usually everybody are

Respondent Codes: R1

Interviews: 4weeks, 1; 10 weeks, 11; 26 weeks 111

Infant Feeding: Breastfeeding, B/F; Formula Feeding, F/F

breastfeeding, after six months they are changing for formula, so I have never thought that I would do anything else” (R11, B/F, 1).

As such, the decision to breastfeed for women socialised within other cultures was not considered so much a matter of choice, but rather something “normal” that is associated with being a new mother. However, within Scottish culture, women’s decisions about infant feeding methods often reflected a pressure to breastfeed. This pressure to breastfeed stemmed from a variety of sources. For example, as a few women were employed in medical occupations, phrases like “I felt that I really had to breastfeed” or “I felt I had to give it a good shot” were common. In addition, the information received from health professionals also contributed to a pressure to breastfeed. As two second-time mothers explained:

“I was always of the opinion of keeping an open mind, it’s not for everyone, and I’ve never really expressed that, but really there’s just so much pressure on mums to breastfeed” (R5, B/F, 1).

“I think it’s the midwives and everyone just expects you to breastfeed or a least try breastfeeding [baby crying]. I suppose with all the information you get about it, you’d feel slightly guilty if you don’t; so there is a lot of pressure on you to do it” (R17, B/F, 11).

Despite the fact that Scotland has one of the lowest initiation rates of breastfeeding in Europe, breastfeeding promotion appears to have had a definite influence on informing women in this study about what is best for babies. Information women received on the benefits of breastfeeding was discussed in relation to public health campaigns, such as television advertisements and the “breast is best” message. All of the women in the study talked about the health benefits associated with breastfeeding as the main driving force behind their decision to initiate breastfeeding; they would relay phrases like “It’s better for their immune system”, “It protects against eczema” or simply “I know it’s the best thing for the baby”. As a result breastfeeding within the sample was considered the best way to feed an infant, which in turn led to powerful links between good mothering and breastfeeding. Similar to the work of Carter (1995) good mothering was commonly associated with breastfeeding in this study. The women had a desire and ability to adopt what they considered a “natural” and “healthy” approach to infant feeding, whereas formula feeding was perceived by one first-time mother as somewhat “evil”:

Respondent Codes: R1

Interviews: 4weeks, 1; 10 weeks, 11; 26 weeks 111

Infant Feeding: Breastfeeding, B/F; Formula Feeding, F/F



“I had this thought that if I gave him formula I would feel like I was poisoning him or something, which is just ridiculous because I actually watch a programme that said that there was more chemicals in breast milk than there is in formula, I don’t know why, but I just really, really wanted to breastfeed him because it just seems so natural” (R4, B/F, 11).

However, almost a third of women suggested that in taking a “natural” approach to infant feeding one was disregarding negative advice from family and friends. Women often found themselves having to “ignore” or “shut off” from unwanted advice and the pressure from others to formula feed. Comments like “my mother-in-law was adamant that I should bottle feed” and “friends tried to convince me not to breastfeed” were common across the sample. One young first-time mother talked about the reactions of her friends when she mentioned that she was planning to breastfeed:

“None of my friend’s breastfed, when I talked to them about it they were quite shocked that I was actually going to breastfeed. I think it’s because I’m young as well. They’re all saying that they didn’t even think about breastfeeding, it was always going to be bottle feeding right from when they found out they were pregnant, breastfeeding hadn’t crossed their minds. But it didn’t matter what others had done, I knew I wanted to breastfeed” (R10, F/F, 1).

In resisting pressures from others to choose formula feeding, women would often defend the negative attitudes of friends and family using phrases like “well everyone is different” or “they are just looking out for me”. Negative advice was often linked to friends or family members who had previously breastfed and stopped early having had experienced difficulties, or from women who had never breastfed. However, advice to formula feed was not limited to the initiation of breastfeeding but was expressed throughout the entire breastfeeding experience, an issue that will be explored further later on in this chapter.

For one first-time mother, until asked by the researcher about which factors may have influenced her decision to breastfeed, she had not really fully considered the potential influence of others in her choice of feeding methods:

“I probably wouldn’t have thought of it before, you know who influences you, I wouldn’t necessarily have thought about it, so it was quite interesting talking to you. I now realise that my friends have been quite a reasonable influence and that made me realise that

Respondent Codes: R1

Interviews: 4weeks, 1; 10 weeks, 11; 26 weeks 111

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obviously sometimes your friends are actually more of an influence than maybe your family” (R12, B/F, 111).

Several women talked about how friends and family members were a positive influence in them choosing to breastfeed. Positive influences stemmed from a tradition of breastfeeding amongst their family and friends. From the sample, one woman suggested that “all my friends have done it; I’m the last to do it (breastfeed)”, while a further 5 women said that “all my family breastfed, it’s just what you do”. However, this family history of breastfeeding was mainly associated with women socialised in cultures outside Scotland. In contrast, 7 women from Scotland mentioned that the previous generation of women (their mothers) had not breastfed, “we were all bottle fed, that was in the 60s and 70s; it was unusual to be breastfed then”. As a result, when women talked about positive breastfeeding influences this was mainly in relation to information they received from their sisters or friends. Positive influences from others were mainly discussed in terms of advice to “try it because of the health benefits for the baby” and from an embodied perspective that breastfeeding can be a “beautiful experience”.

Women’s own motivations to breastfeed were discussed in terms of what they considered was best for their family and the baby’s health. As the following first-time mother explained:

“There are so many baby products you know, use this wipe cause its extra sensitive, and you know, use this formula cause its got this and that, and do this, and do that, but all these things don’t make any difference. Probably the one only difference you can make to their health for six months, unless you completely neglect them, is to breastfeed them, so it kind of feels, you know, everything else you will do automatically but its one thing worth the effort” (R12, B/F, 11).

Several women emphasised that as well as all the health benefits discussed above, breastfeeding was a “cheaper”, “easier” and a “more convenient” option than formula feeding. Women also referred to the psychosocial benefits as an influence in their decision to breastfeed. Three of the women suggested that choosing to breastfeed was not just about the nutritional benefits; it was also about the importance of bonding and the “special cuddles”, “something that you just don’t get with bottle feeding”. A further motivation to breastfeed for one

Respondent Codes: R1

Interviews: 4weeks, 1; 10 weeks, 11; 26 weeks 111

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young first-time mother was associated with the return to her pre-pregnancy body shape:

“One of the main reasons I’m breastfeeding is about getting back into shape. My mum said it (my body) would go back to normal after 3 months, so let’s see, I’m sure it will go back after time. The rest of my body it’s like, I think I’m shrinking, so that’s the reason I wanted to breastfeed” (R9, B/F, 1).

All of the women in this study talked about their commitment to breastfeeding using phrases like “I would have never gone on to formula without trying breastfeeding first” or “it was something I really wanted to do”. Women suggested that knowing how good breast milk is for their infants would have left them with issues of “guilt” if they had not tried to breastfeed at all. However, having some awareness of the difficulties other women experienced in their attempts to breastfeed left the majority of first-time mothers lacking confidence in their ability to breastfeed their infants successfully:

“I didn’t know if I could do it (breastfeed) though, cause my mum couldn’t do it, she tried and couldn’t. My sister had her problems with it, so I thought, well I’ll try it, if I can’t do it then at least I’ve tried it” (R2, B/F, 1).

“I mean I kinda went in thinking I’ll do my best to breastfeed, if it doesn’t work out I would give her formula, if things weren’t working. I had seen a lot of mums in work, and sometimes you think that the poor mum gets exhausted and the baby is frantic. I think what I would have done is given formula and persevered with breastfeeding” (R12, B/F, 1).

Doubting their ability to successfully breastfeed led the majority of first-time women to set themselves short-term breastfeeding goals. Several women talked about how they renegotiated their decision to breastfeed on a weekly basis suggesting “I’ll try it for a week or maybe two and see how it goes”. In many ways this acted as a defence mechanism for women. That is, if breastfeeding was unachievable, they would avoid feelings of guilt and disappointment, an issue which will be explored further in the following section of this chapter.

In summary, women do not make decisions about infant feeding methods in isolation of cultural influences. Rather, the women in the study talked about being influenced in their feeding choices by health promotional messages, their

Respondent Codes: R1

Interviews: 4weeks, 1; 10 weeks, 11; 26 weeks 111

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occupation, family and friends and personal motivations. Although a third of women received encouragement from family and friends to initiate breastfeeding, two thirds of women were actively encouraged to formula feed throughout their early breastfeeding journey; to some extent this reflected the prominence of a bottle feeding culture within their circle family and friends.

## **Early breastfeeding experiences**

Following on from the discussions of infant feeding choices and breastfeeding initiation, women were asked about their experiences of breastfeeding at home. Although it was not the intention of the researcher to raise issues surrounding the physical and emotional challenges associated with breastfeeding. These issues were raised by the majority of women. As such, the intention of this section is twofold: first, to illustrate the physical, emotional and practical difficulties that women encountered when establishing breastfeeding while in hospital and on their return home. The second aim is to discuss strategies that women adopted in order to cope with the challenges that breastfeeding presented. Whilst women were encouraged to think of breast milk as the best food for their baby, the reality was that for some women early breastfeeding experiences could be fraught with emotional and difficult times.

When asked about their early breastfeeding experiences at home, women talked about how, prior to birth, they had read that the baby would “naturally gravitate” toward the breast and attach. However, following birth the majority of women reported this “rose coloured view” was far from their experience, and suggested that having attended “all the classes” and “knowing all the theory” did not prepare them for the difficulties that breastfeeding posed. Women suggested that in promoting the positive elements of breastfeeding, health practitioners have tended to treat breastfeeding challenges with caution. As a result, the majority of women in this study felt totally unprepared for the journey they embarked upon when breastfeeding their baby. As the following first-time mother explained:

“I suppose they (professionals) are just going to try and put a really positive spin on it (breastfeeding), just to try and make you do it, but then I suppose that you could end up, that you end up feeling after a

Respondent Codes: R1

Interviews: 4weeks, 1; 10 weeks, 11; 26 weeks 111

Infant Feeding: Breastfeeding, B/F; Formula Feeding, F/F

week like they said it would be great, and actually it's sore, and it's just so exhausting. I found it useful for people to say, "Oh my nipples were really sore". But I guess if they told you that antenatally, people would be less likely to want to breastfeed, so actually it's quite difficult" (R12, B/F, 11).

Although women felt that the information they received from health professionals had left them feeling unprepared for their experiences of breastfeeding, this is not to say that women had no prior insight into the difficulties associated with early breastfeeding. Seven of the women interviewed had previously breastfed and the majority of the first-time mothers had heard about the breastfeeding experiences of friends and family members. However, phrases like "you have no real understanding of how difficult it will be until you do it" were common, particularly amongst the first-time mothers. As a result, both first-time and experienced mothers expected that their breastfeeding journey would be somewhat easier than it was:

"I just thought that you put the baby on and they sucked and that's it, they did the 10, 15 minutes of feeding and that was it, I didn't expect him (baby) to be on off, on off, you know, it's just been really hard" (R2, B/F, 1).

"I completely thought I wouldn't have that problem of latching on this time, it was like, OH NO, not again. I suppose, you assume that because you're more experienced, that the baby will manage better, but then he's not done it before" (R17, B/F, 1).

The majority of the women experienced some physical pain associated with breastfeeding, although the degree of pain varied. Pain was mainly associated with issues surrounding attachment such as sore nipples, engorgement and mastitis (due to inadequate removal of milk from the breasts) and the development of nipple thrush. Attaching the baby to the breast in order to facilitate effective suckling was discussed as an initial difficulty that the majority of women experienced. Although women in this study were not asked about attachment difficulties, several women talked about how they had problems with attachment at every feed and how often this resulted in some women giving their infants bottle feeds of either expressed breast milk or formula while in hospital and at home. Attachment issues highlighted included infants having difficulties opening their mouths wide enough to attach to the breast; infants showing little interest in feeding and women having difficulties

Respondent Codes: R1

Interviews: 4weeks, 1; 10 weeks, 11; 26 weeks 111

Infant Feeding: Breastfeeding, B/F; Formula Feeding, F/F

reattaching the infant when they frequently came off the breast during feeds. For the majority of mother and infant pairs, it took at least to the third postnatal day before the baby attached and started to feed properly. As the following first-time and second-time mothers explained:

“She was a wee bit slow to attach; I think it wasn’t until about the third night that I think she actually properly latched on. Actually the first couple of days she just didn’t seem to, she just wasn’t actually on properly, it wasn’t till the third night, I remember one of the midwives coming in overnight, and I think that was the first time that I thought, this is what she is meant to be doing” (R12, B/F, 1).

“Actually when he was born straight away he ate, but then at home every time it could take an hour to make him open his mouth wide enough to get him on, but I think by the third day he started to be better” (R21, B/F, 1).

The majority of women in this study also talked about returning home with their baby on the second postnatal day not having fully mastered the skill of attachment. In addition, the “coming in” of breast milk was discussed by several women as occurring following discharge from hospital and that this steady increase of milk into the breast further complicated issues of attachment. As the flow of milk to the breasts increased, women recalled how the breasts become “full”, “heavy” and “hard” and how the inception of milk made it difficult for infants to attach. As one first-time mother recalled:

“The day I came home, my milk came in that night. The midwife came in the next day and I was like Dolly Parton, massive boobs. I think because they were so hard she couldn’t sort of attach or suckle, because my boobs were so hard” (R12, B/F, 1).

The inability of the infant and the mother to develop the art of attachment created several problems. Firstly, infants struggling to attach had a tendency to nipple feed which resulted in extremely painful, cracked nipples. Secondly, engorgement and/or mastitis developed in a small number of women due to inadequate removal of milk from the breasts, while 3 of the women experienced extremely painful feeding associated with thrush. Women described breastfeeding with such conditions as a “complete nightmare”, “frantic”, “frustrating” and an “exhausting” time. Although such difficulties were not

exclusive to first-time mothers, these women did provide the most vivid descriptions of painful experiences:

“I had a problem with sore nipples, very bad, really, really, really sore, (she’s smiling cause she knows what I’m talking about, mum talking to baby). The baby wants milk so she would go on with the gums and like OH. I’m kind of screaming, but, of course not in front of baby, just like kinda of crying you see, and drops coming from my eyes and tears and tears but trying not to, it was really, really bad” (R26, B/F, 1).

“The weekend was probably my lowest point, it was just the pain was building up, it’s not so much when I’m feeding her, it’s when she comes off the breast and the milk starts to fill up in the ducts and it’s a real sort of burning sensation, it’s really quite sort of painful, so it was tears and everything when I was feeding her, you know, the health visitor said I’ve got deep seated thrush” (R18, B/F, 1).

“It was hard I was having like, there was lumps in my breast and under my arms so you know it was quite painful, I was crying. I used to feel quite like cold and my muscles were like quite stiff. I thought I had a fever and I was shivering and had a headache and stuff. I called the midwife at the hospital, it was like two at night, and she said “it’s just because of the mastitis” or something like that. She said that it’s best to keep feeding your baby that will help you. I kept feeding, it was hard, it was painful, it was very sore but I kept feeding her. It was difficult to get her to latch on; she was only sucking the nipple” (R 9, B/F, 1).

The pain associated with breastfeeding led several women to develop a fear and anxiety about attaching the baby. One mother suggested that she would talk the baby through the right way to attach before latching her on, while other women introduced a bottle just to give their “chest a rest”, an issue which will be explored further in the following section. However, despite such challenges, the women in this study believed there was something very special about breastfeeding their infant, which enabled the majority of them to persevere through these difficult times. In using up all their personal resources, breastfeeding was discussed not only as a “huge commitment” for women, but also as an “emotional journey”, fraught with concerns about “doing the right thing” for their baby.

In describing their emotional state when breastfeeding their infants, women used phrases like “going crazy”, being ready for a “nervous breakdown” or

hitting the “low points”. For women, this was associated with exhaustion from the constant and painful feeding, as the following first and second-time mothers explained:

“I was just getting really, really tired, ready for a nervous breakdown, it was just too much, it was just too much, but it would have broke my heart to give up” (R5, B/F, 1).

“I think you have an overwhelming feeling of doing the right thing, surely you can put up with it (the pain) just for the benefits. But it’s difficult you can be quite tearful. One of the things is your hormones, I wouldn’t say I had the baby blues that is early on, isn’t it, when you first come out of hospital? But you do get low points just trying to break through” (R18, B/F, 1).

Several first-time women identified feeling overwhelmed by the emotions of breastfeeding and believed that their difficult journey was not normal, and that others found breastfeeding much easier. Phrases like “if normal people can do it, then why can’t I” were common. As a result, support from peers, family and friends and health professionals and having personal breastfeeding goals were crucial in maintaining their drive and determination to continue breastfeeding. Issues of support and breastfeeding goals will be discussed later in this chapter.

Women also talked about the practical difficulties associated with breastfeeding in the early days and weeks. This was mainly discussed in terms of frequent feeding and the length of time each feed took. For one mother, frequent feeding in the first few days meant “feeding for 2-3 hours at a time, off for half an hour then back on again”. However, following the inception of breast milk, feeding changed for the majority of women to being approximately every 2 to 3 hours with each feed lasting for up to an hour at a time. Women also talked about evening feeds being a particularly difficult time as infants would “cluster feed” with lots of short frequent breastfeeds, which, for some women, meant feeding every twenty minutes. As a result, women in the early days and weeks talked about how they spent their entire time breastfeeding: “oh god, I get nothing else done” and being a new mother “is all about breastfeeding”. Women talked about organising themselves with food, water, the phone and the television remote control in order to sit and breastfeed for long periods. The restrictive



nature and constant demands of breastfeeding persisted for many women up until around 6 weeks following birth.

A third of women, both first-time and second-time mothers, talked less about pain. These women recognised that not having experienced any problems with sore nipples or mastitis made them “very lucky”. Women talked about how they tried to avoid painful breasts by frequently applying a nipple cream and using a breast pump or hand expressed milk in order to relieve full and hard breasts, in turn facilitating easier attachment. Women also talked about being fearful of altering their breastfeeding position in case this would lead to painful breastfeeding and as a result many of the women stayed with the same, sometimes uncomfortable, initial breastfeeding position. Further strategies adopted by women will be discussed in the following section. However, it was not apparent in the early days that a woman having less painful breastfeeding experiences talked anymore than other women about the pleasures or ease of breastfeeding. This reflects the notion that pain is only one part of the breastfeeding journey and that emotional and other physical challenges also play a significant role. The physical, practical and emotional impacts of breastfeeding reported by women in this study are in keeping with previous work conducted by (Bartlett 2002; Schmied & Lupton 2001; Bailey & Pain 2001; Kelleher 2006) that reinforces the notion that early breastfeeding is challenging and women must work at developing their breastfeeding skills over time.

In summary, pain and exhaustion were symptoms experienced by the majority, if not all women, in the early days and weeks of breastfeeding. Women openly shared how their experiences of pain and constant feeding made breastfeeding an incredibly emotional and exhausting journey. Positive experience associated with breastfeeding appeared to be absent in the early days and weeks following birth. However, this is an issue that will be explored further in the following chapters as the skills of both women and their infants became more established. The fact that the majority of these women continued to breastfeed in spite of the challenges shows an inner strength and determination to provide the best for their infants. However, physical and emotional factors did contribute to 4 of the 18 women stopping breastfeeding within the first 4 weeks following birth.

## Strategies used by women when breastfeeding

In order to overcome some of the difficulties associated with early breastfeeding, while acknowledging their motivation to persevere, the majority of women in this study developed strategies to deal with the physical, practical and emotional challenges. Strategies were discussed in two main ways. Firstly, half of the women talked about having set short-term goals in relation to how long they would breastfeed. Secondly, two-thirds of the women talked about the introduction of bottle feeding as a way of coping with the constant demands of breastfeeding. Bottles were used with both formula and expressed breast milk. The main reasons for introducing bottle feeding were discussed as a means of dealing with the physical and practical difficulties associated with breastfeeding. For example, by bottle feeding their infants women could avoid painful breastfeeding, allowing time for their nipples to heal. Secondly, bottle feeding by others in the evenings went some way to alleviate feelings of exhaustion by enabling women to go to bed early. As the following second-time mother explained:

“I was going up stairs to go to sleep but I felt really gutted that I had to do this, why did I have to do this, I should be able to feed him, he’s feeding ok, he’s putting on weight at a rate of knots, so why should I have to give him formula? But really when you’ve got another child, you can’t survive; you can’t sleep when he (baby) sleeps like you did when she (daughter) was born. It’s your sanity, (laughing) you need to, I couldn’t have, I wouldn’t have went on I don’t think if I had to keep doing it all myself (exclusively breastfeeding). I just wouldn’t have managed” (R5, B/F, 1).

“We kind of gave her a bottle feed, why we gave her it was, she had been feeding all day and all night so I thought, I gee my chest a chance to relax cause I was getting sore, so I put her on a bottle, just to get a couple of hours sleep, and I had a touch of cracked nipples and they were so sore to touch, and I couldn’t even touch them to express milk and cause I hadn’t expressed anything, I couldn’t bear to put her anywhere near me” (R15, F/F, 1).

However, the decision to introduce a bottle was fraught with emotions, for several women. Women talked about introducing a bottle as a “difficult decision” and not something they had planned prior to birth. However, one mother talked about being reassured in her decision to introduce a bottle by

Respondent Codes: R1

Interviews: 4weeks, 1; 10 weeks, 11; 26 weeks 111

Infant Feeding: Breastfeeding, B/F; Formula Feeding, F/F

advice of both the midwives and health visitors who suggested “that if it keeps you breastfeeding then its fine”. However, a few first-time mothers reflected that they were unaware that introducing a bottle in the early days may have a negative impact on the amount of milk they produced. A lack of milk supply led to early cessation for some women, while one first-time mother managed to continue breastfeeding with intensive support from family members, and a belief in the herbal remedy that ostensibly increased her milk supply. This woman did manage to re-establish her breastfeeding and continued to breastfeed at 6 months following birth.

Setting short-term breastfeeding goals was a strategy adopted by half of the women in this study. Women, doubting their body’s ability to produce sufficient breast milk for their infants, suggested that setting short-term breastfeeding goals was a means of alleviating any notion of disappointment and guilt if they were unable to breastfeed. As the following first-time mother explains:

“I had always thought I’d just breastfeed, well I always set myself wee short goals: like I’ll try and feed her for a fortnight, then a month, then six weeks sort of, rather than saying I have to breastfeed right through for six months. So I’ve had shorter goals which make it a bit easier, this way you don’t feel you’ve let yourself down if you don’t manage, it’s like well I just try for another couple of weeks and see” (R12, B/F, 11).

In addition, the convenience of breastfeeding also led women to set goals. Three of the women talked about continuing breastfeeding until they returned from their holidays abroad. This was discussed in relation to not having to take lots of formula with them, not being sure of the quality of water in other countries and current restrictions of travelling by air with liquid formula. In addition, breastfeeding on the plane was also considered an ideal way of keeping their infant comfortable while travelling.

Setting goals was not only about continuing with breastfeeding. Women also set goals in relation to the ideal time to stop breastfeeding. Several women discussed stopping in relation to the 6 months recommended by health professionals. Setting limitations on how long women intended to breastfeed was also associated with women regaining ownership of their bodies and returning to work. In terms of regaining ownership over their body, this was discussed by

Respondent Codes: R1

Interviews: 4weeks, 1; 10 weeks, 11; 26 weeks 111

Infant Feeding: Breastfeeding, B/F; Formula Feeding, F/F

women as a “selfish” pursuit that would enable them “to get their life back”. Several women suggested that introducing the bottle afforded them the “freedom to go out themselves or with their partners”. For one first-time mother, this was discussed in relation to breastfeeding for 3 months:

“I always had a goal of trying to exclusively breastfeed for 3 months. I wanted to breastfeed exclusively for 3 months so that was important to me not to introduce the bottle before that, but then part of me wants to put him on the bottle now, but it is purely for selfish reasons so I can get my life back” (R4, B/F, 11).

Of the 9 women who set explicit goals to breastfeed, 3 of the women continued for longer than they initially planned, suggesting that it was they themselves that required to be weaned from breastfeeding rather than their infants. This was mainly discussed in terms of the closeness they felt with their baby and fears of the baby growing less reliant on them.

In summary, women found breastfeeding their infants in the early days a huge commitment that left them physically and emotionally exhausted. However, they talked about how being a “strong” and “determined” person helped them in their efforts to overcome many of the challenges early breastfeeding presented. Setting short-term goals and introducing a bottle in the evenings allowed some women respite from the physical and emotional challenges of breastfeeding, and this was discussed in terms of the restrictive nature of breastfeeding (an issue that will be explored further in the following chapter). For 5 women, early breastfeeding difficulties, coupled with a lack of support, led to early cessation within the first 6 weeks following birth.

## **Breastfeeding support**

Having discussed the difficulties that women experienced in their attempts to breastfeed, and strategies that women engaged in to overcome such difficulties, the intention of this section is to discuss the support that women received while breastfeeding in the early days and weeks following birth. As there is a wealth of literature on supporting women, this section will highlight only the main issues raised by women in the sample. Women talk about receiving support from five

main sources: health professionals, family and friends, the First Mother's Club (FMC), the internet and a breastfeeding peer support counsellor.

Support was something that all of the women considered very important and, as a result, they spent a lot of time talking about it in the early interviews. Support tended to fit in to two subcategories: good support, and unsupportive or conflicting information. Each of the subcategories will be discussed in turn. Good support was something that the majority of women in this study experienced in hospital and at home. As the majority of women experienced difficulties with attaching the baby to the breast and pain while breastfeeding, good support from the midwives and health visitor was an important factor in making breastfeeding an easier and a more comfortable experience. Good support from health professionals was talked about using words such as "brilliant", "fantastic", "reassuring" and "supportive". Such comments reflected both a practical and emotional approach to support. As the following first-time mothers suggested:

"The midwives there were great, they really helped me in hospital they were coming in pretty much every feed and trying to help me make sure that he was on right. It seems that he was in the right position but he would just come back off again but the midwives were great" (R25, F/F, 1).

"The health visitors are brilliant they came in every single day when she was first born and that was exactly what I needed, and then they came every week and by the time they had stopped coming I knew I could go to them if I had a problem. She left her telephone number and there is clinic they have on Tuesdays and Thursdays I can go and see them if I have a problem, but the intensive thing at the start is great, you really need it" (R6, B/F, 11).

The majority of women described the support they received from family and friends as good support. Women talked about how their husbands/partners provided them with practical and emotional support. One young first-time mother talked about how her husband had encouraged her to keep breastfeeding throughout painful mastitis, suggesting "if it was not for my husband supporting me I would not be breastfeeding now". Women also talked about the practical support their husbands offered in the early days. As women often talked about being stuck breastfeeding unable to do things, their husband/partner would

often provide support by helping with the other children, cooking dinner or doing some housework. Practical help from husbands/partners was frequently discussed as helpful for women who had introduced a bottle. Such support was mainly discussed in relation to their husbands/partners giving the last feed at night and allowing women an early night, and a few extra hours of sleep.

Having friends or family members who were currently, or had recently, breastfed was discussed as the most useful source of support for women, particularly for first-time mothers. First-time mothers talked about how reassuring it was to share breastfeeding experiences with other breastfeeding women: “It’s like you take comfort from knowing that you’re all going through the same thing” and that “you’re all in the same boat”. As one first-time mother stated:

“Before you breastfeed you just assume some people breastfeed and some people bottle feed, you don’t appreciate what a huge commitment and a huge struggle it is, just to get to the point to where you are established. It’s kind of nice when you see other mums breastfeeding and you just immediately know what they have gone through as well” (R4, B/F, 11).

Half of the first-time mothers talked about meeting other breastfeeding women while attending the First Mother’s Club (FMC). The FMC is a support/parenting group in a more affluent area of Glasgow south, run by health visitors for new mothers. Mothers were invited to attend for 6 weeks and although it was not designed solely for breastfeeding mothers, breastfeeding was a topic discussed within the sessions. This was considered an “invaluable” source of support by all of the women who attended. In addition to the support received, friendships made within the group continued beyond the 6-week period. Women talked about how they arranged to continue meeting up in coffee shops and went on to attend other mother and baby groups.

The internet was also mentioned by two women as a good way to talk to a “hundred” other women having the same problem. The internet as a source of support was discussed in terms of “Netmums”, a social networking site for parents run by parents. On this site women could chat to other breastfeeding

mothers or just read through the breastfeeding experiences of others within their local area and beyond. As one first-time mother suggested:

“When I’m doing the on-line stuff, it’s more encouraging, because I can speak to other mums, I feel I’m not alone in this, everyone has problems, so I’m not the only one in the world struggling. If I’m feeling a bit, that it’s getting hard it’s an option to go on-line and read how others are doing” (R4, B/F, 11).

One mother sang the praises of the breastfeeding counsellor, a local peer support service she had heard about from a friend. This support service was seen as particularly helpful because it only required her to pick up the phone and the breastfeeding counsellor would come out to the home. This mother talked about how the counsellor stayed and watched her feed. The counsellor was “passionate and encouraging”; “it was just what I needed”, said the mother. Several women suggested that they did not have time to pick up the phone to call a helpline, and that accessing support out with the home in the early days was really inconvenient. The majority of women suggested they needed the support to come to the home.

Having discussed issues around good support, it is now important to consider experiences that women considered to be less supportive. The majority of women talked about receiving unhelpful support from both health professionals and family and friends when breastfeeding. A third talked about how they felt totally unsupported by the advice and information they received from health professionals. Much of this was due to how women perceived the advice and practices of individual midwives. Women described the support they received using phrases like “not good at all”, “it was useless” and when describing midwives and health visitors used words such as “hopeless”, “crap” and “discouraging”. For one young first-time mother, the lack of support in hospital led to the early cessation of breastfeeding and feelings of anger:

“The midwives were getting a bit fed up trying to help me all the time with it. I think she (midwife) kind of looked at me as if I was a silly wee girl, and she said: had I thought about bottle feeding, and I said not really. She was saying obviously, we are not telling you what to do it your place to decide but it doesn’t look like she is going to take to the breast, is she” (R10, F/F, 1).

Respondent Codes: R1

Interviews: 4weeks, 1; 10 weeks, 11; 26 weeks 111

Infant Feeding: Breastfeeding, B/F; Formula Feeding, F/F

Following her conversation with the midwife this young woman decided to change to bottle feeding. However not without consequences, as she went on to explain:

“I changed to the bottle, but I was quite upset about it and I was upset for a couple of days about it. Then I got really quite angry about it, my friend’s mum came up and she is like a breastfeeding coach at the hospital, and she was saying I should definitely have received a lot more support, but it was too late then, she (baby) wouldn’t take it from me” (R10, F/F, 1).

Feeling unsupported also stemmed from the conflicting information that women received in their attempts to breastfeed. Half of the women suggested that the conflicting information they received from health professionals left them feeling unsupported and at times frustrated. As the following first-time mother explained:

“The midwives in the hospital were great but there’s a huge amount of conflicting information and advice, which is very hard cause when you are in hospital you take everything they say as gospel and it depends who you spoke to as to what the (predicted) problem was, you end up totally frustrated” (R4, B/F, 1).

Furthermore, several women talked about how some health professionals, in their view, took a medicalised and misguided approach to breastfeeding support. For example, one woman talked about how her health visitor had suggested to her that she was not eating enough and because of this her breast milk “was not good enough”, an issue that the woman herself disagreed with. However, this apparently unsupportive approach led this mother to increase the number of formula feeds she gave to her infant and subsequently led to a reduction of her breastfeeding. In addition, several women also talked about how health professionals failed to account for the emotional journey women embark on when breastfeeding. As the following first-time mother explained:

“It’s a emotional thing, the whole thing about having a baby and breastfeeding everything is purely driven by emotion and, unless someone can pick that up from you and talk to you on that level, I just feel like there’s no point in them talking to you. I’ve had problems and I thought go to the doctors, and then I thought no, they come up with a medical reason, where a lot of the time it’s about the emotional side and understanding the baby”(R 4, B/F, 1).

Respondent Codes: R1

Interviews: 4weeks, 1; 10 weeks, 11; 26 weeks 111

Infant Feeding: Breastfeeding, B/F; Formula Feeding, F/F



The majority of mothers talked about how their family had encouraged them to stop breastfeeding and put their infants onto formula milk. Although women experienced a similar pressure when choosing how to feed their infants, the pressure to bottle feed while actually breastfeeding was felt as being much greater. This increased pressure to bottle feed in the early days was evident on two levels. Firstly, there was pressure from the mother's husband/partner and family members to be able to bottle feed. The inability of others to feed often equated to them feeling "handless" in their ability to help; others also felt they received a lack of "special cuddles" and a perceived "inability to bond", leaving them desperate to bottle feed the baby. The introduction of formula was also talked about by others as a means of elevating the mother's emotional stress. Phrases like "why are you putting yourself through this, just give him a bottle" were common, as the following second-time mothers explained:

"My two older sisters seemed to struggle a bit, so I don't really get breastfeeding support from them because they have bottle fed. One of my sisters says 'oh, just put her on the bottle if she's not feeding', but that's just the way she is, you know, both of them found it quite hard" (R8, B/F, 1).

"My sisters said "Oh get him on a bottle, get him on a titty (dummy)" and that made me even more determined to keep breastfeeding. I'm sure they were trying to wind me up, because they knew how strongly I felt about, you know continuing, doing it. "Oh you can't go on like this, give it up, just give it up, and just give him a bottle". You'd think your sisters (laughing) (don't tell them I said this), you think that your sisters would be the ones to say, well encourage you, but I suppose they are looking at it from my state of mind, and how much of a state I was in over it, I was just so tired" (R5, B/F, 1).

## Summary

This aim of this chapter was to explore women's approaches to, and understanding and experiences of, establishing breastfeeding in the early days and weeks following birth. Despite using the SIMD to identify women from the most and least affluent areas, Table 2 demonstrated that the characteristics of women in the sample represented a more affluent population of women. This is evident in terms of housing tenure, age of leaving full-time education and occupational status and may explain why no differences were found in the

Respondent Codes: R1

Interviews: 4weeks, 1; 10 weeks, 11; 26 weeks 111

Infant Feeding: Breastfeeding, B/F; Formula Feeding, F/F

breastfeeding experiences of women across the most and least affluent neighbourhoods.

In choosing to initiate breastfeeding, women talked about how they were influenced by health promotional messages, their occupational role and family and friends and personal motivations. In addition, it was evident from the data that the majority of women felt totally unprepared for their breastfeeding experiences in the early day and weeks following birth and developed several strategies to overcome some of the physical and emotional challenges associated with breastfeeding. Support was viewed by women as an important factor in maintaining breastfeeding, and although the majority of women experienced good support from health professional and friends and family, they also stated others were particularly unsupportive. A lack of support from others led women to question their decision to breastfeed: for some women this led to breastfeeding cessation, whilst others found themselves justifying their reasons to continue breastfeeding to others. Rather than taking a passive approach, women discussed how they went to great lengths to find the most appropriate support in order to help them persevere with breastfeeding and overcome unsupportive or unhelpful advice.

Moving from early breastfeeding experiences, the following chapter aims to address women's experiences of breastfeeding in front of others in private and public.

## Chapter 6: Breastfeeding at home and outside the home

The aim of this chapter is to explore women's experiences of infant feeding at home and outside the home during the first 10 weeks following birth. The chapter will be split into two main sections. Firstly, the early section will highlight the experiences of women breastfeeding both at home and in the homes of family and friends. While acknowledging the impact of cultural discourse associated with breasts and breastfeeding (Stearns 1999) this section will focus on the particular challenges that women encounter when feeding in front of others, in what is otherwise considered to be the private space of the home. The second aim of this chapter is to explore women's experiences of breastfeeding outside the home and how the development of breastfeeding skills and confidence building impacts on a woman's ability to breastfeed in public spaces. The discussion here will also focus on the strategies that women adopt in order to breastfeed their infants while outside the home and environments they considered to be most/least appropriate for breastfeeding.

### Breastfeeding at home

Breastfeeding is commonly construed as a private activity and, as such, the home is generally viewed as the most appropriate and comfortable place in which to breastfeed (Carter 1995). However, with frequent and lengthy breastfeeding schedules in the early days and weeks following birth (see chapter 5), and the continuous stream of visitors that a new baby attracts, there is a fine line between the home as a private and public space. Therefore, breastfeeding as a public activity at home and in the homes of others highlighted challenges for women on two levels. First, all of the women in the study talked in detail about the importance of performing breastfeeding discreetly in order to avoid any potential embarrassment to themselves or others. Second, women were aware that breastfeeding as a public activity at home and in the homes of others may result in perceived or actual negative reactions from others. For the majority of women breastfeeding in front of particular groups of people was deemed an inappropriate activity; such concerns remained pronounced for those

Respondent Codes: R1

Interviews: 4weeks, 1; 10 weeks, 11; 26 weeks 111

Infant Feeding: Breastfeeding, B/F; Formula Feeding, F/F

women with previous breastfeeding experience. Consequently, the majority of women in this study continually negotiated where and with whom breastfeeding was most appropriate, and developed several strategies in order to feel comfortable when feeding in the presence of others. However, before moving on to discuss breastfeeding in front of others at home and in the homes of others, it is important to consider the home as a comfortable space to breastfeed.

### ***Home as the most comfortable place to breastfeed***

From the initial sample of 18 women, 16 of the women breastfed at home (2 women stopped breastfeeding before leaving hospital). All of the women talked about their home as the “most comfortable place to breastfeed”. This was discussed at two levels. Firstly, women talked about their home as a private space receiving visits from only close family members, friends and health professionals. Second, on a more practical level, women suggested that breastfeeding at home was easier in their own surroundings, using the same comfortable chair/sofa to sit on and using particular cushions and pillows for support. The following first-time mothers illustrated this issue below:

“My preference is really to feed at home because I feel more comfortable in my own space and you know all my cushions and all that stuff is here” (R18, B/F, 1).

“Probably my house is definitely more, certainly more comfortable, cause you’ve always got a comfy chairs or sofa. I have my pillow and my wee stool, so probably my own house is the most comfy” (R12, B/F, 1).

Women talked about the importance of sitting comfortably while breastfeeding as a means of ensuring and maintaining good attachment whilst simultaneously supporting both themselves and the baby during lengthy breastfeeds. This was something that several mothers had difficulty achieving while in the homes of others. As one first-time mother recalls:

“Last week I was at my cousin’s and I didn’t use a pillow and she has just moved into a nice new house and I thought I don’t want to ask for a cushion just in case she (baby) vomits all over the cushion or something. I was quite uncomfortable because I wasn’t at the right angle; it’s probably learning wee things like that really. When I’m going to other people’s houses I will take a wee cushion and a wee

Respondent Codes: R1

Interviews: 4weeks, 1; 10 weeks, 11; 26 weeks 111

Infant Feeding: Breastfeeding, B/F; Formula Feeding, F/F

blanket to put over me, it's just learning wee techniques to make it easier when you're out" (R12, B/F, 1).

It seems that breastfeeding in the homes of other may not only be uncomfortable in terms of difficulties with attachment but also in terms of remaining discreet during breastfeeds (an issue that will be explored further later in this chapter). Women discussed how difficulties with attachment and pain often required them to expose their breasts in order to be able to guide the baby to the breast and ultimately to see if the baby was attached properly. However, exposing the breast to attach the baby or the fear of becoming exposed during feeding was something that women were particularly uncomfortable with in the presence of others (with the exception of the health professionals and husbands/partners). As the following second-time mother suggested:

"With my first there was a couple of times I would go upstairs and feed because it was so sore, and needed to make sure she was latched on properly. I didn't want to do that in front of others you know, really because I needed to expose myself to see what was going on" (R17, B/F, 1).

The majority of women talked of how they retreated to the bedroom in order to gain some privacy while breastfeeding, and as a means of avoiding breastfeeding with others at home and in the homes of others. For example, breastfeeding in front of in-laws was something this first-time mother found difficult to achieve:

"I think to be honest every time I've seen them (in-laws), no-one has said to me not to feed in front of them but I do feel uncomfortable feeding in front of them, so I usually go to the bedroom to feed when I'm there" (R6, B/F, 1).

Feeding only in privacy and feeding alone was talked about by a few women. For example, one young woman talked about how she knew during pregnancy that she would be uncomfortable breastfeeding in front of others at home and had always planned to go off into the bedroom to feed during visits from family and friends. However, this woman stopped breastfeeding prior to leaving the hospital and never actually breastfed at home or in front of family and friends. Another first-time mother who shared her home with extended family members (in-laws) felt comfortable breastfeeding only within the confines of her own bedroom.

Respondent Codes: R1

Interviews: 4weeks, 1; 10 weeks, 11; 26 weeks 111

Infant Feeding: Breastfeeding, B/F; Formula Feeding, F/F

When asked to say more about this, the woman explained that she was “shy” and felt that breastfeeding was more “comfortable” and “far easier” in the privacy of her bedroom. As a result, this woman suggested that for the first two months following birth she would stay at home to breastfeed and would only leave the house for short periods between breastfeeds.

The notion of breastfeeding as a private activity was common throughout the sample of women. Over half the women, both first and second-time mothers, talked about using the bedroom, or a private space within their home and the homes of others, as a way of avoiding breastfeeding in front of others. Women suggested that while not being “confident” or “discreet” during breastfeeds, the bedroom offered them a “private and quiet time” with their baby. However, there was evidence to suggest that using a private space at home and in the homes of others often left women feeling excluded and isolated, particularly in the early days when feeding could last for up to an hour at a time. This is demonstrated in the comments of a first-time mother:

“My partner has sisters my age, you would think they would come to the bedroom and talk to me, but they don’t. I was really surprised by that, but then I suppose it’s nice to have private time too” (R6, B/F, 1).

On the other hand, half the women in the sample stated that they took ownership of the appropriateness of their breastfeeding within their own home. This was illustrated by using phrases such as “it’s my house, I have the right to give the breast” and “they know where the door is, if they don’t like it” or “it’s their problem if they are uncomfortable”. However, women’s words did not always reflect their behaviour. The majority of these women later in the interview process went on to talk about how at times they used the bedroom to breastfeed during visits from, or to, friends and family. Only three of the mothers interviewed talked about how they would not go “hiding” or “disappearing off” to the bedroom to breastfeed when family and friends visited, suggesting for them that this would be just too “awkward”. One mother, when talking about her in-laws visiting, stated that “it’s just not going to work if we can’t all sit in the same room together”. A few women suggested that while breastfeeding in front of others was initially a “bit strange” and “awkward”, getting past that initial first feed in front of others did enable them to feel a bit

Respondent Codes: R1

Interviews: 4weeks, 1; 10 weeks, 11; 26 weeks 111

Infant Feeding: Breastfeeding, B/F; Formula Feeding, F/F

more comfortable and confident the next time. As the following first-time mothers explained:

“I found it was bit strange at first, my aunt and uncle they came in unannounced and I was in the middle of feeding her when they came through the door. I was a bit, OH GOD, you know, just for the initial few seconds. Then I was like, well it’s the most natural thing in the world, and they were absolutely fine with it, they have been here since when I’ve been feeding and it’s been absolutely fine” (R18, B/F, 1).

“I think it’s that way, once you’ve fed the baby in front of them, then it’s sort of accepted that that’s just what you are going to do, whereas, if I had kept disappearing off all the time to feed then I would feel I can’t feed in front of them now, so. I think once you have done it a few times then you realise. I suppose the more times you do sort of feed when other people are here, then it’s more comfortable” (R12, B/F, 11).

Although all of the women in this study felt that home was the most comfortable and relaxed place to breastfeed, they accomplish breastfeeding with constant attention to where, and with whom breastfeeding felt most appropriate. This fits neatly with the theory of performativity discussed by Butler (1990, 1993, 1997) and Bartlett (2002) whereby each breastfeed is specific to each act, rather than a homogeneous experience for one woman over time and place.

### ***Breastfeeding with others***

As discussed above, breastfeeding in front of others at home and in the homes of others was a particular challenge for the majority of women in this study. Breastfeeding in front of others was mainly discussed in relation to family/friends and strangers. However, such groups covered a whole range of subgroups varying in terms of gender, people who women were familiar with or relative strangers, those with or without experience of breastfeeding and people of differing generations. When discussing breastfeeding with others, the majority of women proposed that breastfeeding in front of other women within their own home or in the home of others felt “comfortable” and “fine”. However, 4 women disclosed how uncomfortable they felt feeding with certain women visitors, mainly their partner’s mother, or women with no previous

experience of breastfeeding or female strangers. As one first-time mother suggested:

“If there is someone in the house that I didn’t know I would feel a bit uncomfortable, like my friend’s friend was in and I didn’t know her, and that makes me feel really uncomfortable” (R2, B/F, 1).

While two of the four women chose not to breastfeed in front of some women, they discussed this in terms of a perceived or actual lack of support from these women who had no previous experience of breastfeeding themselves (see McIntosh 1985). Despite feeling uncomfortable, the other two women did go on to breastfeed in front of their mother-in-laws. However, they did have concerns about the prospect of this, as these first and second-time mothers demonstrate in the following quotes:

“I was more worried about his mum kind of thing. I know it sounds a bit strange but more his mum than his dad, guys don’t bat an eye lid they don’t kind of bother. It’s more women you see moaning and groaning about it, and she was a wee bit put out cause I was feeding her myself, just cause she couldn’t get the extra special cuddles” (R15, F/F, 1).

“The first sort of couple of times that I was down visiting my mother-in-law I wouldn’t feed in front of her, but now, that last time I was down, I was like, she knows now this is how I’m feeding, but I think that it was a confidence thing for me” (R18, B/F, 1).

The above quotes suggest women may feel uncomfortable breastfeeding in front of other women for a variety of reasons. The first quotation suggests that in choosing to breastfeed women must, at times, deal with the negative reaction of others. This quotation also suggests that feeding is an important element of bonding, which others feel they should be part of. This was demonstrated previously (see chapter 5) where mothers were encouraged by others to introduce a bottle to enable shared feeding. The second quotation suggests that women require a level of confidence when breastfeeding with others, in order to overcome their fear of causing embarrassment to themselves and others.

The majority of the women suggested that breastfeeding in front of males (other than husbands/partners) also created significant challenges that led them to question the appropriateness of their breastfeeding both at home and in the



homes of others. The majority of women talked in great detail about how they knew from the outset that they would not be “very comfortable” breastfeeding in front of males. As these first-time mothers explained:

“If there are men there I’m not too comfortable, any men generally, I would say that’s probably the biggest thing, even if it’s relatives, an uncle or my husband’s uncle I’m not comfortable with that” (R2, B/F, 1).

“When my mum and her partner come to stay I go to the bedroom to feed, to be honest I don’t feel comfortable breastfeeding in front of my mum’s husband” (R6, B/F, 11).

Women struggled to articulate factors underlying why they felt particularly uncomfortable or chose not to breastfeed in front of men. It was evident that women talked about these issues in terms of “self” and “others”. Several women talked about being unable to overcome such difficulty because they were “shy” and “reserved” about parts of their body being visible to others: concealment may have been linked to respectability and exposed breasts linked to sexual imagery. In relation to “others”, women talked about “not really knowing what men’s thoughts were about it or how they might react”; this was fuelled by a lack of breastfeeding tradition within their extended family. Furthermore, women also talked about how they perceived men to view “breasts as boobs” (sexual objects) and that any chance of “accidentally exposing yourself” would create embarrassment, something that women wanted to avoid at all costs. This was demonstrated in the quotes of two first-time mothers:

“I won’t feed in front of, like my partner’s mates, I would never feed in front of them, just cause I think they would be embarrassed” (R6, B/F, 11).

“I did feel uncomfortable breastfeeding in front of my sister’s husband, I went to visit them and when I was breastfeeding I felt, I don’t know, it didn’t feel right breastfeeding in front of my brother-in-law sort of thing but I can’t not feed her, so you just have to overcome that shyness” (R18, B/F, 1).

However, overcoming this “shyness” was not achievable for all women. For a few women, this resulted in the introduction of formula feeding. As one second-time mother with a teenage daughter, who had previously breastfed almost everywhere, explained:

Respondent Codes: R1

Interviews: 4weeks, 1; 10 weeks, 11; 26 weeks 111

Infant Feeding: Breastfeeding, B/F; Formula Feeding, F/F

“Before I came home from hospital, I think I knew I wouldn’t be very comfortable feeding in front of men. Recently, I had visitors and I went to my bedroom to feed but I didn’t want to leave the visitors sitting on their own, so I decided the next time I had visitors I would just give him a bottle” (R16, B/F, 1).

This quote reflects the complexity of home as a private space: when others enter the home women may feel uncomfortable and negotiate their breastfeeding behaviour or feel that breastfeeding is not appropriate in the company of particular others.

However, several women talked about how they felt that the younger generation of males were slightly “more in tune with breastfeeding” and were more comfortable with it when their wife had previously breastfed. In contrast, over half of the sample of women suggested that breastfeeding in front of the older generation would conjure up feelings of “awkwardness” and made them feel “uncomfortable”. Women suggested that this reflected the lack of breastfeeding throughout the previous generation and that older people are simply not exposed to breastfeeding within Scottish culture. As these first and second-time mothers explained:

“The 50s 60s and 70s were all bottles, if you were breastfed then it was kind of, not normal. I was bottle fed, we were all bottle fed and my husband and his brother and a lot of our peers my age were all bottle fed” (R8, B/F, 1).

“I think, I more feel, well, if it’s an older man, that they would maybe feel a bit, “oh my goodness, there’s a breast there” and feel a bit uncomfortable. I kind of feel a bit, a wee bit funny with my husband’s dad but more because I wonder if he would feel a bit awkward about it” (R12, B/F, 1).

The lost tradition of breastfeeding within Scottish culture and the belief that breasts are to be enjoyed by men, and not infants, all contribute to the challenges women faced in their attempts to breastfeed in front of others. Women talked about how older men and women were “less in tune” with the “whole breastfeeding thing” and felt that they would be far more likely to be embarrassed about it and pass comment to breastfeeding mothers (reactions from others will be explored further at the end of this section). In order to avoid

feeding in front of the older generation, one second-time mother talked about how she timed her breastfeeds:

“Well I went to my mum and dad’s house because their friends were coming over to give us a present. I was kind of timing the feeds. I thought I’ll have fed him before they come, kind of thing. Probably, I don’t know if I would have fed him in front of them or not, I’d probably have gone to the next room (laughing), but just cause they’re older, it’s that older generation” (R17, B/F, 1).

Breastfeeding in front of male strangers also left mothers feeling particularly uncomfortable while at home. This first-time mother talked about her traumatic experience of breastfeeding at home when the window cleaner started to clean the sitting room windows:

“The other day I was sitting breastfeeding and the window cleaner came (we don’t have blinds up), and because he’s not feeding well, he’s coming on and off the nipple all the time, so as soon as he’s off I’m exposed. I was like “please don’t come off, please don’t, please don’t” and I didn’t want to make eye contact with him (window cleaner) in case he was looking, cause that would have made me even worse, so I was trying, to turn and all that kind of stuff but I would have been mortified if he came off” (R4, B/F, 1).

As demonstrated above, breastfeeding occurs in front of others and raises many issues around public performance at home. Women were aware that breastfeeding in front of others might result in negative feedback. As a result they spent a considerable amount of developing strategies and participating in self-surveillance in order to breastfeed in front of others comfortably and discreetly. As such, women continually consider and negotiate the appropriateness of their breastfeeding in relation to their location and the observer.

### ***Breastfeeding discreetly***

All of the women interviewed emphasised the importance of breastfeeding discreetly in order to avoid embarrassment to themselves or others. Discretion for breastfeeding women typically referred to not showing any part of the breast or abdomen while feeding. Women went to great lengths to achieve, not only

discretion, but also “invisible breastfeeding”. A second-time mother suggested that:

“You can stick them under your jumper and no-one really knows you are doing it, it just looks like you’re cuddling your baby” (R 8, B/F, 1).

However, as discussed above, trying to get the baby positioned correctly on the breast, while at the same time keeping all parts of the breast and stomach area covered, was a skill that did not always come easy for all women. The majority of first-time mothers perceived that other women manage discretion with great ease, while they themselves felt “slightly awkward” with it all and talked about still trying to get the “knack” of it. This was particularly evident for the following first-time mothers:

“I remember watching my friend and she was really discreet, she just went like that (hand motion to the breast) where I’m still a bit like awkward, he comes off and it’s still a bit more showy” (R2, B/F, 1).

“I’ve not quite mastered the, you know when you see people that just go (hand motion to attach baby) and you don’t see anything, I do not understand how they do that, I get in a terrible pickle with the whole thing, cloths, clothes everywhere and planning outfits and things, its like, OH GOD” (R4, B/F, 11).

The majority of women found that in the early weeks following birth breastfeeding discreetly was almost an unachievable goal. Two mothers feeling extremely uncomfortable about breastfeeding in front of male friends/colleagues at home talked about how they had asked them to leave the room for five minutes just while they latch the baby on. They then went on to use clothing and cushions in order to continue breastfeeding discreetly. It is evident from this example that there are undoubtedly tensions around the home as a private space when others enter.

All of the women, in their efforts to breastfeed discreetly, talked about using baby blankets, shawls and scarves as a way of ensuring they were covered and that nothing would be visible. However, the most important factor raised by women in achieving discretion focused on “suitable” clothing. All of the women talked about how they spent a considerable amount of time thinking about what to wear when breastfeeding with others. As this first-time mother explains:

Respondent Codes: R1

Interviews: 4weeks, 1; 10 weeks, 11; 26 weeks 111

Infant Feeding: Breastfeeding, B/F; Formula Feeding, F/F

“You definitely have to think about what you wear, and it takes time to realise what kind of clothes are easy to open and give the breast to the baby, and as well to pull over her in order to be discreet” (R26, B/F, 11).

Both first and second-time mothers suggested that the best type of outfit for discreet breastfeeding was a loose fitting T-shirt with a cardigan.

“If I’ve got a wee tee-shirt on I just flick my bra down and stick her under, up ma juke as they say in Glasgow, it’s a good saying (mum talks to baby) I’ve got a few things, but not many I just manage with stuff that’s loose, as long as you have a loose top on, you know you’re fine” (R 8, B/F, 11).

“I always really wear a tee-shirt with a cardigan on top. The cardigan is good because my stomach could be exposed when I’m feeding; and my cardigan covers my stomach area” (R2, B/F, 11).

However, as breastfeeding continues over a period of months, women struggled and felt restricted having to continually wear clothing suitable for breastfeeding. Women felt that they had few tops that were particularly suitable for breastfeeding and were reluctant to buy loose clothing, especially when they were starting to regain their body shape. As this first-time mother explains:

“You feel like suddenly you don’t have a big tummy anymore so you don’t want to wear big baggy tops anymore” (R12, B/F, 11).

As well as using clothing as a means of breastfeeding discreetly, several women talked about how they would alter their body position or sit in a particular seat while breastfeeding in order to remain as discreet as possible. One second-time mother talked about how when her brother-in-law came into the house she would turn her body sideways in order to face the other way. However, the proximity to others within the confines of the home and the homes of others adds further challenges to the art of discretion. Women talked about how they had a tendency to sit in a particular chair, and used pillows as a protective screen. As a result, women constantly developed their skills and negotiated their breastfeeding behaviour in order to remain discreet. This fits neatly with Bartky (1988) and Spitzack (1990) theory of three dimensions of objectified body consciousness: beliefs about appearance, control of the internalisation of

cultural body standards and body surveillance. Here women participate in self-surveillance, and see themselves as others see them as a necessary part of complying with cultural body standards while avoiding causing any embarrassment to themselves and others while at home and in the homes of others.

### ***Reactions from others***

All of the women interviewed negotiated their behaviour and developed several strategies aimed at achieving “invisible breastfeeding”, both at home and in the homes of friends and family. When women were asked about the reaction from others, some suggested that they had not received any negative reactions from others. However, when asked about feeding in front of others, the majority of women did mention that male visitors appeared visibly uncomfortable being in the same room as them while they breastfed. One mother talked about being at her parent’s house and her dad asking if she was “going upstairs to feed him”, and this mother translated this to “can you please go up the stairs to feed him, because I’m a bit uncomfortable”. In addition, several women talked about how men had a tendency to get up and leave the room when they started to breastfeed. As this second-time mother explains:

“The one thing that was funny is that my father-in-law was up at the weekend and he can’t watch me feed, he stayed out of the room: I think he is a bit embarrassed but it doesn’t bother me, he just doesn’t want to see his daughter-in-law’s boobs” (R8, B/F, 1).

Similarly, another woman talked about how her husband’s friends would always leave the room to go outside to smoke when she was breastfeeding. Or they would say, “sorry, sorry, sorry” when they entered the room while she was breastfeeding. Witnessing men being “uncomfortable”, “awkward” and “not knowing where to look” sent a strong message to women that men believed that breastfeeding was something that should be done in privacy. However, this may have been reinforced when women retreated to the bedroom to feed. A second-time mother talked about how uncomfortable she felt by her father-in-law’s reaction when she breastfed her first child:

“Well I remember once feeling really uncomfortable, my father-in-law was saying ‘oh put them away’ he was just kind of joking but I think he is generally embarrassed about breastfeeding. He’s that sort of person, so I would go up the stairs a lot to breastfeed” (R1, F/F, 1).

In describing how awkward men felt around breastfeeding women, one woman who breastfed in front of her brother perceived him to be a bit “paranoid” and “scared” to look at her in case he got a “flash of his sister’s boobs”. Likewise, the majority of women talked about how male friends and relatives struggled with where to look and at times overcompensated by “really focusing on your face” while trying “not to look anywhere else”. Conversely, the majority of women found that feeding in front of men whose wives had previously breastfed was a far more comfortable experience, and that men seemed far less embarrassed about breastfeeding when they had previous exposure. As this second-time mother illustrated:

“I think men in general or family relatives probably think they shouldn’t be there when you’re feeding. I think especially because my sister didn’t breastfeed so maybe those two brothers-in-laws might be embarrassed but my other brother-in law of my sister who has previously breastfed he’s not bothered, and I wouldn’t be bothered about him seeing me breastfeed” (R8, B/F, 1).

However, the reactions of children and teenagers to breastfeeding also left women in this study with feelings of bemusement and surprise. For example, a few of the women talked about their child’s reaction or the reaction of other children to their breastfeeding. Children frequently approached women who were breastfeeding to ask them what they were doing. This first-time mother talks about the reaction of her friends’ two children:

“My friend’s two wee boys were absolutely fascinated and just sat watching me feed; they completely ignored the television, (laughing), they thought it was amazing. They don’t remember each other being fed, so they thought it was amazing. They were kind of asking if the baby could have some coca-cola, cause they were having coca-cola. I told them if I drank it, the baby would get it, so the baby is getting it now, as I’m drinking it (laughing), educating the next generation of boys (laughing)” (R13, B/F, 11).

Another woman talked about the reaction of her 8 year old daughter to her breastfeeding:

Respondent Codes: R1

Interviews: 4weeks, 1; 10 weeks, 11; 26 weeks 111

Infant Feeding: Breastfeeding, B/F; Formula Feeding, F/F

“She thinks it’s funny that I get milk out of my boobies though (laughing), she finds that hilarious. I said that’s where you got it from as well, “oh”, where else did you think it came from, “oh”, she just kinda thinks about it” (R8, B/F, 1).

However, for one woman the reaction of her teenage daughter came as a bit of a surprise:

“My daughter was a bit grossed out at first she thought it was really unpleasant, but now she has got use to it, and she just ignores it. She was like, ‘who would want to do that’, but that’s just an age thing I suppose. She has teenage friends and she didn’t want me to feed in front of her friends either, but I do with her best friend, I just have to do it” (R16, B/F, 1).

As such, breastfeeding discreetly within the confines of the home or in the homes of others was not always enough to prevent negative reactions. Even when women were comfortable and relaxed breastfeeding at home, they found that they adopted several strategies to breastfeed discreetly and were left with a “bad” feeling when other people were uncomfortable and wanted to leave the room. At the same time, women fully understood the sexual nature of breasts may cause embarrassment to others.

However, a second-time mother talked about how her teenage nephew and his friends were comfortable with her breastfeeding in the same room:

“Like yesterday up at my sister’s my nephews and his friends were in. I was sitting feeding him and like they are bigger boys about 14 or 15 but they can’t even tell, they don’t even know, they just think I’m sitting holding him. They don’t even; I suppose they were used to it with me feeding (daughters name) anyway. At first they were a bit curious and a bit OH, but because I didn’t make a big deal of it, it was almost dead natural to them, and they don’t bother, so that’s nice (R5, B/F, 11).

The majority of women in this study suggested that breastfeeding in the presence of others who had previous experience/exposure to breastfeeding was a much more comfortable experience.

Although women described their home as the most comfortable place to breastfeed, it was also at times an uncomfortable environment when receiving visits from others. Women talked about how they developed several strategies in

Respondent Codes: R1

Interviews: 4weeks, 1; 10 weeks, 11; 26 weeks 111

Infant Feeding: Breastfeeding, B/F; Formula Feeding, F/F



order to breastfeed comfortably in the presence of others. In spite of attempts by women to take ownership of their breastfeeding at home, the home was not always a place where women were free to breastfeed without surveillance and self-management of their breastfeeding bodies. The majority of the women in the study found breastfeeding in front of the younger generation was something that they on the whole were comfortable with. On the other hand, males and the older generation were found to be particularly challenging and a few women talked about how they felt uncomfortable feeding in front of other women. However, where others and particular men had previous experience of breastfeeding, women reported that they felt more comfortable and relaxed when breastfeeding. Gender and generational factors do played a role in the perceived and actual reactions from others, and as a result the majority of women suggested that they negotiated their behaviour and developed strategies in order to maintain “invisible breastfeeding” at home during visits from others.

## **Breastfeeding outside the home**

Having discussed where and with whom women feel most comfortable while breastfeeding at home and within the homes of others, the main aim of this section is to explore women’s experiences of breastfeeding outside the home within the first ten weeks following birth. Women talked in great detail about the issues surrounding breastfeeding outside the home; these issues are addressed within three main categories. First, all women in this study suggested that they spent a considerable amount of time at home preparing for breastfeeding outside the home. Preparation related mainly to building on their breastfeeding skills and confidence, a thread that will run throughout all of the following sections. Second, the majority of women talked about developing strategies that enabled them to restrict, hide or “breastfeed invisibly” when venturing out. The third section will focus on environments women considered being most/least appropriate for breastfeeding when outside the home.

### ***Preparing for breastfeeding outside the home***

Preparing for breastfeeding outside the home was something that all women talked about in the early weeks following birth, and was discussed at two levels.

Respondent Codes: R1

Interviews: 4weeks, 1; 10 weeks, 11; 26 weeks 111

Infant Feeding: Breastfeeding, B/F; Formula Feeding, F/F

First, all women talked about feeling comfortable breastfeeding outside the home only once they had developed their skills and confidence when breastfeeding with others. Women used phrases like “once we get better at it” and “when I feel a bit more confident, I definitely will breastfeed out”. However, in the early days and up to 4 weeks following birth, the majority of women stated that they had not yet breastfed outside their home, or the homes of others. Women highlighted two explanations for their withdrawal or limited time spent outside the home. First, women talked about how exhaustion and the constraints of a constant feeding regime in the early days prevented them from going out. Second, the majority of women talked about how they withdrew from public spaces due to a lack of confidence in their ability to breastfeed discreetly and comfortably while out with their baby. As the following first-time mothers explained:

“I think, as I say I will try and do it in public in front of people when I’m a bit more confident with it. He is only four weeks and he is still learning himself, and I’m still learning. Each week it changes, so once we get better at it, and when I feel a bit more confident, I definitely will breastfeed when I’m out” (R2, B/F, 1).

“I can’t imagine how I’m going to manage to feed in a café or anything yet but I’m sure I’ll get a good technique with time. I need to learn to feed in cafés and places like that. I don’t feel embarrassed or scared in public, as much as just getting my technique right. I’m sure the first time I do it in a café I’ll be a bit, oh gosh; I hope no-one minds or whatever” (R12, B/F, 1).

However, the unpredictable nature of infant feeding led the woman (quoted directly above) to overcome her lack of confidence about breastfeeding in public when her infant needed fed during a meeting she had at work. Despite having a strategy in place to avoid breastfeeding in the meeting, this mother goes on to explain her thought process and actions when deciding whether to feed her infant in the meeting:

“I went to try and feed her before the meeting but she was sleepy and didn’t want to feed. After about an hour I sneaked out of the meeting and went down, and she was screaming her wee head off and I felt really bad, I thought, she needs fed. I kind of thought should I go back into the feeding room and feed her there, or go back into the meeting. I thought it’s a maternity hospital (laughing); I think it’s probably ok to feed in the meeting. So I just went in and sat in the

corner and just kind of draped a muslin over me, so that I didn't feel anybody could see anything, so it was actually ok" (R12, B/F, 1).

Despite the fact that this meeting took place within a maternity unit that promotes, protects and supports breastfeeding, this woman felt unsure of the appropriateness of her breastfeeding in the meeting. While breastfeeding, this woman felt the need to sit in the corner and monitor her body to ensure she fits in with what is considered 'normal' behaviour. As such, a woman's ability to breastfeed outside the home was not only about women developing their skills of attachment, it is also their ability to self-scrutinise in order to breastfeed comfortably, discreetly and confidently. However, as this second-time mother explains:

"It a weird thing, you can't always think I'm going to feel comfortable and confident here and not there, it really depends on how you're feeling that day, and if your feeling up to it. If you're feeling miserable you might not want to breastfeed in public that day. I don't have a reason not to be confident about breastfeeding but there is maybe an inbuilt British sense of modesties about it, and I have only seen a few other mums breastfeeding in public, so that really doesn't help your confidence" (R17, B/F, 11).

Cultural influences and the general lack of visibility of breastfeeding women in public spaces do impact on a woman's ability to breastfeed comfortably and confidently in public. Although only a few women mentioned the Breastfeeding etc. (Scotland) Act (2005), they did suggest it gave them additional confidence when thinking about breastfeeding outwith the home. As the following first-time mother illustrates:

"My mother-in-law who works in the school told me that it's against the law for somebody to stop you from breastfeeding in public, and that made me feel better. It gives me more confidence when I'm out to know that" (R2, B/F, 1).

While working to build up their confidence and their ability to breastfeed discreetly, the majority of women talked about how they prepared themselves for breastfeeding outside the home by going out between feeds and "sussing out" spaces that they deemed would be comfortable and appropriate while breastfeeding. As the following first and second-time mothers suggested:

Respondent Codes: R1

Interviews: 4weeks, 1; 10 weeks, 11; 26 weeks 111

Infant Feeding: Breastfeeding, B/F; Formula Feeding, F/F

“There is a nice park down the road and they have a nice café that’s always filled with loads of children and everything. I imagine it would be one of the first places I would go, I would feel quite happy feeding her in there, and that would probably be a good place for me to meet friends” (R12, B/F, 1).

“Well, I have been at Braehead and looked at the feeding room there. I was at Silverburn yesterday and I thought let’s go and look at the feeding facilities, cause obviously it’s much different from eight years ago when I last used them. I was quite impressed I have to say, there’s a lot of private rooms now that you can go into” (R8, B/F, 1).

Although women spent considerable time preparing for breastfeeding outside the home, few actually did in the early weeks following birth. Not feeling particularly confident in their ability to breastfeed discreetly, while at the same time feeling somewhat restricted at home, some women adopted several strategies in order to combat the restrictive nature of breastfeeding.

### ***Venturing out: strategies used when feeding outside the home***

In their attempt to re-enter the public sphere with the new identity of a breastfeeding mother, women devised several strategies in order to feel confident and achieve, what could be considered, invisible breastfeeding. Such strategies occurred at 3 levels. First, women talked about how they would “time” their baby’s breastfeeds in order to avoid any breastfeeding outside the home. This was mainly achieved by planning short trips out of the home between feeds, explained in phrases like: “to be honest, I try to go out between feeds”. This was common amongst the sample. Women also talked about the introduction of bottle feeding as a means of avoiding breastfeeding outside the home. Second, women talked about how they used their cars in order to feed their infant or only felt confident breastfeeding in the confines of the infant feeding rooms within department stores and shopping malls. Often women considered their cars and feeding rooms as an extension of their domestic space. Although the feeding rooms were open to all members of the public with small children, there was an expectation amongst the women that other women rather than parents would use them. Thirdly, women used specific clothing and blankets in order to breastfeed comfortably and confidently when outside the home, a similar strategy to that used when feeding at home with others.

Respondent Codes: R1

Interviews: 4weeks, 1; 10 weeks, 11; 26 weeks 111

Infant Feeding: Breastfeeding, B/F; Formula Feeding, F/F

The majority of women talked about how they spent a considerable amount of time planning their time out of the home in order to avoid breastfeeding when out with their baby. Women talked about how they planned short-trips into town, the local shopping centre and supermarket without having to breastfeed. As the following first-time and second-time mothers suggested:

“Some mums might have done what I’ve done; they might go out in between feeds, just because it’s so much easier” (R8, B/F, 11).

“I’ve been in town, but I’ve not needed to feed, I tend to work it in with the feeds, you know, so she’ll get her feed at 9.30 in the morning and then as soon as her feed is finished she’s winded in the pram, sort of thing, and cause you’re knackered you’re not spending ages in town, so then I’m home in time to feed her” (R18, B/F, 1).

A few women talked about the difficulties of getting out and back between breastfeeds, and how they faced time constraints that did not enable them to stop and feed while out. These women suggested that feeding their baby formula milk before going out kept the baby satisfied for longer. A second-time mother also demonstrated this through the suggestion:

“I was finding if I had to go for my shopping and stuff when I’m breastfeeding, it takes such a long time. I found if he had a bottle he was more satisfied, you know he wasn’t going to be waking up in the middle of the supermarket hungry. It’s the time that it takes to get there, and then him waking up for a feed in the middle of the shopping. I don’t really want to sit in the changing room and feed him for an hour, and then it takes so long to get home again, so it’s handy for me to give him the bottle” (R16, B/F, 1).

Bottle feeding also offers an opportunity for women choosing to breastfeed to be out with their baby without actually having to breastfeed. Bottle feeding outside the home was a strategy adopted by a third of the sample, when they did not feel confident about feeding in public. As the following first-time mother explained:

“If I go to town or something, say I’m in Debenhams or something like that, and I’m shopping and I decided that and baby needs to have her food, I’ll give the bottle. I try to breastfeed the baby before I go out so the baby would have plenty and be settled. But my baby sometimes gets very, very hungry, so I said to my mum we need to walk and find somewhere to feed, because I had a bottle you see” (R26, B/F, 1).

However, on finding a breastfeeding room within the shopping mall this first-time mother (R26, quoted above) opted not to use the formula bottle she had prepared, and instead sat comfortably in the room and breastfed. As she excitedly explained:

“There was a bottle on the door, when you open the door a huge room, I’ll not be kidding, with a nice leather sofa in a semi circle and very light, but not over the eyes... Once you are there you feel just so comfortable and whoever will be there will be another mother, breastfeeding or giving the bottle here, but there was no one there. It’s good cause the only people that would enter would be parents, so I breastfed there, rather than use the bottle, it’s a great place I will go back there, and of course it’s very comfortable” (R26, B/F, 1).

The area described in the above quote is illustrated in figures 22 and 23 below:



**Figure 22: Parent Corridor in Silverburn Shopping Centre**

Respondent Codes: R1

Interviews: 4weeks, 1; 10 weeks, 11; 26 weeks 111

Infant Feeding: Breastfeeding, B/F; Formula Feeding, F/F



**Figure 23: Feeding Room in Silverburn Shopping Centre**

The majority of women in the study emphasised the importance of having an area where they could breastfeed comfortably, particularly when they were still struggling with mastering the art of discretion, and building up their confidence. As one mother explains:

“I’ve not fed out in public, as in sat in a coffee shop or anything like that, because if he just went on and fed that would be fine, but he’s not, so I’ve been going into the feeding rooms. I’m sure when I’m more confident I will do it in a cafe” (R2, B/F, 1).

Similar to breastfeeding at home, the majority of women suggested breastfeeding in front of others outside the home was particularly challenging. As a result, women went to great lengths to plan their trips out around the infant feeding rooms in order to achieve a degree of privacy and to feel comfortable and relaxed while breastfeeding outside the home in shops and shopping malls. As the following second-time mother demonstrated:

“If I’m taking him (baby) out by myself then in my head I’m planning the places I’m going, and where the feeding areas are. If I’m going into town I always end up in the Debenhams or Marks & Spencers cause I can feed there, you kinda do a rough thing in your head before you go out anywhere” (R5, B/F, 1).

In addition to the feeding rooms, women also frequently talked about how they used their cars as an extension of their domestic space. The car was regarded as space where women could also achieve some privacy, away from the public

Respondent Codes: R1

Interviews: 4weeks, 1; 10 weeks, 11; 26 weeks 111

Infant Feeding: Breastfeeding, B/F; Formula Feeding, F/F

gaze. As discussed by Pearce (1999) the car has the ability to act as a private dwelling as the walls/doors offer protection from the outside world and others can only enter when invited to do so. The following woman talks about the privacy of feeding in her car:

“I’ve had an outing where I didn’t get back in time and I ended up feeding her in the car. I was in a car park so it wasn’t as if, you know, there was any visibility sort of thing. It’s kinda needs must and when they’re screaming their heads off and getting all frantic you’re just like, oh well you’ve got it there, it’s on tap, why not just give her it you know” (R18, B/F, 1).

Similar to breastfeeding at home, all of the women in this study also talked about the importance of suitable clothing when breastfeeding outside the home. However, a noticeable difference emerged when women talked about restrictions on what they could wear at special events such as christenings, weddings and other family gatherings. For example, the following second-time mothers talked about difficulties in wearing a dress for an upcoming wedding and christening:

“We are going to a wedding, and it’s quite a long wedding, and you know I’ll be wearing an evening outfit you know? I’m thinking how I will manage to breastfeed; it will be not easy to take this outfit off and to breastfeed. It’s still a problem for me; I always have to think about it. I don’t have a choice of thinking about it because it must be something special I wear, but we’ll manage somehow” (R21, B/F, 11).

“I had a dress on that day, and I don’t often wear dresses just cause you can’t really breastfeed with a dress on. I didn’t have a breastfeeding bra on either. We had everyone back at the house and there was a lot more people than we anticipated. I thought I’d sneak off upstairs to feed him because it was a hard day and a bottle wasn’t doing it for him. The other thing is you need to lift the dress up to feed, that wouldn’t work” (R5, B/F, 11).

However, the need to wear a dress and feel dressed up was important to women and something that breastfeeding women valued highly. Women talked about how they continually compromised what they would wear in order to continue breastfeeding, as demonstrated by the following woman:

“I won’t be able to wear a dress I’ll just wear a top or something. On my Christmas night out, I wasn’t breastfeeding so I was able to wear a dress then, which was great” (R17, B/F, 11).

Respondent Codes: R1

Interviews: 4weeks, 1; 10 weeks, 11; 26 weeks 111

Infant Feeding: Breastfeeding, B/F; Formula Feeding, F/F



This indicates a conflict with breastfeeding and continuing normal life: which fits with the theory of liminality that women are in a transitional zone that they move into to breastfeed and move out of to reintegrate with society (see Mahon-Daly and Andrews (2002)).

### ***Defying the crude categories of the public and private***

By the 10-week interviews the majority of women continuing in the study had some experience of breastfeeding outside their home and the homes of others. The majority of women had a tendency to gravitate towards infant feeding rooms within department stores and shopping malls; such rooms were viewed as an ideal way to achieve a degree of privacy and feed their infant comfortably outside the home. However, the availability and standard of feeding rooms varied considerably. Within this final section there are two main themes. Firstly, the discussion will address the criteria developed by women about what is important within breastfeeding facilities. Secondly, the section will move on to explore which environments women considered most/least appropriate when breastfeeding, and strategies they used in order to feel comfortable breastfeeding within these spaces.

Feeding rooms were highly valued by all breastfeeding women, particularly when out shopping on their own and while not feeling confident enough to breastfeed in cafés. As the following first-time mother suggested:

“I’ve been to Silverburn a few times... I went on my own, so I didn’t want to feed her, like I didn’t really feel like I wanted to go into a café and have a coffee, not when I’m on my own, I didn’t feel like I wanted to do that. They (Silverburn) have actually got a feeding room, they’ve got quite a good baby area, they’ve got like a changing area and they’ve got like a private room with a wee cream sofa in it for feeding. I just went in there and fed her, which is quite nice to know because it means you’re not having to restrict your outing to having to be back within the three hours” (R12, B/F, 11).

Feeding rooms in public spaces did offer women an alternative to going out only between feeds. Within the sample, the shopping malls at Silverburn and Braehead were discussed by all of the women as having “great breastfeeding facilities”. In Silverburn this was mainly described as “a big feeding area”, with

Respondent Codes: R1

Interviews: 4weeks, 1; 10 weeks, 11; 26 weeks 111

Infant Feeding: Breastfeeding, B/F; Formula Feeding, F/F

“a nice leather sofa”, a “comfortable and quiet” space and “perfect for breastfeeding” (see figure 23). The majority of mothers suggested this was a place where they could happily spend time feeding their baby while chatting with other mothers. However, few women actually met other breastfeeding mothers while in these rooms.

Having large, separate toilet facilities was also important for women in this study, as the following first-time mother explains:

“When I found that they’ve (shopping centres) got family toilets where you can fit a pram in, it was great. Before I always went to the disabled ones so I could fit the pram in, cause you can’t exactly go to the toilet and shut the door and leave the baby outside. I had mentioned that to someone and they said to me, oh, no, they’ve got family toilets and I thought oh, right, I’ll get the pram in there” (R2, B/F, 11).



**Figure 24: Baby Area in Braehead Shopping Centre**

Figure 24 depicts the view on walking in to the baby changing area in Braehead. The top of the picture shows a blue seating area designed to accommodate parents choosing to bottle feed their infants. The first exit on the right leads to a large adult toilet area, whilst the second exit provides an area for breastfeeding mothers only. To the right of the bottle feeding area is an area for baby changing, illustrated in figure 25 below:

Respondent Codes: R1

Interviews: 4weeks, 1; 10 weeks, 11; 26 weeks 111

Infant Feeding: Breastfeeding, B/F; Formula Feeding, F/F



**Figure 25: Baby Changing Area in Braehead Shopping Centre**



**Figure 26: Breastfeeding Area in Braehead Shopping Centre**

Several mothers referred to the feeding rooms in Braehead as being a “brilliant” and “colourful” space; again with separate toilet/changing and feeding/breastfeeding areas. Having a separate room specifically for breastfeeding women was an important factor for several mothers. The idea of being able to change the baby in one area and move through to another area to feed, and possibly interact with other breastfeeding mothers, was seen as the ideal breastfeeding facility by all of the women in this study.

However, women also referred to some facilities that were far from desirable for breastfeeding. Several mothers talked about how they tended to avoid going into the city centre, as finding a suitable place in which to breastfeed was difficult. Feeding rooms within city centre shops were frequently described as

Respondent Codes: R1

Interviews: 4weeks, 1; 10 weeks, 11; 26 weeks 111

Infant Feeding: Breastfeeding, B/F; Formula Feeding, F/F

just toilets, baby changing rooms or “cold tiny little cubicles with a chair and a curtain that shut over”. A few women had strong objections to feeding in such areas, suggesting that breastfeeding should not take place “behind curtains” or in “toilets”. As two second-time mothers suggested:

“I ended up feeding him in the (ladies) changing rooms in Asda. I was in there at the time and asked the woman (shop assistant) if there was a feeding room and she said no just the toilets really. But I’m sorry I’m not feeding in a toilet, so I fed in there (changing room), I was in there a lot longer than they thought I should be” (R5, B/F, 1).

“There are a couple of places you have to breastfeed in smelly toilets, mostly in shops or sitting in this little cubicle (laughing). I remember sitting there thinking this isn’t very nice, you could smell the nappies and things, that why I haven’t used them this time, it just feels like you’re shutting yourself away it’s a bit weird” (R 17, A, B/F, 1).

Below are two images of feeding facilities in John Lewis, Glasgow. It is clear from figure 27 that the feeding rooms are for parents with children, and the bottle logo on the door of all the feeding areas discussed in this study reinforces the notion of the prominence of a bottle-feeding culture.



**Figure 27: Door to the Feeding Room in John Lewis, Glasgow**

Figure 28 clearly demonstrates that this parent and child toilet is designed so that women can sit and feed their infants and also have an area in which to change the baby’s nappy. However, as there is only one chair in the room, this is therefore not a social space where women can meet other breastfeeding

Respondent Codes: R1

Interviews: 4weeks, 1; 10 weeks, 11; 26 weeks 111

Infant Feeding: Breastfeeding, B/F; Formula Feeding, F/F

women. In addition, men are also likely to use this space when accompanying small children. Finally, as one women stated above, close proximity of the nappy bins to the feeding area at times created an environment where women did not feel particularly comfortably while breastfeeding.



**Figure 28: Feeding Room in John Lewis, Glasgow**

Separating feeding areas from association with baby changing and toilets facilities was very important to the majority of the women, as was the notion that breastfeeding should not need to take place behind a curtain in a small cubicle big enough for only one person. As breastfeeding can take a considerable amount of time, sitting in a relaxed environment in a comfortable chair, with large toilet and changing areas in adjoining rooms, was something that women considered important. The lack of appropriate private breastfeeding facilities in the city centre led the majority of women to shop and spend time in their local shopping mall rather than the city centre. Furthermore, one woman highlighted the importance of having an area for breastfeeding:

“There was a guy and a girl in the feeding room, so I kind of swerved it a little bit in the hope that the guy would go... I just went in for a couple of minutes and sat and then they left. They were bottle feeding their wee one, who was a bit older, in the feeding room? The feeding room (door) has a bottle on it and it doesn't say breastfeeding only or anything like that... I wasn't going to breastfeed with him there, you know what I mean” (R2, B/F, 1).

Respondent Codes: R1

Interviews: 4weeks, 1; 10 weeks, 11; 26 weeks 111

Infant Feeding: Breastfeeding, B/F; Formula Feeding, F/F



As discussed above, there was an assumption that feeding rooms are for women rather than parents. The idea that parents would use a feeding room to bottle feed their infant was considered “strange” by this mother. However, it does reinforce the notion that feeding rooms are semi-public spaces open to all persons accompanying children, whether male or female. As women attempt to make these spaces breastfeeding friendly, they may experience a level of annoyance when such spaces are entered by men. This reinforces the fact that feeding rooms are not private spaces but that they do feel like that until men enter.

Outwith the shopping areas, two women talked about their experience of breastfeeding within venues run by Culture and Sport Glasgow. In the newly refurbished Kelvingrove museum, a second-time mother talks about her surprise at being unable to find any breastfeeding facilities:

“I was surprised about Kelvingrove museum, it’s a very good museum, and there is plenty of stuff to do for the children, but they don’t have any breastfeeding area, they don’t have any at all. I don’t know why they didn’t think at all about breastfeeding. It’s such a family place but when you get to breastfeeding there is just nothing. Even more, in all these places there are things to warm up your bottles and food you know for babies and even toys for toddlers but nothing there for breastfeeding” (R21, B/F, 11).

However, directly across the main road in what was previously the Transport Museum, another second-time mother talked about how she felt confident about breastfeeding there when she noticed a “Breastfeeding Welcome Sign” displayed in the lift to the café:

“I was out somewhere, it was in a lift, and it said “breastfeeding mothers welcome here” and I was like “ooooo” (laughing). I thought that’s quite a nice sign. It did actually have an impact on me feeding there, although I would have done it anyway but I felt more, more kind of confident and, you know, I don’t know, it was weird, that it was allowed, and if someone else seen the sign that they would also be aware that women were breastfeeding here. It was quite nice to see but I’ve only ever seen that one. Oh, it was the transport museum and it was going up to the café” (R17, B/F, 111).

The absence of a feeding room within public buildings, coupled with the provision of bottle feeding facilities, reinforced for this mother the notion that

bottle feeding is the culture norm and that breastfeeding was not welcomed. However, displaying a sign welcoming women to breastfeed in the transport museum café enabled one woman to feel more confident and comfortable while breastfeeding in the public area of the cafe.

Cafés were discussed by the majority of women as a comfortable place in which to breastfeed when out with a baby, although feeding in cafés was not something that came particularly easily and was only achievable when women felt confident enough to breastfeed discreetly. However, feeling confident and comfortable while breastfeeding in one particularly café did not imply that women would feel confident and comfortable breastfeeding in all cafés rather women talked in detail about how they spent considerable time deciding which cafés were most appropriate for breastfeeding. Cafés suitable for breastfeeding were described as places where lots of women and their infants gathered. However, open-air cafés in malls and department stores and small cafés with no discreet areas were seen as less appropriate. As the following first-time mother explained:

“There are some coffee shops in Silverburn that I wouldn’t go in and breastfeed, and some like Starbucks that are OK. Starbucks has got an upstairs and you see quite a lot of mothers up there doing it, up there it’s more discreet. Upstairs, well it’s a bit quieter and there are only so many seats, there is also a bigger space for a passer-by, so it’s more comfortable. Like downstairs there is the queue and the seats on the other side of the queue, so everyone can see what you’re doing, I definitely wouldn’t sit there and feed. There is another coffee shop near Tesco end, you could go in there and go round the corner, there’s a wee corner bit you could sit round there at the back, which would be alright, for me it’s really important to be out of the way” (R2, B/F, 1).

Women in this study constantly used strategies, and negotiated their breastfeeding behaviour, in order to reduce their level of anxiety when breastfeeding in cafés. Women talked at great length about how important it was for them to find a discreet location within the café in which to feed. For example, women preferred an area at the back of the café; somewhere they could have their “back to others” and “avoid any eye contact”. In addition, women looked for a comfortable supportive seat, preferably a sofa. Once seated, women talked about how they wore particular clothing when out with

their baby and took additional wraps and cloths to cover themselves as much as they possibly could to ensure discretion while breastfeeding. Meeting all the above criteria enabled women to feel confident and comfortable while breastfeeding in cafés and, in turn, they hoped it would prevent them from receiving any negative reaction from others.

The majority of women suggested that they preferred to use cafés when out with friends and family, while only a few women talked about breastfeeding in a café when out on their own:

“The second time I went shopping I found a table in a café. I had my back to everyone and it was fine, there was only one person that looked or didn’t know where to look, but it was quiet. I think if it had been busy I wouldn’t have done it in that place. I always thought I wouldn’t do it (breastfeed in public) but god it’s restrictive enough as it is” (R4, B/F, 1).

Although not all spaces are inherently breastfeeding friendly, women tend to pick certain spaces/cafés and make it breastfeeding friendly. Once a group of women gathered in a particular space they then define it as that, and arrange to meet their friends there. As a result, women can make some public places breastfeeding friendly spaces. As the following first-time mother explains:

“Last week when we went with the mum and baby group down to the Rukenglen park and there is a wee café so we all went in and sat in a wee corner. There was three of us breastfeeding in the group, so we have actually, we said to them when we left, because we were in a wee corner that was a wee bit more discreet, we actually said can we book that wee corner for next week, just so we were a wee bit more hidden in a way” (R12, B/F, 11).

Although the majority of women talked about cafés that were appropriate for breastfeeding, restaurants, on the other hand, were deemed as one of the most inappropriate place to breastfeed. As the following mother explains:

“I’m sure there would be some restaurants and places that I would feel a wee bit funny about it. We have tended to go to baby type places for lunches where I could feed and change her. Probably, maybe being in a restaurant is the most likely places that you might be, well that I wouldn’t feel comfortable” (R12, B/F, 11).



Several women talked about receiving negative reactions from others while out with their baby in restaurants. One woman talked about how a male restaurant employee reacted to her breastfeeding:

“We used to go to a restaurant in Shawlands, the guy who served us at the bar, just stared, he was obviously quite interested (laughing), but he really wasn’t offended or anything, he obviously didn’t see it often in there” (R5, B/F, 11).

Restaurants, more than any other social space discussed made women feel uncomfortable and, as a result, few women chose to breastfeed in them. It is possible that women in this study regarded restaurants as adult space where children and breastfeeding are not welcome, and this notion was strongly reinforced by a lack of baby facilities available in such spaces.

One women went on to suggest that “some people have a problem with breastfeeding in public” and proposed “that if someone has gone to a restaurant to eat a meal, they don’t expect to go in and have someone breastfeed in front of you”. This woman then stated:

“Like I wouldn’t want someone next to me picking their nose, and I know its two different things, breastfeeding is not a disgusting thing to do, but if they think that, then you need to have more consideration for other’s feelings. I would feel uncomfortable if I thought someone else was uncomfortable” (R4, B/F, 11).

As breast milk is a human secretion, it may lead others to regard it as unclean. Grosz (1994) introduced the notion of disgust and repulsion in relation to bodily fluids and discussed maternal bodies as “liquid sites of pollution”. Kitzinger (2005) also argued that breast milk is regarded by some as a “social disgrace” which should be hidden.

Other places deemed particularly inappropriate for breastfeeding by mothers included church and health centres. As the following mother explains:

“I did actually take a bottle when I went to church on Sunday.... I took a wee bit of expressed milk in a bottle, cause one time previously I had gone out into the wee foyer bit and put her to the breast, but I was a bit like, I hope someone doesn’t come out. I didn’t feel very comfortable there... I feel like I can’t breastfeed her in church. I

suppose that there are times that maybe having a wee bottle as an emergency is quite handy actually. It more as much as anything for me to have that comfort to know that if she did wake up and seemed hungry then I knew I could give her a wee bit, rather than having to go out and feed her myself” (R 12, A, B/F, 11).

The church was deemed an uncomfortable place to breastfeed based on the close proximity to others and the older demography (a group identified earlier as less culturally attuned to breastfeeding among breastfeeding women). Similarly, health centres were also deemed as inappropriate for breastfeeding; this related to the seating, proximity to others and the type of people in the waiting area. This was demonstrated in the following quotes:

“I had to breastfeed in the doctor’s surgery when he was getting his jags, and that was the most uncomfortable place to breastfeed ever. I couldn’t do anything else about it cause he needed a feed, and I had to wait, they were running late, I was really embarrassed (laughing). I was right in the middle of the waiting room (laughing) and everybody was sitting and they could obviously see what I was doing and (daughter’s name) was like what are you doing mummy. I’m like I’m feeding the baby and everyone is going, you know, trying to look somewhere else (laughing), it was so open I couldn’t hide. I was, completely covered, nobody could see anything but it was just the fact that everyone knew what I was doing kinda thing” (R17, B/F 11).

“Actually, it’s not very comfortable they have these new seats, before they were normal seats not it’s a bit of designer seats and it’s not comfortable at all to breastfeed there. There is no feeding area, you sit in a very open area, because it’s so open and there are lots of these people drug addicts, you just see them and you don’t know what’s in their minds and you try to avoid feeding” (R21, B/F, 11).

As breastfeeding is a public health priority it seems ironic to think that the health facilities used by several women in this study were described as the most uncomfortable place in which to breastfeed. Women talked about how they preferred to use their car when attending doctor’s appointments. Despite the Breastfeeding etc. (Scotland) Act 2005 women highlighted a number of places as not being very breastfeeding friendly.

Similar to breastfeeding in the car, women discussed how comfortable and convenient it was to breastfeed within the confines of some forms of public transport. For example, several women talked about the benefits of

breastfeeding while travelling by plane. As the following first-time mothers explained:

“I breastfed her on the plane it was no problem for me. There are special seats for babies and mums, which is a seat that has leg room, as well as, the basinet where you can put your baby, these are provided for long flights so I had quite a space and in front of me there was not anyone so that was quite good. And I fed her, of course, I try to use clothes that can be a bit loose but she was fine, it was no problem at all” (R26, B/F, 111).

“I decided to keep breastfeeding, and I know it sounds daft, but on the plane in case the air pressure was hurting her ears, I decided I could stick her on my breast cause the sucking helps. So rather than faffing about you know there’s all these controls and security about milk and stuff but she slept through the whole thing the way there and back she was great it was only a 2 hour flight so she just had a wee seatbelt on her knee and she just had a wee kind of gurn on the way home and she just fell asleep, it was great” (R8, B/F, 111).

Despite the fact that people sit in close proximity to each other on plane journeys, there is a level of privacy that can be achieved from the high backed seating and that women are not visible to others seated two rows away. In addition, having family member sitting in the next seat may also enable women to feel more confident and comfortable when breastfeeding.

## ***Summary***

In choosing to breastfeed their infants, women spent a considerable amount of time and energy developing their skills and confidence to enable them to breastfeed discreetly in front of others, both at home and outside the home. For a few women, feeding in front of particular individuals was not achievable, at such time women would breastfeed in privacy. It was important to note that women were not passive in their attempts to breastfeed comfortably with others. They work at developing their confidence and went to great lengths to develop strategies in order to breastfeed discreetly, whilst avoiding any potential embarrassment to themselves or others. From the findings presented within this chapter, it does appear that women made a gradual transition from feeding at home to feeding outside the home. They achieved this by developing their breastfeeding skills at home and used their car and feeding rooms within

Respondent Codes: R1

Interviews: 4weeks, 1; 10 weeks, 11; 26 weeks 111

Infant Feeding: Breastfeeding, B/F; Formula Feeding, F/F

the shops and shopping malls as extension of their domestic space. As women felt more confidence they talked about breastfeeding in cafés, mainly with others: such areas were deemed by women as appropriate places in which to breastfeed. The most inappropriate places for breastfeeding were restaurants, and ironically health facilities; this was discussed by women in relation to cultural expectations and proximity to others. None of the women at the 10-week interviews talked about feeding in open public spaces, such as the park, or cafes in the centre of the mall. In addition, there was no notable difference in the breastfeeding experiences of women residing in the most and least affluent areas.

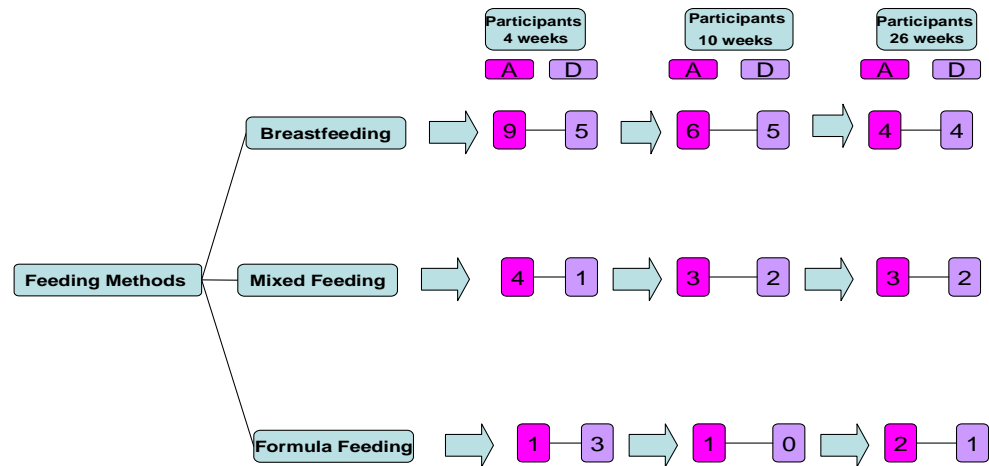
The proceeding chapter aims to explore women's experience of breastfeeding at home and outside the home throughout their breastfeeding journey.

## **Chapter 7: A breastfeeding career: changes over time**

Having addressed women's early experiences of breastfeeding at home and outside the home the main aim of this chapter is to explore women's breastfeeding experiences over the first six months of the infant's life. Section one will briefly discuss changes in feeding methods over the 6 month period, exploring factors which influenced women to stop breastfeeding once their skills and confidence were established. Section two will move on to examine women's experiences of breastfeeding over time, and will show how the practice of continued breastfeeding goes beyond gaining skills and develops in to much more than just providing nutrition for infants. Central to the research question set, the final section of this chapter will explore whether the skills and confidence women develop throughout their breastfeeding journey enabled them to breastfeed confidently and comfortably both at home and outside the home.

### **The transition to formula feeding**

The aim of this section is to discuss changes in infant feeding methods within the first 6 months following birth and factors that influence such change. Figure 29 demonstrates the changes in infant feeding methods over time for women living in the most affluent (A) and least affluent (D) areas, measured using the SIMD. There was little difference in breastfeeding continuation rates between women living in the most and least affluent neighbourhoods (for a further discussion on SIMD in relation to the study sample see chapter 4).



**Figure 29: Changes in Feeding Methods over Time**

Figure 29 demonstrates that of the 18 women who exclusively breastfed at birth, 14 continued to breastfeed at four weeks following birth; of these, 9 mothers continued to exclusively breastfeed while 5 of the 14 women chose to combine breastfeeding with formula feeding. However, within the first four weeks following birth 4 of the women stopped breastfeeding. For 2 of the 4 women, the transition to formula feeding occurred prior to leaving hospital.

Of the 12 women participating in the ten-week interviews, 11 continued to breastfeed, 6 exclusively breastfed and 5 of the 11 women used a combination of breastfeeding and formula feeding. It is also worth mentioning that two mothers who had used mixed feeding, due to the early challenges associated with breastfeeding, went on to resolve such difficulties and returned to exclusively breastfeeding their infants. However, the physical and emotional challenges associated with early breastfeeding led one woman to stop breastfeeding at six weeks following birth.

Of the 11 women continuing to the end of the study, 8 continued to breastfeed their infants. Of this group 5 of the 8 women chose to use a mixture of breastfeeding with formula feeding and other solid foods, while 3 women exclusively breastfed (while also introducing solids). At approximately five months following birth 3 of the final 11 chose to stop breastfeeding their infant.

Respondent Codes: R1

Interviews: 4weeks, 1; 10 weeks, 11; 26 weeks 111

Infant Feeding: Breastfeeding, B/F; Formula Feeding, F/F

### ***Factors influencing the transition to formula***

In chapter 5 the cultural, social and personal factors influencing women's decision to breastfeed were explored as was the introduction of bottle feeding as a strategy used by women as a means of coping with the pain and exhaustion associated with the constant demands of breastfeeding. In chapter 6 women talked about the use of formula feeding as a way of avoiding breastfeeding in front of others at home and outside the home. However, the aim of this section is to identify factors which influenced women's decisions to stop breastfeeding in the later weeks and months once breastfeeding was established, when issues surrounding pain and exhaustion had subsided, and women had developed their skills and confidence when breastfeeding.

At the 10-week interviews the majority of women discussed stopping breastfeeding. Their decision fell into four main categories. First, the majority of women talked about the gradual early introduction of bottle feeding and stopping breastfeeding in preparation for their return to work. Second, women suggested that having reached their breastfeeding goals, formula feeding was less restrictive and this enabled them to regain some personal freedom and ownership of their bodies. Third, women suggested development of infant teeth was also a catalyst for stopping, as was the notion that as their infant grew breastfeeding was less publicly acceptable. Finally, a small number of women talked about their decision to stop breastfeeding as something out with their control, a "natural" occurrence.

The majority of women talked about how stopping breastfeeding was a gradual process that occurred over a number of weeks amid concerns about whether their infant would actually feed from a bottle following prolonged breastfeeding. As a result, several women suggested that: "it can be good to get them used to taking a bottle so once you are eventually going to stop breastfeeding they'll know what to do with it". In addition, a few mothers went further to suggest that they had heard from other women that there was an optimum period in which the bottle had to be introduced to ensure successful bottle feeding in breastfed infants. As one first-time mother suggested:

Respondent Codes: R1

Interviews: 4weeks, 1; 10 weeks, 11; 26 weeks 111

Infant Feeding: Breastfeeding, B/F; Formula Feeding, F/F

“Supposedly you’ve got a window between 4 and 6 weeks to try and get them on a bottle.... Wee boys supposedly, you know, if you do it wrong, or at the wrong time they will not take the bottle ever, and that’s it, so you need to time it right. So it’s between this four and six weeks, so he’d better take it, if you leave it too long, they say the baby will never take a bottle” (R2, B/F, 1).

This perceived belief of an optimum time in which to introduce bottle feeding was shared by many women in the study; two of the women reported that their infants were a “wee bit funny with it (the bottle)” as they got older. Both of these women went to great lengths to find the “right” bottle and the “right” teat in order to establish and maintain bottle feeding. Ensuring their infant’s ability to successfully bottle feed was discussed in terms of preparation for their return to work, the inception of teeth and feeling uncomfortable about breastfeeding an older infant in public spaces.

Preparing for their return to work was discussed by all of the women in the study as a major influence in their transition to formula feeding. However, of the 12 women continuing to breastfeed beyond 4 weeks, only 2 women actually returned to work within the first 6 months. For one first-time mother, the stress of breastfeeding while at work was discussed as the catalyst behind her decision to stop breastfeeding prior to her 6-month goal:

“I just had a week when I was trying to breastfeed and work. I was trying to feed her and express, and my breasts were really quite sore. So it probably made me decide that this probably was not going to work. I wasn’t expressing enough either, particularly on the days when she was hungry. I was getting up during the night cos that was the only time I could actually fill up enough after her feeding to express. It was just becoming crazy it really was” (R18, F/F, 11).

All of the mothers in the study suggested that they would stop breastfeeding prior to their return to work, and phrases like “it would be terrible”, “it would be too stressful” or “it’s just not practical” were common phrases amongst the sample. As the following first-time mother returning to work at 6 months suggested:

“I don’t think I would be able to continue to breastfeed her when I was back at work, I wouldn’t be able to. I guess I could express through the day and give lots of expressed milk into the nursery but I just don’t think it would end up being practical. Even the thought of

Respondent Codes: R1

Interviews: 4weeks, 1; 10 weeks, 11; 26 weeks 111

Infant Feeding: Breastfeeding, B/F; Formula Feeding, F/F



it, you know and if you don't get a chance to go off and express you'll end up getting a bit engorged. I get quite leaky you know, quite a lot, I've always been quite leaky, the thought of being leaky and everything, no" (R12, B/F, 11).

Although women were aware of facilities for breastfeeding/expressing at work, they suggested that breastfeeding/expressing at work would be a "nightmare", "inconvenient" and fraught with time constraints. As one woman who had previously expressed breast milk at work explained:

"I tried the last time to breastfeed but in the job I've got you can't express, it's just too much. I can't take the time out, it's just a nightmare working it around patients and I only work two days, so taking time out to express is too much. I'm not doing that; I don't want to give myself even more stress" (R17, B/F, 11).

However, stopping breastfeeding in preparation for a return to work was discussed by women as fraught with emotional difficulties. Women suggested that although they felt they needed to stop, they were not really prepared to give breastfeeding up completely. As one woman explained "hormonally you want to keep doing it, but I knew that I need to stop, well because I need to, well cos I'm going back to work". Several mothers talked about how they continued to offer their infant morning and evening breastfeeds until they felt ready to stop completely. As the following first-time mother suggested:

"I thought when I went back to work it would be quite a nice wee thing to come home and give her a breastfeed at night-time, just as a wee kind of extra bonding thing when I'm not seeing her so much, but I guess I'll just wait and see. I've not really decided how long I'll try and keep that going for, probably another month or two once I'm back at work, and then I'll just see how I feel" (R12, B/F, 111).

It is evident from the discussion above that breastfeeding at work is not just about providing facilities for women in which to breastfeed or express milk. Women viewed breastfeeding at work as an added pressure/stress and giving their infants morning and evening feeds enabled them to alleviate their perceived feelings of guilt they had about introducing formula feeding in preparation for a return to work. While all mothers discussed preparing for a return to work as a catalyst for stopping breastfeeding, many of these women were not returning to work for several months. As such, women may have felt a

need to frame their decision to stop breastfeeding in the context of an external pressure, and to limit the perception that stopping was a personal choice.

Several women talked about how their previously set breastfeeding goals acted as a means of avoiding their need to justify to others their decision to stop breastfeeding, while escaping what women described as the “restrictive nature of breastfeeding”. Such breastfeeding goals were either set by women themselves or from the information they received from health professionals: that all infants should be exclusively breastfed for the first 6 months following birth (as discussed in chapter 5). However, setting shorter goals than recommended by health professionals did lead women to report an element of guilt and anxiety when stopping. As the following first-time mother suggested:

“It’s so ingrained in my brain about the breastfeeding for the 6 months thing. I feel a wee bit bad not doing it for the 6 months, it’s just so much pressure, and very unrealistic. It’s very unrealistic that anyone could exclusively breastfeed for 6 months, even if they are off work, because you would go insane, it’s so restrictive” (R4, B/F, 11).

For the woman quoted above, having reached her set breastfeeding goal of three months, she suggested that her decision to stop breastfeeding was a self-centred act in an attempt to restore some personal space:

“(Partner’s name) and me don’t have a relationship while I’ve been breastfeeding, the two of us can’t go out on our own and leave him with anybody, you just can’t do it, so that’s the big reason why I’m putting him on the bottle, cos I need to get my life back, but then I feel guilty, thinking that it’s so selfish” (R4, F/F, 11).

Getting their life back and feeling liberated from the restrictive nature of breastfeeding was described by a few women as crucial in terms of rebuilding their relationship with their partner/husband and being able to re-establish their own social life while regaining some ownership of their body.

Regaining ownership of their body was discussed in terms of the joy of returning to their “normal” clothing: getting rid of those “loose tops” and “hideous bras”. One mother talked excitedly how having stopped breastfeeding, she went shopping for new underwear: “I went and bought myself two bras last week and that was great, now I can wear other tops that you can’t wear with a

breastfeeding bra". The majority of women talked about the restrictive nature of breastfeeding bras. As one mother explains:

"I found that the bras are not the great helpers for someone who is breastfeeding, because first you need to see the clothes will be handy for breastfeeding, and if the clothes are low then you can see your bra, the colours are not the best... I like greens and pinks and whites is ok, some are black but they're not the best, they're not attractive. I would like something much more sexy" (R26, B/F, 111).

However, feeling "sexy" in a breastfeeding bra was something that women struggled with at times. One woman talked about how she never actually felt "sexy" while she was breastfeeding, and that the term "feeding machine" was the way she described herself. The notion of the breast as having a dual purpose as a sexual object and a means of infant nutrition was something that both women and their partners struggled with:

"My partner he's changed his view of my breasts so much. It's not as it used to be, because the breasts were used in a different way, like now he is used to looking at them all the time and seeing (baby's name) eating from them, and I think he's thinking it's changed a bit. I think he thinks they are not as sexy" (R11, F/F, 11).

Women also talked about changes to their body having breastfed, and other factors associated with stopping breastfeeding that women were less happy about. For example, several women talked about changes in their breast shape following breastfeeding. Phrases like: "the worst thing about breastfeeding is that your breasts change shape, and they don't change shape for the better let's say" was mentioned by several women. As one mother suggested:

"My boobs are atrocious. They're just wee saggy things, I hate them. That's the one bad thing after breastfeeding your chest is just non-existent" (R4, F/F, 111).

Another woman summed this up by suggesting: "it's like my sister says, it's like having a tennis ball in a sock, all the bulk's down here and there's nothing there (pointing to the top) and I know exactly what she means". However, this mother also talked about how hopeful she felt about regaining her breast shape now she was no longer breastfeeding.

The development of infant teeth was also discussed by some women as an optimum time to stop breastfeeding. One woman talked about how glad she was to have stopped breastfeeding prior to her infant's teeth coming in. Another women suggested "teeth oh no, let's not go there; maybe not". This woman reflected about her decision to stop breastfeeding when her first child cut her first tooth:

"It was then I thought no, it's time to stop. I couldn't bear the thought that she could bite me and that was the only reason I stopped. Eventually he'll (baby) go on to a bottle too, when he gets teeth, cos that too dangerous" (R5, B/F, 11).

However, two women talked about how they sought support in order to overcome the difficulties of their infants biting them. This support enabled these women to continue breastfeeding. As the following second-time mother demonstrates:

"I was having a problem when his teeth came in; he was biting me which was quite uncomfortable. I spoke to a couple of my friends who had breastfed a little bit longer than I had the first time. Like when (daughter's name) got teeth that's when I stopped before cos she was biting me, and I was like right, I've had enough. This time I spoke to a couple of friends who had breastfed longer than me and they had the same problem, they said look just bear with it and he'll learn not to bite you, and that has been true" (R17, B/F, 111).

However, the majority of women suggested that their child becoming more independent and walking signalled an optimum time in which to stop breastfeeding, and that breastfeeding an older infant was viewed as less socially acceptable:

"Personally I feel that after they can walk, beyond about a year the mum is doing it for themselves, and not necessarily for the baby, so I think when they can, when they can actually walk over to you it's time to stop but that's just a personal thing" (R12, B/F, 111).

"When they are more independent they should not need it as much, especially, cos she was an early walker she started to walk at nine months, by the time her first birthday came she was running about. I think when they start getting that bit more independent you should stop: other people think they shouldn't be breastfed then either, you know" (R5, B/F, 11).

As the majority of infants in the UK are only breastfed for a short time, a common belief amongst women in this research was that breastfeeding beyond infancy was viewed, both by themselves and others, as inappropriate, and not nutritionally necessary. The pressure to stop breastfeeding from husband/partners and family/friends left women feeling that extended breastfeeding was not an option for them. As the following second-time mother illustrates:

“I mean (husband name) joked one day “oh you’re gonna have him lying at the bottom of the bed when he’s 17 going bitty mummy, bitty”. I wasn’t in a good mood that day and it was not really a joke, I mean fair enough he is his dad, you know, he maybe just wants me back to himself (laughing). It’s a selfish man thing, but he’s like oh you just need to stop now, you should stop now. I don’t know whether it’s because he’s a boy or because I’ve been unwell myself but people are really keen for me to stop” (R5, B/F, 111).

The quote above suggests that, as this infant reaches 6 months old, breastfeeding is viewed as an inappropriate activity. This woman (quoted above R5) went on to say how the pressures from family and friends led her to breastfeed her previous child in secret, away from the gaze of others:

“I found it so hard to give up before; I mean I would tell people that I had stopped, when I was still sneaking upstairs for a wee feed (laughing). My husband doesn’t know I did that” (R5, B/F, 11).

For a small number of women the decision to stop breastfeeding was something they felt they had little control over. For one woman the gradual introduction of formula feeding meant that stopping breastfeeding at 5 months following birth felt like a “natural process”, something that both mother and infant were ready for. However, another mother who had exclusively breastfed for 5 months felt totally shocked and unprepared when one day she realised she didn’t have any more milk:

“Suddenly he started to really cry near my breasts, and I was thinking what’s going on? I tried to express and there was nothing, and then I realised, I don’t have milk at all. In the beginning I was really trying hard to feed him, I was feeling awful, I was crying because I was trying hard. I wanted to feed him at least till he is six months, and I can’t now” (R11, F/F, 111).

Although this woman went to a great deal of effort to get her breast milk flowing again, she suggested that it was too late, and that she was happy now to be formula feeding:

“I’m happy changing to formula because he is gaining more weight now. When he was on the breast he wasn’t putting on enough weight, he was underweight, but now he’s perfect” (R11, F/F, 111).

For the majority of mothers, stopping breastfeeding was discussed as something “hard to describe in words”, a “weird emotion” and a time of “sadness”. There was a definite expectation that stopping breastfeeding would equate to “letting go” and “losing the nice closeness you get from breastfeeding”. As one mother explained: “I was terrified that if I stopped breastfeeding he wouldn’t be reliant on mummy anymore”. The majority of women in this study suggested that the gradual introduction of formula feeding did help them prepare for stopping:

“It’s 6 months this weekend, that would be my cut off point, so I might just completely stop, but I don’t really, I don’t really want to stop, if you know what I mean, I quite like it. I think as long as he wakes up in the middle of the night I’ll breastfeed him... so just maybe the night feeds when he wakes up and when he stops waking up that’ll be it. But I’m not ready to stop completely yet” (R2, B/F, 111).

Another mother summarised:

“Well at the end of the day, I love doing it and I suppose it’s difficult to start with, it’s difficult to stop it (laughing), but it’s a nice bonding thing, you get a really good, close bond with your baby because you do it” (R17, B/F, 111).

This woman quoted above also talked about stopping breastfeeding in terms of weaning themselves rather than their infant. As she explains:

“I’ve been saying to friends I’m going to stop, I am going to stop but then I haven’t. It’s bizarre, but I will stop eventually but I think I just need to do it gradually” (R17, B/F, 111).

It was common amongst the sample for women to justify their decision to stop breastfeeding using phrases like “any health benefits that the infants received from breastfeeding are diluted at this stage” and “in my head he’s had any goodness that he was going to get”. In addition, several women suggested that

continued breastfeeding beyond 6 months was more about the needs of the woman and less about the health benefits awarded to the child, as the following first-time mother stated:

“It’s not about the benefits of the milk anymore, it’s really because I like it, and he likes it, and it’s easier than making formula. I’m doing it now for different reasons than it started out for. Now it’s about bonding, it’s about it being easier and less time consuming, the health benefits are less of an issue now” (R4, B/F, 11).

It seems apparent from the accounts that women gave that they felt they could not give up breastfeeding without having a socially acceptable reason to do so. This is evident when women talked about getting their lives back; they appeared torn between providing a good start for their baby and achieving more freedom for themselves in public space. As mentioned above, preparing for a return to work gave women a reason to give up breastfeeding and spend more time with their husband/partner, who may, at times, have put pressure on them to stop. Breastfeeding creates a conflict for women: stopping breastfeeding appears to be a decision that women could not make without justification, because otherwise they were left with feelings of guilt. However, on stopping, one woman reflected:

“All of a sudden because you can go out it just seems so superficial and not such a big deal. I’d rather stay in with him (baby name); do you know what I mean? But that’s just life, the grass is always greener” (R4, F/F, 111).

Having discussed changes in infant feeding methods and factors influencing women’s decision to stop breastfeeding, the chapter moved on to explore the evidence that women constantly manage their breastfeeding both at home and outside the home. Management of breastfeeding was discussed in terms of when, where and how long an infant should receive their mother’s milk. Several women talked about how pressured they felt by others to stop breastfeeding and, how they on reflection how they would have liked to have continued to breastfeed longer.

## The breastfeeding journey

The aim of this section is to explore women's breastfeeding experiences over time, addressing how women and their infants worked together to accomplish the art of breastfeeding at home and outside the home, and how breastfeeding over time went beyond simply providing nutrition for their infants.

On an emotional level the majority of women talked about how breastfeeding was particularly challenging and that getting through that difficult period made them "feel brilliant". On a physical level, by 10 weeks following birth, the majority of mothers suggested that their infants were "more able to latch on properly" and their infant had become "more efficient" at breastfeeding and, as a consequence, issues surrounding painful breastfeeding had more or less subsided. All of the mothers continuing to breastfeed talked about how their baby's ability to "attach and breastfeed properly" enabled them to feel confident and comfortable at home and outside the home. As one first-time mother explained:

"I find it easier, it gets easier and easier the longer you do it. I suppose it's the experience of doing it, cos at first you think am I doing it properly? Are they latched on properly? and you get quite nervous about it all, and now that she is older she can actually latch herself on, so I don't have to worry about that anymore cos I know that she's doing it properly, so that's fine, she much better at it" (R6, B/F, 11).

In addition, all of the women in the study suggested that the ease of breastfeeding seemed to occur at a specific point in time, typically between 6 and 8 weeks following birth. As the following first-time mothers explained:

"There is a point you get to, like a click and it's not painful anymore, and the baby attaches easily, it's just like a click. It's becomes very easy, the baby knows how to do it, the mum knows how to do it, and the milk is just there" (R26, B/F, 111).

"Since about 6-8 weeks it's been great. It takes a long time to get established and get your milk supply right, I'm still feeding regularly, but it's much quicker, I am really enjoying it now. Before in the early days it was all about feeding, your whole day revolved around feeding, now it's just about feeding when he actually needs fed" (R4, B/F, 11).

Respondent Codes: R1

Interviews: 4weeks, 1; 10 weeks, 11; 26 weeks 111

Infant Feeding: Breastfeeding, B/F; Formula Feeding, F/F



All of the women reported a dramatic change in their breastfeeding skills at the 10-week interviews. The majority of mothers reflected back on how their previous expectations of breastfeeding were now in keeping with their experiences. As the following first-time mother illustrates:

“When I was pregnant I thought it would be like how it is now, easy and there is no pain. I really never thought it was going to be very easy but I never thought the first weeks were going to be, like, so painful. My perception of breastfeeding that I had before is like what I’m experiencing now, which I’m happy with. After I delivered the baby I realised that breastfeeding was different from what I thought, in the sense of, it needs time, it needs patience, also like to deal with pain, but my perceptions now are better and I’ve come back to my old perception when I was pregnant” (R26, B/F, 11).

However, ease with breastfeeding was not only about the physical aspects. Practical challenges associated with feeding also changed over time. By 10 weeks following birth breastfeeds were far quicker and lasted approximately 15-20 minutes; this ease of breastfeeding over time was discussed using phrases such as: “you get to a point where it’s a breeze”, “it so easy, there is nothing like it, it’s wonderful” and the “convenience of it is fantastic”. The following first-time mother described the changes she experienced over time:

“At the beginning when they take a long time you’re just kind of like just settle down for the hour, but now he can be fed in about 15 minutes and we get much longer spells between feeds, it’s like “I’m full mum, I don’t want anymore”, so you’re not permanently stuck somewhere and that kind of gives you a bit more time. At the beginning it was a big thing being just stuck in the house you just felt a bit restricted but now we can get out and about a lot more, it’s so nice to be able to do things” (R13, B/F, 11).

Having some time between each feed and having shorter feeds was something that all of the women highly valued. Women talked about how the convenience of shorter, less frequent, breastfeeds allowed them some personal time to do their hair and make up and, most importantly, let them get out with their baby. Breastfeeding had now developed into something that women enjoyed:

“I really enjoy breastfeeding, it sounds lazy but it’s so much easier than messing around sterilising things and getting formula together. I think it’s much easier for me, if she’s upset, if she cries, or if she’s hungry all I have to do is put her on and that’s it” (R6, B/F, 11).

Respondent Codes: R1

Interviews: 4weeks, 1; 10 weeks, 11; 26 weeks 111

Infant Feeding: Breastfeeding, B/F; Formula Feeding, F/F

Women suggested that by breastfeeding their infant they developed a different kind of closeness, and a “pleasurable connection” with their infant “far greater than love”. Women talked in the beginning about how they “didn’t think I was going to be able to do it” to how “proud” they felt at six months following birth having given their infant the “best start in life”. In describing her breastfeeding journey over time the following first-time mother suggested that breastfeeding offered a bonding experience that is simply not achievable with bottle feeding:

“It’s a different kind of closeness totally, totally I think. That’s how my sisters don’t really understand, because it’s just different from bottle feeding, totally, and you know that they want you, and he gives this wee giggle and laugh when he knows what’s happening (laughing) and he get’s all excited, and it’s amazing and you just lie and stare at them and when you’re tired you can just lie beside them. It’s just a different kind of closeness altogether, totally” (R5, B/F, 111).

Several women talked about the act of breastfeeding as a special gift that promoted good health and embodied closeness beyond the actual breastfeeding period. As the following first and second-time mothers suggested:

“I don’t know, for me I feel it is something, you know it’s like a treasure you give to somebody, and I think, I hope he’ll be breastfed till he’s one year old because it’s his health, and the contact of me and you know, just the time spent together before and after birth. I think it’s very important that we are; they are more confident in themselves after and healthy and strong and happier” (R21, B/F, 111).

“We were really close to each other, I don’t think I would be so close with him, and for sure I will love him all the time. I don’t think if I, maybe I wouldn’t love him so much if I wouldn’t breastfeed, I don’t know. It’s not about love, it’s about connection between both of us, I think, it’s a really good thing breastfeeding” (R11, F/F, 111).

One first-time mother spoke of an intense embodied closeness between her and her child, something that she thought all mothers should experience:

“I think it’s just so lovely, it’s such a lovely time, it’s something you can do for them that nobody else can, and, yeah I think I’d definitely say to people that they should try, just try and keep going. There are days where you just wish somebody else would take them and feed them because you’re not feeling yourself, but those days are completely outnumbered by the days when they finish feeding where they just look up at you and smile or they fall asleep in your arms. It’s just, it’s so lovely” (R13, B/F, 111).

Respondent Codes: R1

Interviews: 4weeks, 1; 10 weeks, 11; 26 weeks 111

Infant Feeding: Breastfeeding, B/F; Formula Feeding, F/F

For those women choosing to continue breastfeeding past the 6-8 week period, breastfeeding became a comfortable and pleasurable experience as their confidence grew. Undoubtedly, the breastfeeding journey was not as women initially expected it to be and, in order to continue breastfeeding women talked about how they continued to negotiate their breastfeeding behaviour at home and outside the home in order to feel comfortable feeding in front of others.

## **Breastfeeding: The private and public continuum**

The previous chapter demonstrated that women faced several challenges when breastfeeding in front of others and that there appeared to be no clear distinction between breastfeeding experience in front of others at home, or while outside the home. As such, the aim of the remainder of this chapter is twofold. First, the intention is to explore the extent to which breastfeeding careers were enacted in private and public spaces over time. Second, the chapter addresses whether the attitudes of others had an impact on a woman's confidence when breastfeeding their infants in private and public spaces.

The majority of women in this study talked in great detail about how, over time, they felt more comfortable and confident when breastfeeding at home and outside the home. Phrases like: "I've got more confident cos he can latch on better" and "it's so much more discreet" were common among mothers, as was "you don't think about others so much now, you just do it". The majority of women described how breastfeeding at home and outside the home became "comfortable", "natural" and somewhat "easier" over time:

"In the beginning when a colleague came round I wouldn't feed till she had gone. I wasn't confident enough with her or with my pals' husbands but now that has changed, just cos I'm more confident. I'm more discreet now and people wouldn't really know I'm doing it. Like when I was out I used to ask my mum and friends "can you see anything, can you tell" and then after a while I just stopped asking" (R2, B/F, 111).

Women talked about their growing confidence when feeding in public and private as stemming from two separate sources. First, women talked about how, having developed the skill of attachment, breastfeeding at home and outside the home was far more discreet. In fact, women talked proudly about having

Respondent Codes: R1

Interviews: 4weeks, 1; 10 weeks, 11; 26 weeks 111

Infant Feeding: Breastfeeding, B/F; Formula Feeding, F/F

achieved what they considered to be invisible breastfeeding. Phrases like “no one would know I was actually breastfeeding” or “it looked like I was just giving her a cuddle” were common amongst women. One woman talked about how over time she had become so “blasé” about breastfeeding in front of others at home and outside the home:

“I’ve become so blasé about it, it is just so normal for me now. It’s so normal for me to be sitting in front of my partner and friends doing it. Sometimes I forget when I’m out I need to be a bit more careful about covering up” (R4, B/F, 11).

There is a suggestion here that as breastfeeding continues and confidence builds over time, this has a positive impact on how comfortable women feel breastfeeding in front of others both at home and outside the home.

However, the level of comfort and confidence discussed above was more evident with particular groups of people, mostly their partner and other women. For the majority of women, breastfeeding over time continued to feel uncomfortable in front of other males, the older generation and strangers. As a result, this was an element of breastfeeding that witnessed little change over time. As the following first-time mothers explained:

“Although I’ve become blasé about it, I still think I wouldn’t feed him with men. If I had a lot of couples come over with boyfriends I still wouldn’t do it in front of them, I’d probably go up the stairs, so I don’t think things have changed in that respect” (R4, B/F, 11).

“If there’s any men coming into the house I won’t feed in front of them, just because I don’t want to embarrass them (baby screaming, woman changes baby’s nappy). With men I tend not to feed in front of them, like my boyfriend’s mates I would never feed in front of them, cos I think they would be embarrassed, but my female friends I have no problem with it at all” (R6, B/F, 111).

It is fair to say that on one hand women were feeling far more confident and less worried about covering up when breastfeeding in front of others. However, breastfeeding in front of males and the older generation remained particularly challenging for some women when breastfeeding at home. One woman suggested that having to constantly defend one’s right to breastfeed, and dealing with a

general lack of understanding and negative attitudes, left this women feeling unable to breastfeed in front of her mother-in-law:

“The only person who still doesn’t like it is my mother-in-law, but she never did, and she never will. I was down seeing her at the weekend and she has not altered her perception at all. I mean she really thinks it’s far too much trouble to breastfeed, and I said well it’s my decision to do that. I don’t mind if it’s too much trouble but she does, I mean she’s the same age as my mum but she’s got a totally different attitude, but there you go. But yeah, she’s never gonna change her opinion of it, so when I’m down there I just feed in the bedroom” (R6, B/F, 111).

Although this woman talked about feeling uncomfortable feeding in the home (with men) and in the homes of others (mother-in-law) she has also throughout this research talked about how comfortable she felt breastfeeding outside the home when meeting up with friends in town. As such, outside of the home can be a more comfortable and relaxing space for breastfeeding than the home when others come to visit.

However, women did talk about how the positive attitudes of others enabled them to feel more confident and supported when breastfeeding at home and outside the home. For example, a few women suggested that over time they felt less of a need to defend their right to breastfeed or go off to feed in private areas, particularly when others around them developed a greater understanding of the benefits of breastfeeding. One woman talked about how her mother and her mother-in-law’s attitudes to breastfeeding changed over time:

“My mum was a bit surprised, she was on holiday with us and she couldn’t believe how easy it was to breastfeed him on holiday. Now she says “it’s so convenient”, which it was, it was brilliant. Also my mother-in-law said there are breastfeeding posters all over the school she works in, saying how good breastfeeding is. So now they realise how good it is for the baby” (R2, B/F, 111).

It was important for this woman to feel that family members understood and supported her decision to breastfeed. In turn this enabled this woman to feel more confident, comfortable and relaxed while breastfeeding in front of others at home and outside the home.

The majority of women recognised that breastfeeding became easier as their infant grew. In the early weeks women talked about how they did not spend a great deal of time outside the home, and when they did they were more likely to choose to feed in a feeding room or in a quiet area of a café:

“I remember in the beginning I was so terrified about doing it in public, but you just need to get over that, it no longer dictates me. I started off only breastfeeding in the baby rooms and then I progressed in to cafés and restaurants” (R4, F/F, 111).

Several women talked about how their feeling about breastfeeding in public had changed over time as their confidence grew. As the following second time mother explained:

“I’m not really bothered now (breastfeeding in public), that’s something that has changed. I just kind of stopped thinking about what other people are thinking and just get on with it. I think because you’ve got more used to feeding and just more comfortable in yourself. I think not having any, I’ve not really had any bad comments or anything, I think that’s probably a big thing, that nobody’s ever kind of made me feel uncomfortable by anything they’ve done or said. I think that kinda helps” (R17, B/F, 111).

When breastfeeding in cafés with friends, women also talked about being far more confident in their ability to breastfeed comfortably, and felt far less self-conscious. For example, this first-time mother talked about how she felt more confident breastfeeding in a more open space with a bit of encouragement from her friend:

“The other day I was at the park with my friend, she is bottle feeding, we went to the café and were sitting next to the till right in the middle of everything, in full view, and he needed to be fed. My friend encouraged me by saying just feed him here, so really quickly I put him on, he wasn’t really in a good position, but he was feeding well. I kept asking my friend if anyone was looking, and she said “no it’s fine”, but it was really open and a few people smiled at me, but you couldn’t see anything. I did feel a bit uncomfortable at first, but if I’m on my own then I would use the feeding room” (R2, B/F, 11).

Breastfeeding in open spaces remained an issue for women in this study despite having developed their skills and confidence. As the following second-time mother explained:

Respondent Codes: R1

Interviews: 4weeks, 1; 10 weeks, 11; 26 weeks 111

Infant Feeding: Breastfeeding, B/F; Formula Feeding, F/F

“I was looking for somewhere to feed him, and we were in Dynamic Earth, we were there for about two hours and I was like, where am I going to feed him? There were only wee benches right in the middle of the place, where everyone walking past. So we went on this ride and it went dark, and I was like perfect, and we were spinning round (laughing) not fast or anything (laughing), like it wasn’t a health and safety issue (laughing) but he got fed” (R17, B/F, 111).

Although women felt more comfortable and relaxed when breastfeeding in public spaces, the location in which breastfeeding occurs remained important to women throughout their breastfeeding journey. For women, knowing there was a Breastfeeding etc. (Scotland) Act (2005) enabled them to feel more confident and comfortable breastfeeding outside the home. As the following second-time mother explained:

“I’d quote it, do you know what I mean, so you can’t object to me breastfeeding in public cause it’s a normal and natural thing to do. I wouldn’t be bullish about it but now that I’m aware of it I would say something” (R8, B/F, 11).

However, by the time infants were 6-months old, women reported that breastfeeding discreetly in front of others became increasingly challenging. Women talked about how their infants became interested in what is going on around them. As a result, woman reported that their infants were more likely to be easily distracted, and come off the breast quickly, leaving the woman exposed. Women suggested that breastfeeding in public was now “risky” and that it now seems more appropriate to be feeding small babies outside the home than it did to feed a growing infant. As this second-time mother explains:

“I know as my other child got older she became easily distracted, which makes it more difficult to be discreet. Around 10 weeks is probably the easiest time to breastfeed in terms of being discreet” (R17, B/F, 111).

On one hand women talked about their baby getting bigger and more able to latch on themselves and be discreet, while at the same time the infant was far more easily distracted and would come off the breast quickly leaving them exposed and, at times, leaking. As one mother recalls:

“Because he covers most of you now, especially as he’s got bigger, you don’t really see anything when they are feeding at this stage. It’s

only when he decides, oh, I've had enough and I want to look around, you're kind of like, you just have to, kind of, just keep your eye on what he decides to do. You don't want to distract them when they are feeding, you just want them to feed and not let go, so you don't get milk everywhere" (R13, B/F, 111).

A woman's fear that their infant would be distracted during a breastfeed, leaving them exposed, resulted in women suggesting that at 6 months following birth they were far less comfortable feeding in public. Furthermore, women were anxious that feeding an older infant would be viewed by others as inappropriate. As the following second-time mothers suggested:

"I wouldn't do it in public because he is bigger now, people start to look at you, and I know people do. A couple of people have said, not in a bad way, not in a nasty way or anything but you know, OH are you still breastfeeding him, that kind of thing" (R5, B/F, 111).

"Well I'm starting to think that maybe people are thinking, oh, he's a bit old to be breastfed, you know how there is a kind of, like certain people have issues with breastfeeding anyway, maybe not so many issues when they're wee babies but when they're starting to get a bit bigger and sitting up and eating that they maybe have, you know, like why is he still breastfeeding" (R17, B/F, 111).

Such attitudes led women to question the appropriateness of breastfeeding their growing infants in front of others while outside the home.

In summary, women reaching the end of the study at 26 weeks following birth described their breastfeeding journey as being a wonderful thing they had been able to do for their baby. Breastfeeding was something that was very special to them, and only other women who had breastfed their children would really understand their commitment. Throughout their breastfeeding career women talked about how they developed the skills and confidence they required to breastfeed in front of others and continued to negotiate where, when and with whom breastfeeding was appropriate, as breastfeeding growing infants presented additional challenges. However, despite having a Breastfeeding etc. (Scotland) Act (2005) the majority of women continued to face challenges in their attempts to breastfeed their infants at home and outside the home.

The proceeding chapter will move on to link the key findings of the research with the existing literature.

Respondent Codes: R1

Interviews: 4weeks, 1; 10 weeks, 11; 26 weeks 111

Infant Feeding: Breastfeeding, B/F; Formula Feeding, F/F



## **Chapter 8: Discussion**

### **Introduction**

The aim of this chapter is to discuss the key findings of this exploratory study and to identify its contribution to the wider literature. The discussion is structured in two key sections. The first section presents a thematic discussion of findings related to the research questions and places these within the context of the existing literature. The second section addresses the strengths and limitations of the research design; identifies policy and practice recommendations; contribution to the existing literature and areas for future research.

The thesis set out to address a range of research questions in relation to women's experiences of breastfeeding in private and public spaces; the environments women identified as most comfortable for breastfeeding, and the development of women's breastfeeding career over time. Such themes are not independent, rather they are interlinked. In the early days women spent a considerable amount of time at home developing their skills of attachment and building their confidence in order to breastfeed comfortably in front of others in private and public spaces. During this period women spent only a limited time in public spaces between breastfeeds, often seeking out spaces they considered appropriate for breastfeeding. However, over time, as their skills and confidence developed, women tested the boundaries of their breastfeeding in front of others both in private and public spaces.

### **Social and spatial influences**

Within this section the core argument will address women's breastfeeding experiences at home and outside the home, before addressing how the concept(s) of what is considered public and private space requires more sophisticated understanding.

Home is seen as synonymous with private space and women in this study talked about their home as the most comfortable and relaxing place to breastfeed. With the frequent, lengthy and, at times, painful breastfeeds in the early days

and weeks following birth, women talked about home being the most comfortable place to breastfeed on two levels. First, women talked about their home as a space where they could achieve a degree of privacy, only receiving visits from family members and friends. Secondly, on a more practical level, all of the women suggested that breastfeeding at home felt more relaxed and comfortable in their own surroundings, having a comfortable chair/sofa to sit on, and using cushions for support while breastfeeding. In addition, having home comforts to hand, such as food and drink, the telephone and TV remote control made breastfeeding a more comfortable and relaxing experience. In addition, whilst developing their skills, women talked about their need to expose their breasts in order to guide the infant to the breast and ensure good attachment; this was something that women only felt comfortable doing in privacy at home. Carter (1995) also found that the home is generally viewed as the most appropriate and comfortable place in which to breastfeed.

However, feeling comfortable breastfeeding at home was also a challenge for the majority of women in this study. Within the confines of a woman's own home, breastfeeding was not a neutral activity. Often, with the arrival of a new baby comes an influx of visitors. This changed what would be generally considered as a private intimate space of the home, into a more public space, where women were required to negotiate where and with whom, breastfeeding is most appropriate. As a result, the boundary between what is considered private and public space for breastfeeding is at best blurred when others enter the space; points also raised by Carter (1995), Britton (2000; 2009) and Stearns (1999).

Outside the home is equated with public space and women report early on that they had reservations about going out in public to breastfeed. As a result, in the early days and weeks following birth, women in this study tended to withdraw from public spaces, or went out only for short periods between feeds. Two explanations were offered for women's withdrawal from public space. First, women talked about how frequent feeding and feelings of exhaustion restricted the time they spent out of the home. Secondly, the majority of women suggested that they lacked the confidence to breastfeed comfortably and discreetly outside the home. Women at this time talked about how they spent a considerable amount of time at home developing their breastfeeding skills,

building their confidence and cultivating the art of discretion in order to feel more comfortable breastfeeding at home and outside the home. Although not feeling confident enough to breastfeed in public, during their short trips out of the home, between breastfeeds, women talked about how they considered spaces that they thought may be appropriate for breastfeeding. The Breastfeeding etc. (Scotland) Act (2005) and the Breastfeeding Welcome Award (2003) are both examples of how the external world is changing to make breastfeeding in public more culturally acceptable.

For women in this study breastfeeding in front of others was particularly challenging. Breastfeeding in front of others was discussed in relation to family, friends, work colleagues and strangers. However, these groups covered a range of subgroups varying in terms of gender, people of differing generations and those with or without experience of breastfeeding. The majority of women suggested that breastfeeding in front of other women, children and those with previous experience of breastfeeding was something that they were particularly comfortable with. However, breastfeeding in front of males, the older generation, work colleagues and strangers presented the most significant challenges, and often led women to question the appropriateness of their breastfeeding; it also lead them to develop strategies in order to feel comfortable when in the presence of other (strategies will be discussed later in the chapter).

Women struggled to articulate factors underlying why they felt particularly uncomfortable breastfeeding in front of particular groups. However, it was evident that women talked about this in terms of “self” and “others”. Women talked about feelings of shyness when feeding with others and had concerns about part of their body becoming visible to others; within this concern concealment may be linked to respectability, and exposed breasts linked to sexual imagery. In relation to “others”, women stated that having little or no tradition of breastfeeding within either their family or circle of friends left them feeling unsure about how others may perceive or react to their breastfeeding, an issue that often left women feeling particularly uncomfortable or unable to breastfeed in the presence of others. Such feeling seemed to stem from two main sources: a lost tradition of breastfeeding also discussed by McIntosh (1985), Scott and Mostyn (2003), as well as the sexualisation of breasts (Carter 1995;

Young 1998; Stearns 1999; Mahon-Daly & Andrews 2002; Shaw 2004 and Bartlett 2005).

The majority of women in this study stated that breastfeeding in front of the older generation was particularly challenging due to a lost tradition of breastfeeding. Several women suggested that because bottle feeding was a cultural norm for the previous generation, they felt that older people may have a lack of knowledge or understanding about breastfeeding, and may never have seen a woman breastfeed. As a result, women felt particularly uncomfortable when feeding in front of older people. However, there were exceptions to this: where women had grown up in other cultures, breastfeeding in front of their visiting family and friends was described as being a comfortable, relaxing and supportive experience.

Breastfeeding in front of male relatives, friends and strangers was also particularly challenging for the majority of women in this study due to the sexualisation of breasts. Women perceived males to feel “uncomfortable” and “awkward” around them, and suggested that males “struggled” with the concept that they would choose to breastfeed in front of them. This was demonstrated by women in this study who suggested that men would apologise if they entered the room while they breastfed, or they would choose to leave the room if women showed any sign they were about to breastfeed. Women in Stearns (1999) study also found breastfeeding in front of male relatives and strangers particularly challenging due to the sexualised nature of women’s breasts. This perceived awkwardness sent a strong message to women in this study that men believed breastfeeding was a private activity that should occur in private. It is important to note, that several women suggested that where they knew men had previous experience of breastfeeding, they felt more comfortable and relaxed when breastfeeding. The sexualisation of breasts will be explored later in this chapter within the concepts of the “good maternal body” (Stearns 1999).

Although home was discussed as the most comfortable place in which to breastfeed their infant, women also talked about public areas where women felt equally comfortable and confident while breastfeeding. Similarly, both home and public areas at times could also be the most uncomfortable place to breastfeed when others entered the space. Although the constriction of spatial

freedom in relation to breastfeeding has previously been associated with something that occurs outside the home in public spaces (McIntosh 1985; Whelan & Lupton 1998; Stearns 1999; Guttman & Zimmerman 2000; Bailey & Pain 2001; Mahon-Daly & Andrews 2002; Paz Galupo & Ayers 2002), the finding from this study suggests the constriction of spatial freedom occurs, both within the home and outside the home.

## **In which environments do women feel comfortable and relaxed while breastfeeding?**

As discussed above, there is a fine line between what is considered private and public space. The home was considered to be the most comfortable place to breastfeed. A place where women felt they had a degree of privacy and enjoyed home comforts. However, when others entered the home it became a public space, where women question the appropriateness of their breastfeeding and negotiated where, and with whom, breastfeeding was most appropriate. As such the boundaries between private and public spaces are blurred. At times, women in this study found breastfeeding outside the home a comfortable and relaxing experience, than inside the home. As such, both private and public spaces can be comfortable or uncomfortable spaces for breastfeeding as others enter these spaces.

In order to achieve some privacy at home and in the homes of others, women in this study talked about using the bedroom as a way of avoiding breastfeeding in front of others. Women suggested that while not feeling particularly confident and discreet in the early days and weeks following birth, the bedroom offered them a “private and quiet” time with their baby. Over half of the women, both first and second-time mothers, talked about how, at times, they had used the bedroom or a private space as a way of avoiding breastfeeding in front of others in the home, during visits to and from family and friends. Women suggested that while not feeling particularly confident in their breastfeeding skills, and in order to avoid perceived negative reactions from others, or causing embarrassment to others, the bedroom offered women a “private and quiet” time in which to feed their baby away from the public gaze. Such breastfeeding behaviours are referred to by Mahon-Daly & Andrews (2002) as “behaviour rituals” where

women move in to a particular space to breastfeed and then move out to socialise with others and participate in everyday activities.

However, women did suggest that breastfeeding in private areas away from others did leave them feeling restricted and socially isolated, particularly in the early weeks when their infant could be breastfeeding for up to an hour at a time. A few women stated that for them breastfeeding would never have worked if they had to disappear off each time their infant required fed. These women suggested that although breastfeeding with others was initially a bit “strange” and “awkward”, getting passed that initial feed in front of others did enable them to feel a bit more comfortable and confident the next time they had visitors.

On venturing outside the home, the majority of women talk about using feeding rooms as a means of achieving privacy. These rooms were often discussed as an extension of their domestic sphere. Women talked about the convenience of being able to go to what they considered to be a private area within a public space and feed their baby. Feeding areas within the shopping malls were described as being large “colourful” spaces, “very comfortable” and “perfect for breastfeeding”. Furthermore, there was an expectation by women in this study that only other women and children should occupy such areas. Women were surprised and showed disgruntlement in discovering that men also use these areas to bottle feed and change their infants. As such, made to measure breastfeeding rooms have certain facilities which make it easy for women to breastfeed and change their baby, and although the feeding rooms are not actually a private space they did feel like that to women in this study until men enter.

As women progressed on their breastfeeding journey, and their skills and confidence developed, they tested the boundaries of their breastfeeding world by feeding in a whole number of places to see how it went. Cafés were popular places in which to breastfeed for women in this study. Women talked about how they preferred cafés where other women and children gather; a place with a discreet area and comfortable seating. These café were not inherently breastfeeding friendly: it was the interaction between the space and the women that make these spaces breastfeeding friendly environments. Women talked

about using and returning to these particular cafés to breastfeed, meet friends and socialise. As groups of women meet regularly in these spaces they create a comfortable and familiar setting.

Transportation considered as public spaces, were also discussed by women in this study as a somewhat private and comfortable place for breastfeeding. Women spoke of their experiences breastfeeding in cars, trains and aeroplanes. For example, the car offered women a degree of privacy and security when breastfeeding outside the home. Women can shut the door of the car and lock out the outside world; no one else can enter the space without direct invitation. In addition, the car surrounds the women with its doors and walls, offering a degree of privacy. Marsh and Collett (1986) and Pearce (1999) discussed the car as an extension of private space, a 'home from home', a place to perform activities deemed as private and in this case breastfeeding. Similarly, trains and aeroplanes are designed with rows of high backed seating, where a person seated two rows away is not visible to others; this enabled women to achieve a degree of privacy and enables them to breastfeed comfortably without others being aware.

However, a range of places were mentioned as being particularly uncomfortable and challenging for breastfeeding. Several women suggested that restaurants and health centres were the most inappropriate places in which to breastfeed. Women discussed restaurants as adult spaces that were not baby friendly. This notion was reinforced by a lack of baby changing facilities and the negative reactions that mothers received from restaurant staff and their customers while they breastfed their infant; women did not return to these spaces during the study period.

What is most surprising is that health facilities were deemed as inappropriate for breastfeeding. Several women talked about how attending hospital and doctors appointments were particularly challenging due to a lack of facilities for breastfeeding. Women felt that breastfeeding in the waiting area was not an option; mainly because of the proximity to others whilst seated in a large open space. As the majority of women had to keep appointment times, it was difficult to go between feeds. In addition, women felt that if they ask for a private room in which to feed they may miss their appointment. Women suggested that their

infant could be fed in the car once they left or they could take a bottle in order to avoid any breastfeeding. Whelan and Lupton's (1998) study suggested that everyday activities could be out of bounds with a breastfed baby, as breastfeeding mothers deem many places inappropriate for breastfeeding. These findings will be explored further in this chapter within the concept of "Liminality" (Mahon-Daly & Andrews 2002).

## **Negotiating breastfeeding in private and public spaces**

A fundamental theme of this thesis is not to portray breastfeeding women as passive in their attempts to breastfeed in private and public spaces. Rather, throughout their breastfeeding journey, women developed many strategies and negotiated their breastfeeding behaviour in order to breastfeed comfortably, confidently and discreetly with others in private and public spaces.

However, as discussed earlier, the act of breastfeeding is often complicated by conflicting cultural beliefs about women's breasts (Dettwyler 1995). Within Western societies the dominant view is that breasts are the most visible sign of sexuality and are therefore to be enjoyed by men, rather than babies. This existence of a strong cultural preference for sexualised breasts often means that women, in choosing to breastfeed, challenge the boundaries between the good maternal body and women as sexual objects. As a result, breastfeeding women must consider how they will breastfeed their infants in front of others in private and public spaces. Within this section the concepts of the good maternal body, self-surveillance, performativity and liminality introduced in the background, will be discussed in relation to the research findings and the role of the multidimensional breast.

### ***Good maternal body***

Women's breasts have been characterised as multidimensional, having both sexual and nurturing functions (Stearns 1999). However, the characterisation of the "good maternal body" as non-sexual predominates within Western culture (Stearns 1999): women must be constantly vigilant to how their breastfeeding is viewed by others in order to avoid perceived or actual negative reactions. It was apparent to women in this current study, from the reactions of others, that



breasts are more commonly viewed as sexual objects rather than objects providing nutrition. Reactions from others discussed above included negative comments, walking out of the room and struggling with where to look. These reactions were apparent across gender and differing generational groups. Consequently, the majority of women in this study negotiated where and with whom breastfeeding was most appropriate, and developed several strategies in order to maintain the good maternal body.

All of the women in this study emphasised the importance of breastfeeding discreetly in order to avoid causing any embarrassment to themselves or others. However, in the early days and weeks following birth women talked about the difficulties of attaching the infant at the breast, whilst at the same time ensuring that the breast and abdomen remained covered, a point also made by Stearns (1999). All of the women in this study suggested they used soft furnishings and clothing as a means of achieving discreet breastfeeding. Women also suggested that cushions acted as a protective shield, covering the stomach area and they used a shawl/blanket over their shoulder and breast area to ensure that they remained covered and discreet when feeding in front of others at home. Women also talked about how they spent a considerable amount of time thinking about what to wear when breastfeeding with others. For the majority of women this involved wearing maternity bras, large loose fitting tops, and/or wearing layers of clothing, such as a vest top and cardigan. Although women did not always feel particularly attractive in such clothing, it did enable them to breastfeed discreetly and fulfil the notion of the good maternal body.

In their attempts to breastfeed discreetly, women also developed a number of strategies that enabled them to restrict or avoid breastfeeding while in the presence of others both at home and outside the home. As discussed above, women searched out spaces where they could achieve a degree of privacy and avoid breastfeeding in front of others. Another strategy adopted by women in order to avoid breastfeeding in front of others, both at home and outside the home, was bottle feeding. A third of women suggested that while not feeling particularly comfortable breastfeeding in front of others, the bottle offered them respite from the social constraints of breastfeeding.

Several women also talked about how they timed and planned their breastfeeds in order to restrict or avoid breastfeeding when out with their infant. Women suggested they planned their shopping trips out around the location of feeding rooms and preferred cafés. For women in this study, these strategies were mainly, but not exclusively, used in the early days and weeks while women were developing their skills and confidence to breastfeed comfortably in public space. Stearns (1999) contends that maintaining the good maternal body was more achievable within the confines of the home surrounded by family and friends than outside the home. In contrast, this study concludes that achieving the good maternal body requires constant self-surveillance and management both at home and outside the home when breastfeeding in front of others.

### ***Self-surveillance***

In their attempts to breastfeed comfortably in front of others, women in this study participated in self-surveillance, and what McKinley (1995) describes as objectified body consciousness (OBC), whereby women were required to see themselves as others see them. The concept of self-surveillance was also echoed in the work of Shildrick (1997) who suggested that women are required to police their body, ensuring that they complied with the cultural prominence of breasts as sexual objects. Within this current study women engage in self-surveillance of their breastfeeding bodies in order to avoid any opportunity for others to react negatively towards their breastfeeding. Self-surveillance and the management of the breastfeeding body were very important to women in this study, as they perceived that men viewed their breasts as “boobs”. In light of the sexual nature of breasts, women suggested that “accidentally exposing yourself” would create embarrassment and this was something that women wanted to avoid at all cost. The risk of accidental exposure during breastfeeding was a real concern for several women in this study, particularly when breastfeeding an older infant. Here, women suggest that as their infant reached the age of 6 months, breastfeeding discreetly was challenging. Women reported that their infants were more easily distracted, and more likely to come off the breast quickly, thus leaving them exposed. As a result, women suggested that breastfeeding in public was too “risky” and increasingly uncomfortable. However, the appropriateness of women’s breastfeeding in this study was determined by a women ability to perform breastfeeding each social situation.

## ***Performativity***

Bartlett (2002) suggests that performativity portrays “breastfeeding as quite specific to each act, rather than assuming homogeneous experiences between women or even for one woman over time and place” (2002: 113). This analogy of performativity was apparent in women’s experiences of breastfeeding in private and public spaces, the central topic of this research. For example, women in this current study suggested that their level of confidence on any particular day, and the degree of privacy that could be achieved within each social situation, predicted how comfortable and relaxed they felt breastfeeding. As such, women acknowledged that feeling confident and comfortable on one occasion, in one location, did not guarantee that they would feel comfortable and relaxed on another occasion in the same space. Rather, it depended on how they felt on a particular day. This suggests that space is not inherently “baby friendly” rather the interaction between the space and the women’s ability to perform breastfeeding that makes them so.

## ***Liminality***

Mahon Daly and Andrews (2002) discuss the concept of liminality as a means of explaining the experiences of breastfeeding as a state, time or space in which women neither belong to their old world or a new world but rather they are suspended in a transitional period. Particularly relevant to this study is the concept of liminal space. Here they suggest that women move into a space (private space) to breastfeed, and out to reintegrate with society. However, the findings from this current research suggested that breastfeeding in private and public space is a complex continuum. Undoubtedly, women in this study moved in to private/semi private spaces, particularly in the early days following birth, and at around 6 months when their infant became more easily distracted while breastfeeding. However, women in this study also worked to develop their skills and confidence, and tested the boundaries of their breastfeeding in both private and public spaces, in order to remain integrated with society. In fact, women talked about how it would have been impossible to maintain breastfeeding if they were unable to feed in front of others. In addition, having achieved what they considered to be invisible breastfeeding, women perceived, at times, they could be sitting chatting to others in private and public spaces, and no-one was

aware they were actually breastfeeding. Women engaged in a variety of behaviours in order to breastfeed comfortably, confidently and discreetly in a variety of situations. In doing so women actively aimed to achieve “the good maternal body” paying particular attention to their “location, situation and the observer” (Stearns 1999: 322). As Stearns suggests:

“The actual labor of breastfeeding is increased because women must constantly negotiate and manage the act of breastfeeding in every sector of society - in public and in the home” (1999: 322).

## **Breastfeeding duration**

The duration of breastfeeding does appear to impact on a women’s ability to breastfeed in private and public spaces. Breastfeeding is a learned skill and women and their infants work together and develop the skill of attachment and discretion. The majority of women in this study experienced painful breastfeeding and difficulties with attaching the baby to the breast at each feed in the early days and weeks following birth. At this time women talked about how they spent their entire day breastfeeding and therefore having little or no time for anything else. Achieving discretion while breastfeeding for both first and second-time mothers was difficult; women spent little time outside the home and breastfeeding in front of others at home was particularly challenging at this time.

However, by the 10-week interviews, women stated that they and their infants had mastered the art of discretion and they felt much more confident about feeding in front of others. In fact, women talked proudly about having achieved what they considered to be invisible breastfeeding, where no one would know what they were doing. Women talked about how over time they became “blasé” about breastfeeding in front of others and proud about how they would breastfeed almost anywhere.

Despite their growing confidence, women talked about stopping breastfeeding in order to combat what women described as the “restrictive nature of breastfeeding” and because they planned to return to work. Preparing for a return to work was discussed by all of the women in the study as influencing their transition to formula feeding. However, of the 12 women continuing to

breastfeed beyond 4 weeks only 2 women were actually returning to work within 6 months, while the majority were not returning for several months. Women suggested that stopping breastfeeding was emotionally challenging, but they felt they needed to overcome this in preparation for their return to work. It does seem that women feel a need to justify their decision to stop breastfeeding and returning to work gives them a socially acceptable reason for stopping.

However, by the time infants were 6-months old, women reported that breastfeeding discreetly in front of others became increasingly challenging. Women talked about how their infants became far more interested in what was going on around them. As a result, women reported that their infants were more likely to be easily distracted and come off the breast quickly leaving them exposed. Several women went on to say that breastfeeding in front of others in private and public spaces had again become challenging due to the risk of becoming accidentally exposed; as a result, these women talked about withdrawing from public space and their preference to breastfeed at home.

## **Breastfeeding support**

Much of the literature portrays breastfeeding as a naturally occurring activity where the baby gravitates to the breast and feeds. However, both first and second time mothers described their early breastfeeding experiences as far from natural but rather fraught with physical challenges. The majority of women in this study talked about painful breastfeeding in relation to issues of attaching the infant to the breast, and emotional challenges from feelings of exhaustion. Women suggested that despite having attended “all the classes” and “knowing all the theory” they felt somewhat misled about the realities of breastfeeding a new baby. In addition, women suggested that in promoting the positive elements of breastfeeding, health professionals played down the challenges.

Encouragement to breastfeed is a local, national and international policy objective. However, despite this, there is the potential for local health care advice and support to be contradictory. Women in this study suggested that the breastfeeding support they received fell into two categories: that of good support and unsupportive/conflicting information. Women talked about good support in hospital as the midwife being present at every feed to help them

develop their skills of attachment; good support at home included intensive practical and emotional support from the midwife and health visitor. However, a third of women reported feeling totally unsupported by the advice and information received from health professionals both in hospital and at home. Much of this was due to how women perceived the advice and practices of individual health professionals. Women's perceived lack of practical and emotional support, alongside painful breastfeeding, negatively impacted on women's ability to continue breastfeeding. For several women this led to early cessation, while others introduced formula to supplement their breastfeeding. Tappin and colleagues (2006) found that where health visitors had received breastfeeding training within the previous two years women were twice as likely to continue breastfeeding.

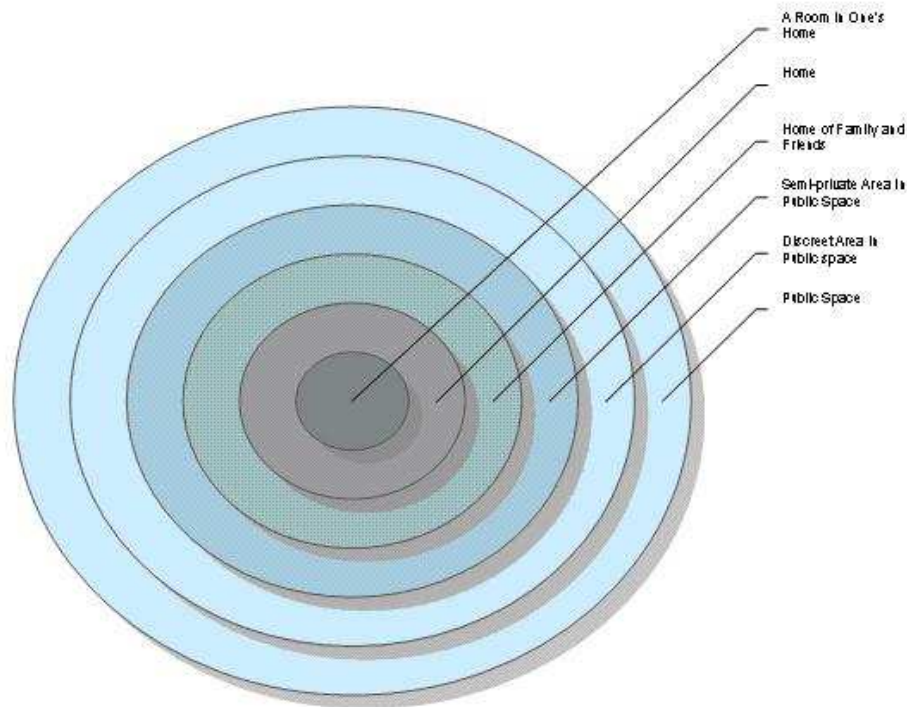
Several women within this study talked about how their health visitor left their contact number and information about clinics where they could access additional support. However, despite experiencing breastfeeding difficulties, none of the women used this additional support. Women suggested that they did not have time to pick up the phone, and accessing support out with the home in the early days was an unachievable goal. An issue that will be explored further within the recommendation for policy and practice.

Women in this study were encouraged by health professionals to think of breastfeeding as a natural, free and convenient way to feed their infant. However, this often meant that the challenges women experienced left them feeling overwhelmed, exhausted, isolated and failing in their duty as a breastfeeding mother. These findings are reflected in women's belief that their difficult journey was unusual, and their perception was that other women had an easier and more comfortable breastfeeding experience. For these women, seeking support may be particularly challenging, believing they are the only one facing such difficulties.

## **Concentric circles of public-ness**

In the process of analysing the participant's perspectives on breastfeeding in private and public spaces and locating those within a theoretical context, the researcher became aware of an absence of a suitable theory within the existing

literature. This led the researcher to develop an original tool of analysis. This tool, entitled “concentric circles of public-ness”, is central to this research in illustrating women’s experiences of breastfeeding in private and public spaces, environments where women felt comfortable and relaxed while breastfeeding and whether breastfeeding over time enabled women to move freely within these spaces.



**Figure 30: Concentric Circles of Public-ness**

The core of the circle represents a room in the home. This room could represent the bedroom, a room where women could achieve privacy while breastfeeding in their own home and the homes of others, away from the gaze of others. A central part of private space means to be in the home; women can control who enters and when. The main living areas of the home, such as the sitting room and kitchen, become public areas when receiving visits from others. Within these spaces women negotiated their breastfeeding in order to achieve discretion and feel comfortable and relaxed whilst breastfeeding in front of others. When moving out of the home into what is considered public space, women initially chose to use what they considered to be the private space of infant feeding rooms. These semi-private spaces try to replicate or act as an extension of the domestic space of the home. Moving outwardly into what was considered by women as more public space; this was represented by

breastfeeding in discreet locations within cafés, restaurants or museums. The outer layer represents more open spaces such as the waiting room in the health centre, the main walkway of the shopping mall or the park.

However, the aim here is to demonstrate how the circles of public-ness breakdown. Private and public space is a complex continuum. Breastfeeding is commonly discussed as a private domestic event, however it also occurs in public spaces and women find themselves aware of appropriate and inappropriate spaces for breastfeeding. Although a central part of privacy means to be at home, and public is outside the home, in terms of performing breastfeeding, the boundaries between private and public space are blurred. Privacy can, at times, be more or less achievable in public spaces; privacy in the home depends on how the space is occupied. Within this study, the majority of women talked about how they felt far more comfortable breastfeeding in spaces occupied by other women and children, whilst the presence of males both at home and outside the home made breastfeeding more challenging.

Women developed many strategies in order to overcome the difficulties they faced when breastfeeding with others. Such strategies were developed in order to restrict, hide or avoid breastfeeding with others. For example, women timed and planned their breastfeeds in the presence of others; used clothing and soft furnishings in order to breastfeed discreetly and introduced a bottle to avoid breastfeeding when out or in the presence of others at home. As women continued on their breastfeeding journey they talked about how, at around 12 weeks following birth they had mastered their breastfeeding technique and their ability to remain discreet while feeding with others. Women suggested that over time they thought far less about the space they occupied when breastfeeding, and the people around them. However, a few women also commented that breastfeeding discreetly at 26 weeks following birth was much more challenging. Women suggested that as their infant grows they were far more likely to be distracted during breastfeeding, coming off the breast quickly, and potentially leaving them exposed. As a result, a few women suggested that breastfeeding an older infant in front of others was particularly challenging; these women felt far more comfortable only feeding within the confines of the home.



This final section addresses the strengths and limitations of the research design; identifies policy and practice recommendations; contribution to the existing literature and areas for future research.

## **Strengths and limitations of the research**

### **Strengths**

Although there is a wealth of literature in relation to breastfeeding, much of the research on breastfeeding has a health education emphasis and focuses on improving breastfeeding rates. A particular strength of this research is that there are no studies to my knowledge that have taken a prospective approach to exploring women's lived experiences of breastfeeding in private and public spaces throughout the first 6 months of motherhood.

A further strength of the study was that an unforeseen high number of women followed the researcher through the study, which was particularly good given the possible time restraints and other pressures in their lives. In terms of achieving validity and reliability, a thorough analysis took place in the sense that the researcher conducted the interviews correctly, following the procedures stated. In addition, iterative readings and discussions of the transcripts by the researcher and her two supervisors facilitated the development and refinement of the final coding frame. It is also clear from the data that women did not just answer the questions in a methodological manner. Women reflected on their experiences during the gaps between interviews, which demonstrate their engagement with the study over time.

### **Limitations**

Breastfeeding is known to class related, whereby women living in the most affluent neighbourhoods are 3 times more likely to breastfeed than women living in the least affluent areas. This study methodology attempted to explore this by sampling whether living in the most/least affluent neighbourhoods had any bearing on a woman's experience of breastfeeding in private and public spaces. In order to gain an insight and understanding of women's experiences of breastfeeding at home and outside the home within the most and least affluent

areas, an area-based sampling tool (Scottish Index for Multiple Deprivation) SIMD was employed. However, as an area-based measure, it is important to note that the index does not claim to identify deprived individuals. As such, not all deprived people live in areas identified as having multiple deprivations; equally, not all those living in the deprived areas are deprived (Scottish Executive 2006). Using an area-based measure (SIMD) within this research did not allow any meaningful explanations or comparisons between the breastfeeding experiences of women residing in the most and least deprived areas. This is not surprising as others have come across similar issues (see Pickett and Pearl 2001 and Macintyre et al 2002). However, this had minimal effect on the study's research objectives as the focus was to explore women's experiences of breastfeeding in private and public spaces.

## **Policy implications and recommendations**

The findings presented here offer some insight into women's perceptions and experiences of breastfeeding in private and public spaces. Whilst statistical generalisations cannot be made, some recommendations can be proposed that are relevant to breastfeeding policy and practice.

Women in this study suggested that their decisions about infant feeding were made prior to direct contact with health professionals. Such findings were also supported in previous research (Earle 2000). On the other hand, breastfeeding promotional campaigns (such as television campaigns and the "breast is best" message) appeared to have a definite influence on informing women in this study about the health benefits of breastfeeding their infant. However, these campaigns did not seem to reach a wider audience, as the majority of women in this study reported that there was a lack knowledge and understanding of breastfeeding amongst their circle of family and friends. Similar findings were reported by McIntosh (1985) and Scott & Mostyn (2003). The implications of this are that breastfeeding promotion must not be the sole responsibility of health; community partners in areas such as education, councils, social work and leisure also have a role to play. For example, within education the use of a breastfeeding drama and lesson plans that span across the *Curriculum for Excellence* would provide young people with an opportunity to learn about the benefits of breastfeeding long before becoming a parent. The breastfeeding

drama could also be targeted to the older generation within local community groups, as women in this study found breastfeeding with older people particularly challenging.

The findings of the current study further suggest that women continually negotiate their behaviour in order to breastfeed comfortably in public spaces for fear of negative reactions from others. In addition, they spent time seeking out and planning trips around what they considered to be the most appropriate places for breastfeeding. As such, rolling out the Breastfeeding Welcome Award (BWA) in all community establishments would be an ideal way to address the barriers women face in their attempts to breastfeed in private and public spaces. The gains from this award are two fold: first it provides an opportunity to share information about the health benefits of breastfeeding to individual workers, who may also be members of the local community. Second, when visible, the BWA sends a strong message to breastfeeding women and others that these establishments create a welcoming atmosphere and promote breastfeeding as the natural way to feed infants and young children. A surprising finding of this research was that hospitals and GP surgeries were discussed as the most uncomfortable place in which to breastfeed. Breastfeeding Welcome Training (a 2 hour training programme) should also be delivered to all NHS staff to ensure hospitals, GP surgeries and other health facilities promote breastfeeding as the natural way to feed an infant.

The findings from this research also suggest that a bottle feeding culture continues to persist. Despite local and national policies aimed at promoting and protecting breastfeeding, parenting and infant feeding rooms visited by women in this study were identifiable by a logo of an infant feeding bottle. Changing the signage to the Breastfeeding Welcome image (illustrated below in figure 31) would send a clear message to women and others that breastfeeding is the natural way to feed an infant.



**Figure 31: Breastfeeding Welcome Sign**

The final recommendation relates to breastfeeding support. Breastfeeding is often portrayed as a natural activity where infants gravitate towards the breast and feed. However, women in this study suggested that despite having attended antenatal classes and read the literature they felt totally unprepared for their breastfeeding journey. Women also talked about good support in the early days and weeks as key to maintaining their breastfeeding. As such, a recommendation from this research would be to offer breastfeeding women an opt out programme of home support provided by both health professional and peer supporters (who had received breastfeeding training within the previous two years) during the first 6 weeks following birth.

## **Contributions to the body of knowledge**

Much of the research about breastfeeding within the UK adopts a quantitative approach, focusing on breastfeeding rates and factors that influence them. There are far fewer studies addressing the complexities of women's experiences and the meanings women ascribe to breastfeeding. This research represents an original contribution to the literature by examining women's experiences of breastfeeding in private and public spaces throughout the first six months of motherhood. A qualitative approach was adopted within this study to capture the lived experiences of women and to ensure that their voices were heard.

In the absence of a suitable theory within the existing literature, the researcher developed an original tool of analysis. The "concentric circles of public-ness" were used to explore women's experiences of breastfeeding in private and public space. The suggestion here was, as women move through the layers from the home to more public areas, the degree of privacy is reduced. However, the concentric circles of public-ness breakdown as women, at times, felt a greater

degree of privacy breastfeeding within public space than they did within their own home.

The findings from this research have also highlighted the areas women deemed as most and least appropriate for breastfeeding. Home is commonly considered as the most appropriate place in which to breastfeed. However, the findings from this research suggest that the home was also discussed as an uncomfortable place in which to breastfeed when visiting or receiving visits from family and friends. Within public space, the majority of women talked about the most and least appropriate places for breastfeeding. Appropriate places were discussed as places that represent an extension of domestic spaces, such as infant feeding rooms and cars. Cafés and public transport were also viewed by women in this study as appropriate and convenient when breastfeeding in public space. Ironically, the findings of this research suggest that health facilities (hospitals and GP surgeries) were deemed as the most inappropriate place in which to breastfeed an infant. This issue will be explored further as a possible avenue for future research.

## **Future research**

Throughout this research, areas of interest that would warrant further study became apparent.

Women in this study did not talk in any detail about using local facilities for breastfeeding. Rather, the majority of women put their babies in cars or used public transport to go shopping and meet friends within shopping malls or the city centre. However, for future research it would be interesting to consider why women choose to travel with their infants in cars to shopping malls, and to examine what facilities exist for public breastfeeding within local communities, and how appropriate or inappropriate these spaces are for breastfeeding.

The majority of women within this study found health facilities such as hospital and GP surgeries to be amongst the most inappropriate places in which to breastfeed. In addition, women suggested that breastfeeding in front of others while developing their skills of attachment was particularly challenging. Against this background, similar research could be conducted to build on the findings of

this research and explore women's experiences of breastfeeding in front of others within the postnatal wards.

This research also found that women faced particular challenges breastfeeding in public space. In the early days following birth women tended to withdraw from public space or only leave the home for short periods between feeds. During this period women would seek out places deemed appropriate for breastfeeding. An interesting area for research would be to evaluate women's experiences of breastfeeding in public spaces accredited with the Breastfeeding Welcome Award: a tool developed to promote breastfeeding as the natural way to feed an infant within establishments.

This study highlighted the extent and nature of the support offered by health professionals to new mothers while breastfeeding their infant. The majority of women discussed the information they received in the antenatal and postnatal periods in terms of good support or unsupportive and conflicting. Women also suggest that additional support was available, and this could be accessed by phoning their health visitor. Despite facing challenges, none of the women phoned their health visitor for additional support. A further research question would be to explore women's role in taking responsibility for accessing information and support from health professionals.

## Chapter 9: Conclusion

This thesis set out to explore women's experiences of breastfeeding in private and public spaces throughout the first 6 months of motherhood within a sample of mothers residing in the most and least affluent neighbourhoods of Glasgow south. A summary of the key findings and conclusions are presented in this final chapter.

Breastfeeding is commonly constructed as a private domestic activity and home is discussed as the most appropriate and comfortable place for women to breastfeed. However, with the frequent and lengthy breastfeeding schedules and the continuous stream of visitors a new baby attracts, the boundary between private and public space is blurred.

Outside the home is considered public space and women in the early days and weeks following birth women suggested they withdrew from public space, or ventured out for only short periods between breastfeeds. Women spent this time at home developing their skills, building up their confidence and cultivating the art of discretion in order to feel comfortable and relaxed breastfeeding with others.

The majority of women in this study found that breastfeeding in front of other women, and those with some familiarity of breastfeeding, enabled them to feel comfortable and relaxed. However, owing to the sexualised nature of breasts and a lost tradition of breastfeeding, the majority of women perceived breastfeeding in front of males, the older generation and strangers particularly challenging. As a result, half of the women in this study suggested, while not feeling particularly confident and discreet themselves, the bedroom or a private space offered them some time to breastfeed their infant away from the gaze of others. However, breastfeeding alone did leave women feeling restricted and socially isolated. A few women suggested that breastfeeding would not have worked for them if they had to disappear off to breastfeed. Although these women suggested breastfeeding with others felt strange at first, over time they became more comfortable and relaxed.

Progressing on their breastfeeding journey, having mastered the skills and confidence required to breastfeed discreetly, women tested the boundaries of their breastfeeding world by feeding in a wide variety of places. Women ventured out to the home of others, used feeding rooms and cars as extensions of their domestic space and as a means of gaining privacy in semi-public spaces. Cafés were also used by the majority of women in this study as a discreet location in which to breastfeed and socialise with friends. Although these cafés were not inherently baby friendly the interaction between the space and the women made them so. Women also talked about the use of public transport as a means of achieving a degree of privacy in a public space, describing how discreet, comfortable and convenient it was to breastfeed on aeroplanes and trains.

However, despite having the Breastfeeding etc. (Scotland) Act (2005) and Breastfeeding Welcome Award (2003) in Glasgow, there was a range of places mentioned as being particularly uncomfortable for breastfeeding while out with their baby. These included public buildings such as churches, museums, restaurants and ironically health centres. Women suggested that the lack of any/adequate facilities for breastfeeding, and being in an open space in close proximity to others, made these environments particularly uncomfortable.

Women in this study found themselves aware of appropriate and inappropriate places for breastfeeding both at home and outside the home. In addition, women emphasised the importance of breastfeeding discreetly and suggested that they negotiated their breastfeeding behaviour with each breastfeed and in each social setting in order to avoid causing any embarrassment to themselves or others in private and public spaces. Over time women talked about how they had become “blasé” about breastfeeding in front of others and how proud they felt being able to breastfeed almost anywhere.

Despite having established their skills and confidence, the majority of women at the 10 week interview discussed their intention to stop breastfeeding prior to their return to work. However, only 2 women planned to return to work within the first six months of birth. It does seem that women felt the need to justify to others their decisions about stopping breastfeeding and returning to work gave them a socially acceptable reason for doing so.



As breastfeeding is socially classed, this study methodology attempted to explore by sampling whether living in the most/least affluent neighbourhoods had any bearing on a woman's experience of breastfeeding in private and public spaces. The Scottish Index for Multiple Deprivation (SIMD), was an area-based tool was employed to identify women living in the most and least affluent areas within this research. However, not all deprived people live in areas identified as having multiple deprivations; equally, not all those living in the deprived areas are deprived (Scottish Executive 2006). As a result, using the (SIMD) did not allow any meaningful explanations or comparisons between the breastfeeding experiences of women residing in the most and least deprived areas.

The concentric circles of public-ness have been central to this research and were used to explore women's experiences of breastfeeding in private and public spaces. Here they demonstrate how the circles of public-ness break down. At the core, women may have a room in which they may choose to use for optimum privacy while breastfeeding. Moving out through the layers to more public space, the degree of privacy a woman can achieve is reduced. However, this does not hold true for women in this study who at times felt a greater degree of privacy breastfeeding within public spaces than they did in private spaces during visits from family and friends. It is also important to say that only a few women felt comfortable enough to breastfeed in the outer layer of the circles of public-ness, while others, on reaching the end of the study, stated they had reverted to only feeding at home.

## List of Appendices

### Appendix 1: Ten Steps to Successful Breastfeeding

1. Have a written breastfeeding policy that is routinely communicated to all healthcare staff.
2. Train all healthcare staff in skills necessary to implement the breastfeeding policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.
4. Help mothers initiate breastfeeding within half an hour of birth.
5. Show mothers how to breastfeed, and how to maintain lactation even if they should be separated from their infants.
6. Give newborn infants no food or drink other than breast milk, unless medically indicated.
7. Practise rooming-in, allowing the mothers and infants to remain together 24 hours a day.
8. Encourage breastfeeding on demand.
9. Give no artificial teats or pacifiers (also called dummies or soothers) to breastfeeding infants.
10. Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from the hospital or clinic.

Source: WHO/UNICEF (1989)

## **Appendix 2: Seven Point Plan for Sustaining Breastfeeding in the Community**

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

**Source: UNICEF (2008)**

## **Appendix 3: Aims of the Breastfeeding Welcome Award**

1. To encourage breastfeeding, by making it easier for mothers to feel confident and happy about breastfeeding when and where they want.
2. To encourage positive attitudes to breastfeeding amongst those who manage, work in and use public spaces.
3. To encourage more mothers to breastfeed in public places, so that people become used to seeing breastfeeding, and so in time it becomes a familiar and acceptable event to all; and
4. To promote breastfeeding as the normal way to feed children in Glasgow and thereby help to change negative cultural attitudes.

**Source: The Breastfeeding Welcome Award (BWA) 2003 (FMR Research 2006)**

## Appendix 4: Letter to maternity manager

09 July 2007

Dear Audrey Taggart

I am writing to ask if the Southern General Hospital Maternity Services would be willing to assist me with my PhD research project. The purpose of this research is to explore women's experiences of negotiating infant feeding in private and public spaces. It is expected that the research will run from July 2007 to June 2010 and an outline of the research project is enclosed.

The role of Maternity Services would involve:

1. The midwife identify to the researcher new mothers on their second postpartum day.
2. The midwife would ask new mothers on their second postpartum day if they would like to take part in an infant feeding study and refer them on to the researcher.

In order to conduct the research project within the Southern General Hospital an application will be made to South Glasgow and Clyde Local Research Ethics committee (LREC).

Yours faithfully

Carole Anderson

## Appendix 5: Research proposal

### Negotiating infant feeding in private and public spaces: a study of women's experiences

UNICEF (2005) suggest that more than 3,000 babies die everyday from infections caused by bottle feeding; this equates to approx 1.5 million children dying each year because they are not breastfed. As such, breastfeeding is seen as one of the most important ways of improving child health in all societies. The promotion of exclusive breastfeeding for six months has been established as a global public health issue (WHO 2003). Furthermore, breastfeeding also contributes to targets set by the DOH to reduce infant mortality by at least 10% by 2010 as a core element of reducing health inequalities. The UK NHS Priorities and Planning Framework for 2003 to 2006 includes a target that all Trusts and Strategic Health Authorities increase their breastfeeding initiation rates by 2 percent annually, concentrating efforts particularly on women from disadvantaged groups. The lowest incidence of breastfeeding occurs in some of the most disadvantaged urban areas. Children from disadvantaged areas are more likely to suffer illness in childhood, to place greater demand on health services and to grow up to be unhealthy adults.

Although many women consider breastfeeding or not being able to breastfeed one of the most significant experiences of their lives, it remains one of the most misunderstood, devalued, and invisible aspects of mothering. Our culture is simply not comfortable with breastfeeding and as such may prevent children from the best start in life. In the UK, bearing a breast to nourish and comfort a child is sometimes viewed as a taboo. Palmer (1993) states: "There is a contradiction between societies endorsing breastfeeding as the best infant feeding method on one hand, and its prohibiting of breastfeeding in public because of eroticisation on the other".

Breasts continue to be seen as sexual objects, and therefore bearing a breast discreetly to feed an infant is deemed inappropriate in public space. Societal disapproval means that some mothers may feel unable to feed their babies anywhere other than alone at home, resulting in a view that breastfeeding is isolating. While breastfeeding in the private space of one's home may be considered a comfortable place, this can be disrupted by visits from family or friends which may lead women to adapt their behaviour to minimise embarrassment to themselves and to others. In this respect women may not feel comfortable to breastfeed either within their own home or within public places.

Breastfeeding is no longer the cultural norm within the UK. Research suggests that attitudes towards breastfeeding are based on dominant values and norms within society, and individuals may find it very hard to go against cultural norms. It is assumed that people are comfortable with seeing a baby bottle fed in public, but breastfeeding, particularly in public places, is viewed as a taboo. Guttman & Zimmerman (2000) suggest that public space is a social environment in which the actual practice of breastfeeding is, at best, somewhat socially constrained. Public health policy recommends promoting breastfeeding interventions that increase the acceptance and practicability of breastfeeding,

particularly outside the home. Such interventions include the introduction of the Breastfeeding etc, (Scotland) Act (2005) which makes it an offence to stop a mother breastfeeding her infant in public.

The purpose of the research is to explore women's experiences of breastfeeding in private and public places. The specific objectives are to investigate the social and spatial influences affecting a woman's role in infant feeding. To investigate in which environments women feel comfortable and relaxed while breastfeeding and why. To find out how women negotiate their behaviour in their attempts to feed their infants in social spaces. Finally, to understand whether the above are influenced by living in affluent or deprived areas.

The research will take place over four time stages. Participants for all four stages of the research will be recruited from the Southern General Hospital, Glasgow at two days following birth. The manager of Maternity Services within the Southern General Hospital will be sent a copy of the proposed information sheet, proposed questionnaire and proposed consent form and asked in writing if they would be happy to help with the research project on infant feeding in the private and public sphere. The proposal will also be also discussed with ward managers.

The researcher will ask new breastfeeding mothers (over sixteen years) on the second post-partum day (identified by the midwife) from affluent and deprived neighbourhoods (using the SIMD) if they would like to volunteer to take part in a student research project.

All volunteering mothers referred by the midwife will be given a written explanation of the purpose of the research, a consent form and an attached questionnaire asking for some basic details. It is hoped that a many as possible will volunteer. Recruitment will take place in blocks of 3 weeks; this will allow the researcher adequate recruitment and follow up interview time. Data will be collected over a one year time period. As the focus of the study is to look at mothers living within both affluent and deprived areas the Southern General hospital was considered to be the best site for this research as it offers diversity in its service users and was used by the researcher successfully in a previous study.

## **Stage 1**

The research aims to recruit participants through purposive sampling (selecting women based on their relevance to the research). As such, all breastfeeding women on their second postnatal day, over the age of sixteen, living in the most/least affluent neighbourhoods (identified by the Scottish Index of Multiple deprivation) will be approached by the researcher and asked if they wish to volunteer to take part in a student research project. Volunteering women will receive an information pack containing a written explanation of the purpose of the research and a consent form. Participants will also be asked to provide basic contact details: personal details such as: name; mothers date of birth; postcode; contact number; occupation; date of delivery; and the name of their general practitioner/ health visitor.

## **Stage 2**

At 4 weeks following birth all volunteering mothers will be contacted by telephone and asked if they would like to continue with the research. Interviews will be based on semi-structured questions. Questions will be based on themes of infant feeding methods, feelings of comfort while breastfeeding, perceptions of others while breastfeeding and places they are most or least likely to frequent while breastfeeding and appropriateness of breastfeeding facilities. For women no longer breastfeeding, issues relating the decision to stop breastfeeding will be explored. Women no longer breastfeeding will be dropped from the study at this point.

## **Stage 3**

At 10 weeks following birth mothers will be asked during a telephone call if they wish to continue with face-to-face interviews. Themes to be explored will include how a mother's experiences of breastfeeding have changed over the past six weeks in terms of levels of comfort, feeding in front of others in private and public spaces, perceived/actual reactions from others while breastfeeding and places mothers are most/least likely to frequent while breastfeeding. Issues surrounding the use and feelings about private facilities for breastfeeding outside the home will also be explored. Women will also be asked about their feelings and/or experiences about continuing to breastfeeding and returning to work. For women no longer breastfeeding, issues relating to the decision to stop breastfeeding will be explored. Women no longer breastfeeding will be dropped from the study at this point.

## **Stage 4**

At 26 weeks following birth mothers will be contacted by telephone and asked if they wish to continue with the study. On the final stage of this journey, women will be asked to share their current experiences and reflect on their journeys of breastfeeding over the past six months. Themes will include addressing a mother's comfort level breastfeeding in private and public spaces as her infant grows. This will touch on whether perceived or actual reactions of others have changed as she continues to breastfeed. Issues surrounding returning to work will be explored and what impact this has on their ability to continue breastfeeding, e. g. expressing breast milk and facilities made available by employers.

The research aims to explore women's lived experiences and as such a qualitative approach was adopted. Semi-structured face-to-face interviews will take place at 4, 10 and 26 weeks after birth. The main advantages of this approach are that the researcher will be able to explore women's experiences of breastfeeding, identify points that she may not have previously thought of, and deviate to follow any interesting points made. All data collected will be recorded on a Dictaphone; interviews will take place in a suitable location of the participant's choice. Interviews conducted at 4, 10 and 26 weeks will allow the researcher to identify the duration of breastfeeding within the study sample and how women adapt their behaviour in order to feed their infants in private and public spaces overtime. Results obtained from this research can be obtained by written request to the researcher.



All volunteering women will be asked to complete a consent form having read the patient information sheet and prior to the administration of questionnaires. Information sheets will be distributed to all participants detailing the aims and confidential nature of the research. Participants are assured at all stages of the research that all information collected would be transcribed anonymously and would only be used in this piece of research. Participants will also be informed that they could withdraw from the study at any time without reason.

## **Appendix 6: Patient information sheet**

### **Title of Research Study: Negotiating infant feeding in private and public spaces: a study of women's experiences**

#### **Introduction**

You are being invited to take part in a research study conducted by a doctorate student attending the University of Glasgow. Before you decide to take part it is important for you to understand why the research is being carried out and what it involves. Please take time to read the following information carefully and discuss it with others if you wish. Ask your midwife if there is anything that is not clear or if you would like more information. Thank you for taking the time to read this.

#### **Purpose of the study**

The purpose of the study is to explore women's experiences of infant feeding in private and public spaces. In order to conduct this research, information will be gathered from new mothers giving birth within the Southern General Hospital. It is hoped that as many new mums as possible will agree to be involved in this study. Listening and understanding the views of new mothers in their attempts to breastfeed is important to this study and may inform future policy.

#### **What is involved?**

##### **Stage 1**

Women within the postnatal wards of the Southern General Hospital will be asked to complete a simple form. The form will take about 10 minutes to fill in; a midwife from the ward and the researcher will be able to help you if you have any problems understanding any of the questions. The form will ask you for personal details about yourself. This study will take place over four time periods. All women volunteering to take part in the study will be asked if they can be contacted again at 4, 10 and 26 weeks following the birth of their child. Having read and fully understood the patient information leaflet and, prior to administration of the initial form, mothers will be asked for their consent to participate.

##### **Stage 2**

At 4 weeks following birth all volunteering mothers will be contacted by telephone and asked if they would like to continue with the research. Interviews will be based on semi-structured questions. Questions at this time will be based on feeding methods, levels of personal comfort while breastfeeding, perceived perceptions of others while breastfeeding and places women are most/least likely to frequent while breastfeeding. Women will also be asked if they alter their behaviour in order to breastfeed when in different situations.

### **Stage 3**

At 10 weeks following birth mothers will be asked during a telephone call if they wish to continue with the study and participate in face-to-face interviews. Questions will explore how a mother's experience of breastfeeding has changed over the past six weeks in terms of levels of comfort feeding in front of others and places mothers are most/least likely to frequent while breastfeeding. Issues surrounding women's use of and feelings about private facilities for breastfeeding outside the home will also be explored. Women will also be asked about their feelings and/or experiences about continuing to breastfeed and returning to work.

### **Stage 4**

Within the final stage of this journey mothers will be asked to share their current experience and reflect back on their experiences of breastfeeding over the past six months. Questions will address a mother's comfort level breastfeeding in private and public spaces as her infant grows. Whether perceived or actual reactions of others have changed as a mother continues to breastfeed her infant. Whether returning to work impacts on their ability to continue breastfeeding, e.g. expressing breast milk and facilities made available by employers. Mothers will be asked to identify how breastfeeding has changed in terms of level of comfort feeding in front of others and in private and public spaces. Mothers will also be asked about how it feels to successfully breastfeed and what factors may help future new mothers on their journey.

All information collected during the face-to-face interviews will be collected on a tape recorder, and any quotes provided may be used in the final report. All quotes used will be given anonymity prior to use and verified with the participant to insure there is no misrepresentation of data. Semi-structured interviews will be conducted within the mother's home or another suitable location of the mother's choosing.

All data collected by tape throughout the research will be destroyed at the end of the study.

### **Details about the researcher**

My name is Carole Anderson; I am a full-time PhD student at the University of Glasgow. I am conducting this research for my doctorate thesis.

All information collected on your questionnaire will be forwarded to me. Any personal information identifying you such as your name and telephone number will only be seen by me. I will treat the information you provide me with in the

strictest confidence; I will not pass on your details to anyone else, nor will your name be used or mentioned in any reports. The research will continue until September 2009 and results can be made available to you by contacting the address below.

**Will my treatment be affected if I don't want to take part in the study?**

No. Whether or not you complete the questionnaire, you will receive the same standard of care from the Southern General Hospital. You can also of course change your mind about taking part in the study or withdraw at any time without giving a reason. You do not have to answer all the questions if you do not wish to, nor do you have to give a reason for not answering any of the questions.

**Do I get any benefit from being involved in the study?**

Although your help in this study will not directly benefit you, the information you provide will contribute to research evidence in this field.

**Thank you for your time.**

**Please keep this leaflet for your information.**

## Appendix 7: Participants questionnaire sheet

**Title: Negotiating infant feeding in private and public spaces: a study of women's experiences**

<b>Mothers Name:</b>	
<b>Date Of Birth:</b>	
<b>Address:</b>	
<b>Postcode:</b>	
<b>Telephone No: <i>Home:</i></b>	<b><i>Mobile:</i></b>
<b>Age at Leaving Full-Time Education:</b>	
<b>Occupation:</b>	
<b>Date of Delivery:</b>	

**What feeding method are you using to feed your baby?**

Breastfeeding ☐

Formula feeding ☐

**1. Is this your first baby?**

☐ **Yes**

☐ **No**

## **Appendix 8: Interview schedules**

### **Stage 2: Interview schedule - 4 weeks**

At four weeks following birth all volunteering mothers will be contacted by telephone and asked if they would like to continue with the research. Interviews will be based on the following semi-structured questions.

#### ***Feeding Method***

1. Can you tell me how you are currently feeding your baby?
2. When did you decide that breastfeeding was your chosen feeding method?  
Was breastfeeding something you had always planned to do? Why?
3. What advice have you received from others  
(partner/family/friends/professionals) about different feeding methods?
4. What are your thoughts about breast/bottle feeding?

#### **Prompt**

Have you previously breastfed? How many children and when was this?

#### ***Changing to Formula Feeding***

1. Can you tell me a bit about your decision to change your feeding method?
2. How did it feel stopping breastfeeding?
3. Can you tell me a bit about your experiences since changing to bottle feeding?

#### **Prompt**

Did you feel influenced by others when changing your feeding method? Who and how did they influence you?

#### ***Support***

1. Who would you say provides you with support and how do they do that?
2. What advice/support have you received from others (in hospital/from professionals/partner/and others) about breastfeeding?  
(Wanted/unwanted). How has such advice encouraged/discouraged you with breastfeeding?
3. Is there anyone that you would feel unlikely to ask for support? Or feel that they may not support you in a way you would want to be supported?

#### **Prompt**

Do you have family or friends that are breastfeeding or have previously breastfed?

#### ***Feeding at Home***

1. How have you found feeding at home?

2. How do you feel about feeding in front of others at home? Are there people you feel more or less comfortable feeding in front of? Can you tell me more about this?
3. Can you tell me how others react to you when feeding at home? How did it make you feel? Did their reaction surprise you?
4. Is there anyone you feel uncomfortable feeding in front of? How does your partner feel about you breastfeeding?

### ***Feeding outside the home***

1. Tell me about feeding your baby when you're out and about? (What times of the day and with whom)
2. How comfortable and relaxed do you feel when feeding outside the home? What places or people are most or least likely to make you feel comfortable and relaxed while feeding?
3. Are there particular places that you feel are not comfortable and relaxed environments when feeding? Where and why?
4. Have you received advice from others about feeding in public? What advice have you received?
5. Are you aware of any campaigns/legislation to help mothers in their attempt to breastfeed in public? Do such campaigns/legislation change the way you feel about breastfeeding in public?

### **Other Prompts**

1. Can you tell me a bit about leaking milk?
2. Can you tell me a bit about clothing and breastfeeding?
3. Breastfeeding as a discreet activity
4. Has breastfeeding in public changed for you from the time of breastfeeding your other children?
5. Which places have you continued/discontinued to visit when feeding? Why?
6. When feeding in public, what facilities have you used and did you feel they were appropriate for breastfeeding? Was there anything that fell short of your expectations?
7. You haven't said much about X – is there anything you want to add?

**Women no longer breastfeeding will be dropped from the study at this point.**

### **Stage 3: Interview schedule - 10 weeks**

At 10 weeks following birth women will be asked during a telephone call if they wish to continue in the study and take part in a face-to-face interview. Themes will explore women's breastfeeding experiences in the first 10 weeks following birth.

#### ***Feeding method:***

1. At home have you continued to use the feeding method chosen at the start of the study? If bottle feeding, when did you change and what factors influenced your decision?
2. Have you introduced other food stuffs? What age and what advice have you received about this?

#### ***Changing to formula***

1. Can you tell me a bit about your decision to change feeding method?
2. How has it felt changing to formula?
3. Did you feel you were influenced by others and how did they do that?

#### ***Support***

1. Has the support you were previously received changed? Is there an expectation that you should no longer require support?
2. Who provides you with support and how do they do that?

#### ***Feeding at home***

1. How has feeding at home changed as your baby grows?
2. As your baby grows has that changed the way you feel about feeding in front of others and how is this different from before?
3. Have others offered any advice about you continuing to breastfeeding?

#### ***Feeding in public***

1. How has feeding in public changed as your baby grows?
2. Are there particular places that you feel are more comfortable and relaxed environments when breastfeeding. Where and why?
3. Do you breastfeed in public with others or mostly on your own?
4. What times of the day are you most/least likely to breastfeed in public?
5. Would you prefer to use a private space when out and about feeding your baby and why?
6. Have you received any reactions from others when breastfeeding?
7. What are your experiences of breastfeeding/expressing and returning to work?
8. Has anything surprised you in your attempts to breastfeed at home, public or at work?
9. You haven't said much about X. Is there anything you would like to add?



## **Stage 4: Interview schedule - 26 weeks**

At 26 weeks following birth women were asked during a telephone call if they wish to continue in the study and take part in a final face-to-face interview. Themes will explore women's breastfeeding journey over six months.

### ***Feeding method:***

1. At home have you continued to use the feeding method chosen at the start of the study? If bottle feeding, when did you change and what factors influenced your decision?
2. Have you introduced other food stuffs? What age and what advice have you received about this?

### ***Changing to formula***

1. Can you tell me a bit about your decision to change feeding method?
2. How has it felt changing to formula?
3. Did you feel you were influenced by others and how did they do that?

### ***Support***

1. Has the support you were previously receiving changed? Is there an expectation that you should no longer require support?
2. Who provides you with support and how do they do that?

### ***Feeding at home***

1. How has feeding at home changed as your baby grows?
2. As your baby grows, has that changed the way you feel about feeding in front of others and how is this different from before?
3. Have others offered any advice about you continuing to breastfeeding?

### ***Feeding in public***

1. How has feeding in public changed as your baby grows?
2. Are there particular places that you feel more comfortable and relaxed environments when breastfeeding? Where and why?
3. Do you breastfeed in public with others or mostly on your own?
4. What times of the day are you most/least likely to breastfeed in public?
5. Would you prefer to use a private space when out and about feeding your baby and why?
6. Have you received any reactions from others when breastfeeding?
7. What are your experiences of breastfeeding/expressing and returning to work?
8. Has anything surprised you in your attempts to breastfeed at home, public or at work?
9. Can you tell me about breastfeeding in your local public facilities (libraries, swimming pools) and are you aware of the BWA scheme?

### ***B/F Journey***

1. Which groups are you more or least comfortable with and why? (Talked before about gender, familiarity, and older people?)
2. How would you explain the changes in your how comfortable you feel feeding in public (identity, public stance or assertiveness)?
3. Having breastfed for 6 months, was it how you imagined?

4. How would you describe your breastfeeding journey over the past 6 months?
5. What has breastfeeding your baby meant to you?
6. How has breastfeeding your baby changed your daily routine?
7. What reactions have you experienced while breastfeeding in public?

### ***Body and Breastfeeding***


1. What changes have you noticed in your body while breastfeeding and has your husband/partner noticed these changes?
2. While breastfeeding, are there particular things you have learned about your body? (e.g. periods, contraception)
3. Having stopped breastfeeding would you say you have your body back and what does this mean to you?
4. What impact has breastfeeding had on you and the way you feel about your body?
5. How would you feel talking with others about being a breastfeeding mother?
6. You haven't said much about X. Is there anything you would like to add?

### ***Tenure***

Do you own, rent or privately rent your home?

## Appendix 9: Consent form

Title: Negotiating infant feeding in private and public spaces: a study of women's experiences

South Glasgow Consent Form			
Patient name:		Date of Birth:	

### To be completed by the patient

	Please Initial	
	Yes	No
Have you read the Participant Information Sheet?		
Have you had the opportunity to ask questions and to discuss the study?		
Have you received satisfactory answers to all of your questions?		
Have you received enough information about the study?		

### Who have you spoken to about the study?

Dr / Mr / Mrs /  
Ms

### Do you understand that you are free to withdraw from the study

	Please Initial	
	Yes	No
At any time?		
Without having to give a reason?		
Without affecting your future medical care?		
Do you agree to take part in this study?		

Signed		Date
Signature		
Signature of witness		
Name in block letters		

## Appendix 10: Ethical approval



Ross House  
Hawkhead Road  
Paisley  
PA2 7BN  
e-mail: Evelyn.Macfadyen@renver-pct.scot.nhs.uk  
Telephone: 0141-314-0309  
Facsimile: 0141-848-1414

South Glasgow and Clyde LREC

2 August 2007

Ms Carole Anderson  
PhD student  
University of Glasgow  
Dept of Urban Studies  
25 Bute Gardens  
Glasgow  
G12 8RS

Dear Ms Anderson

<b>REC reference number:</b>	<b><i>07/S0710/72</i></b>
<b>Full title of study:</b>	<b><i>INFANT FEEDING IN THE PRIVATE/PUBLIC PLACES: AN EXPLANATORY STUDY OF WOMEN'S EXPERIENCES</i></b>

The South Glasgow and Clyde Research Ethics Committee reviewed the above application at the meeting held on 31 July 2007. Thank you for attending to discuss the study.

### **Ethical Opinion**

The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation.

### **Ethical Review of Research Sites**

The favourable opinion applies to the research sites listed on the attached form.

### **Conditions of Approval**

The favourable opinion is given provided that you comply with the conditions set out in the attached document. You are advised to study the conditions carefully.

Continued...../

2 August 2007

## Letter to Ms C Anderson, University of Glasgow.....continued/

### Approved Documents

The documents reviewed and approved at the meeting were:

Document	Version	Date
Application	5.4	9 July 2007
Investigator CV	-	-
Protocol	-	9 July 2007
Covering Letter	-	9 July 2007
Interview Schedules/Topic Guides	-	9 July 2007
Participant Information Sheet	-	9 July 2007
Participant Consent Form	-	9 July 2007
Participant's Questionnaire Sheet	-	9 July 2007
Stages and Themes	-	-
Supervisor's CV	-	1 March 2007
Disclosure Scotland	-	17 October 2006

### R&D Approval

The study should not commence at any NHS site until the local Principal Investigator has obtained final approval from the R&D office for the relevant NHS care organisation.

### Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

### Statement of Compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

**07/S0710/72**

**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project.

Yours sincerely

**Gerald F Belton OBE MA LLB**  
**Chair**

Enclosures: List of names and professions of members who were present at the meeting  
Standard approval conditions  
Site approval form (SF1)

## SOUTH GLASGOW AND CLYDE LREC

### LIST OF SITES WITH A FAVOURABLE ETHICAL OPINION

*For all studies requiring site-specific assessment, this form is issued by the main REC to the Chief Investigator and sponsor with the favourable opinion letter and following subsequent notifications from site assessors. For issue 2 onwards, all sites with a favourable opinion are listed, adding the new sites approved.*

<b>REC reference number:</b>	07/S0710/72	<b>Issue number:</b>	0	<b>Date of issue:</b>	02 August 2007
<b>Chief Investigator:</b>	Ms Carole Anderson				
<b>Full title of study:</b>	<b>INFANT FEEDING IN THE PRIVATE/PUBLIC PLACES: AN EXPLANATORY STUDY OF WOMEN'S EXPERIENCES</b>				
<i>This study was given a favourable ethical opinion by South Glasgow and Clyde LREC on 31 July 2007. The favourable opinion is extended to each of the sites listed below. The research may commence at each NHS site when management approval from the relevant NHS care organisation has been confirmed.</i>					
<i>Principal Investigator</i>	<i>Post</i>	<i>Research site</i>	<i>Site assessor</i>	<i>Date of favourable opinion for this site</i>	<i>Notes <sup>(1)</sup></i>
Ms Carole Anderson	PhD student	Southern General Hospital 1345 Govan Road Glasgow	South Glasgow and Clyde LREC	02/08/2007	
Approved by the Chair on behalf of the REC: ..... (Signature of Co-ordinator)					

Research & Development Directorate  
 NHS Greater Glasgow and Clyde  
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 G11 6NT

Ms Carole Anderson,  
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 25, Bute Gardens,  
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Direct Line 0141 232 9524  
 Fax 0141 232 9516  
 Email mary.fraser@ggc.scot.nhs.uk

Date: 15 August 2007

Dear Carole Anderson,

**Project Title: Infant feeding in the private/public places: an explanatory study of women's experiences**

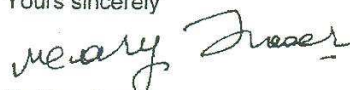
I am pleased to inform you that R&D management approval has been granted by NHS Greater Glasgow & Clyde Community and Mental Health Partnership, subject to the following requirements:

- You should notify me of any changes to the original submission, including copies of notification to ethics committee(s) and send regular, brief interim reports including recruitment numbers where applicable. You must also notify me of any changes to the original research staff and send CVs of any new researchers.
- Researchers covered in this approval are yourself and Dr Mhairi Mackenzie, your supervisor.
- Your research must be conducted in accordance with the Scottish Executive Health Department, *Research Governance Framework for Health and Community Care* (Second Edition, 2006) see Chief Scientist Website <http://www.sehd.scot.nhs.uk/cso> Local research governance monitoring requirements are presently being developed. This may involve audit of your research at some time in the future.
- You must comply with any requirements regarding data handling (Data Protection Act). Advice may be obtained from the Scottish Executive Confidentiality and Security Advisory Group for Scotland website <http://www.csags.scot.nhs.uk/>
- A final report, with an abstract which can be disseminated widely within the NHS, should be submitted when the project has been completed.

Do not hesitate to contact the R&D Office if we can be of any assistance.

We wish you every success with your PhD.

Yours sincerely



Dr Mary Fraser

Ms Carole Anderson,  
PhD student, University of Glasgow,  
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25, Bute Gardens,  
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Dear Carole Anderson,

**Honorary Contract / Conditions of Access to Research Materials**

**Project Title: Infant feeding in private/public places: an explanatory study of women's experiences**

**Project ID:**

I write on behalf of NHS Greater Glasgow and Clyde to set out the conditions upon which the Division provides you with access to certain information and materials to be used for research which you undertake in the course of study with The University of Glasgow.

1. You will have approval to undertake research activities relating to non-commercial NHS Research & Development under the terms of Scottish Executive Research Governance Framework for Health and Community Care. <http://www.sehd.scot.nhs.uk/cso/publications/resgov/framework/rqsedtwo.pdf>
2. You will require to have a named NHS Greater Glasgow and Clyde research contact, (Dr Mary Fraser) who you will be responsible to for the conduct of your research, as laid out in the terms of the NHS Greater Glasgow and Clyde and University policies.
3. You are required to provide the R&D Directorate with a full copy of your current CV and documentation regarding your qualifications and experience.
4. You will continue to be a student with The University of Glasgow at all times and shall not be deemed to be an employee of the NHS Greater Glasgow by virtue of this arrangement.
5. Any employer will continue to pay your costs, and all other contributions by law to be paid in respect of your work on this study.
6. This Honorary Contract / Letter of Access does not come associated with payment for any costs incurred including (but not limited to) travelling, library and hospitality expenses.
7. You will be required to comply with The EU Directive for Good Clinical Practice, Research Governance and Ethics Guidelines, Health & Safety Laws and all other Policies and Procedures as laid down by the NHS Greater Glasgow and Clyde.
8. In the course of your studies you may have access to confidential information from patients and staff. Confidential information refers to all information associated with this study. You may not use this information for your benefit or disclose it to a third party without the consent of NHS Greater Glasgow and Clyde. You must ensure that all confidential information held by you is maintained in secure storage. Disclosure or failure to maintain secure storage of confidential information can result in termination of your work on this study. Removal of the Letter of Access will prevent you



from working with NHS Greater Glasgow and Clyde and legal action can also be pursued against you.

This agreement is in relation to the above study and will be effective from 16<sup>th</sup> August 2007 (start date) to 30<sup>th</sup> July 2009 (proposed end date of study). The duty of confidentiality in respect of confidential information accessed by you will continue indefinitely.

This Honorary Contract / Letter of Access does not obligate you to undertake any duties whatsoever for NHS Greater Glasgow and Clyde including (but not limited to) research, training, education, service delivery and external consultancy.

You are further obligated under this agreement to report to NHS Greater Glasgow and Clyde's contact person, (Dr Mary Fraser) infringements either by accident or otherwise which constitute a breach of confidentiality. NHS Greater Glasgow and Clyde's contact person will then be responsible for notifying the Data Protection Officer.

You are required to read and acknowledge in writing the above information which stipulates your personal obligations as data processor for this study.

a copy of this letter is enclosed and I should be pleased if you would sign the form of acceptance on pages and return one to me as soon as possible and retain a copy for your own files.

Signature of student

\_\_\_\_\_

NAME

MS CAROLE ANDERSON

Signature of R&D contact

*Mary Fraser*

NAME

DR MARY FRASER

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