



A qualitative study of infant feeding decisions among low-income women in the Republic of Ireland

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ABSTRACT

Objective: to explore infant feeding decisions among low-income women living in Ireland to gain an in-depth understanding of the factors, which influence breast feeding initiation and continuation.

Design: a descriptive qualitative study using focus groups and semi-structured interviews.

Setting: community and primary health-care settings in the Republic of Ireland.

Participants: a convenience sample of 33 low-income mothers was recruited from 2 community programmes and 3 primary health-care centres.

Findings: six dominant themes were identified using Thematic Analysis. Prior knowledge of infant feeding, especially from experiences of seeing breast- and artificial milk-feeding in the family and the community, influenced feeding choice. Embarrassment and stigma about breast feeding in public places and in some cases in the private sphere were commonly described as barriers to breast feeding. The decision to bottle feed often reflected a balancing of the needs of the mother and the baby, because breast feeding was often perceived as inconvenient and requiring extreme determination. Breast feeding difficulties in the early weeks were frequently described and those who stopped breast feeding early often lacked practical knowledge and experienced support. In terms of health professional support, the mothers favoured a non-pressurised approach along with practical help with breast feeding.

Key conclusions and implications for practice: there is a need for promotional efforts to normalise breast feeding and for training of health professionals in the provision of appropriate support.

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Introduction

Breast feeding rates in Ireland are among the lowest in the developed world (Freeman et al., 2000; Tarrant and Kearney, 2008; Cattaneo et al., 2010). In the Irish National Infant Feeding Survey 2008, 55% of respondents reported initiating breast feeding in the first 48 hrs after birth (Begley et al., 2009). Large longitudinal studies in other westernised countries show higher initiation rates including 81% in the UK (NHS Information Centre, 2011), 75% in the USA (Centers for Disease Control and Prevention, 2011) and 99% in Norway (Lande et al., 2003). Breast feeding duration rates are also particularly low in Ireland. The Euro-Growth study assessed the infant feeding practices of 2245 mothers from 22 centres across Europe between 1990 and 1996 (Freeman et al., 2000). At four weeks postpartum, the Dublin

centre had the highest cessation rate of exclusive breast feeding; 80% of women in Dublin had ceased exclusive breast feeding, vs. 10% in Athens, Greece and 18% in Umea, Sweden.

Surveys conducted in the Republic of Ireland have identified a number of factors associated with breast feeding initiation and continuation. For example breast feeding rates are particularly low among lower socio-economic status mothers (Twomey et al., 2000; Ward et al., 2004; Begley et al., 2009; Tarrant et al., 2010). Recently, Tarrant et al. (2010) found that breast feeding initiation and 'any' breast feeding at 6 weeks postpartum were both associated with increased maternal age, education to third level, a positive prenatal intention to breast feed and positive postnatal encouragement from a partner to breast feed.

There has been no published research to date, which has examined women's infant feeding decisions in the Irish context using a qualitative approach. Previous research suggests that a cultural barrier exists in Ireland, which needs further exploration (Tarrant et al., 2010). In addition, a recent meta-synthesis of qualitative research in westernised countries on supporting

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breast feeding mothers concluded that more research is needed with low-income women (McInnes and Chambers, 2008). In this paper, we explored infant feeding decisions among a sample of low-income mothers living in Ireland to develop an in-depth understanding of the factors, which influence breast feeding initiation and continuation. This research aims to inform Irish policy on infant feeding, but also to contribute to the existing qualitative literature in westernised countries on infant feeding decisions among low-income women.

Methods

The research was guided by an interpretive descriptive approach that enables researchers to explore experiences and phenomena from the perspectives of the people involved (Merriam, 2002). Focus groups were chosen as the primary methodology because of their known effectiveness in promoting group interaction and debate that can produce insights which would not be derived from individual interviews (Kitzinger, 1995; Powell and Single, 1996). This group dynamic can be useful in illuminating group norms and prevailing cultural values (Kitzinger, 1995). Focus groups were therefore considered an appropriate methodology for exposing cultural barriers to breast feeding in Ireland. A semi-structured interview was conducted in cases for which focus group attendance could not be arranged, due to time and scheduling issues. In addition to scheduling practicalities, the use of individual interviews enabled intimate discussion of infant feeding decisions. In sum, the combination of focus groups and individual interviews was deemed to enhance data richness and depth of enquiry (Lambert and Loiselle, 2008).

Breast feeding rates are low in both urban and rural locations across Ireland (Economic and Social Research Institute, 2011). We therefore sought to include urban and rural dwellers in the research to ensure that a wide range of perspectives were elicited. A convenience sample of low-income mothers living in Ireland was recruited from 2 community programmes and 3 primary health-care centres. The 2 community programmes, which were both based in Dublin city consisted of (i) an early childhood intervention programme for families residing in three designated disadvantage areas and (ii) a community employment scheme that helps long-term unemployed people and other disadvantaged people to re-enter the active work force. Recruitment from the community programmes was carried out by staff members, who facilitated the programs. Recruitment from one inner-city and two rural based health-care centres was undertaken by a public health nurse and two general practitioners.

Inclusion criteria for the study were English speaking women, aged 16 years or above, whose youngest child was below 5 years of age. In the health-care centres, medical card holders¹ only, were included in the research to ensure a low-income sample was obtained. In the community programmes, it was not necessary to include medical card holders only, as these programmes accept socio-economically disadvantaged entrants only—with the vast majority holding a medical card.

Eligible mothers were informed that the research aimed to examine women's views and experiences in relation to breast and bottle feeding. They were also told that participation in the research was voluntary and that they would not be identifiable. Additionally, they were informed that the focus group or

interview would be audio-recorded with their permission. Furthermore, the mothers asked to take part in a focus group were told it would last around an hour and the mothers asked to participate in an individual interview were told it would last around 30 mins. The individual interviews were limited to around 30 mins to encourage participation by minimising the time burden on participants. Recruitment finished when no new relevant information was obtained from the interviewees, indicating that data saturation was reached.

The interview guides for the focus groups and the semi-structured interviews were developed based on an extensive review of the relevant literature on infant feeding and based on recommendations from an advisory committee of breast feeding experts in Ireland. Interview guides covered 5 aspects of infant feeding (1) feeding decision, (2) support—family, health professional, community, (3) knowledge about breast feeding and information received, (4) barriers to breast feeding, and (5) changes needed to support breast feeding. The focus groups and the semi-structured interviews were conducted by a female researcher (first author) with an academic background in psychology. The participants were interviewed in a private room in either a hotel, health-care centre, or a community centre.

Ethical approval for this research was obtained from the Human Research Ethics Committee of University College Dublin. An information sheet was given out at the start of the focus groups and interviews and written consent was obtained from each of the mothers.

The interviews were transcribed verbatim and checked against the recordings for accuracy. An inductive form of Thematic Analysis was used to analyse the data (Braun and Clarke, 2006). Firstly, the analyst (first author) read and reread the entire dataset to familiarise herself with the data and to identify preliminary patterns or themes. Basic codes were then applied to the entire dataset for all themes or patterns relevant to the research question. The codes were then organised into a hierarchical structure of themes and sub-themes by devising a mind map (Buzan and Buzan, 2003; Braun and Clarke, 2006). The mind map was continually refined until it accurately represented the whole dataset and there was little overlap between the 'story' of each theme. The second author reviewed the data coding, development of themes and interpretation of findings to ensure that a comprehensive and robust account was given. A qualitative software program (NVIVO 7) was used as a tool to aid the storage of the themes and sub-themes.

Findings

Four focus groups and 13 semi-structured interviews were carried out with a total of 33 low-income women. Two of the focus groups consisted of 4 participants, one group consisted of 5 participants and another group consisted of 7 participants. Individual interviews were arranged in 13 cases to accommodate participants' work schedules and time constraints. Each focus group lasted between 50 mins and 1 hr 15 mins and each individual interview lasted between 20 and 30 mins.

The mean age of the participants was 31 and they ranged in age from 19 to 40. They had between 1 and 6 children. All of the participants were Caucasian and all but one were native English speakers. Three of the mothers were born outside Ireland (one was English, one was Scottish and one was German). The vast majority of the participants were medical card holders. Demographic characteristics and breast feeding duration are shown in Table 1.

Six distinct themes exploring infant feeding decisions were identified. Pseudonyms were used for the participants' names to protect their identity.

¹ Medical cards allow people living in Ireland to access a range of health benefits free of charge including GP services and hospital care. Most people who get a medical card do so because their income is below a certain level. It is therefore used as an indicator of socio-economic disadvantage (Kelleher et al., 2002).

Table 1
Demographic characteristics and breast feeding duration (n=33).

Characteristic	n
Age range (years)	
19–29	12
30–40	21
Age of youngest child (months)	
< 12	16
12–23	6
24–35	5
> 35	6
Number of children	
1	7
2	10
3	8
4 or more	8
Medical card holder	
Yes	30
No	3
Location of residence	
Urban	23
Rural	10
Duration of 'any' breast feeding	
< 1 week*	7
1–6 weeks	5
> 6 weeks	9
Bottle fed only	12

* Includes any attempts to breast feed.

Prior knowledge of breast feeding

All the women in the study had some knowledge of the health benefits of breast feeding. However, many of the participants expressed that a lack of practical knowledge about how to breast feed influenced their decision to bottle feed. Some of the women also noted that they chose to bottle feed, because they were young or first time mothers, and therefore had little information or experience regarding breast feeding:

I think because, basically because he was my first child, and I wasn't sure how to breast feed to be honest. I didn't ask any questions, and I presumed, ah no, just give me a bottle and I'll feed him the way I know how to feed him. That was it. (Andrea)

Informal sources of knowledge

Previous experience of seeing either artificial milk-feeding, or breast feeding in the family was interpreted as a strong influence on feeding choice. The women described a tendency to automatically follow the norm they had encountered in their immediate family surroundings:

It [breast feeding] was just a family tradition, I mean mum did it. I was the first of the sisters to have babies so I did it and they all did it. (Imelda)

It [breast feeding] was never in my family, it was never brought up. I never seen anybody actually, personally, family wise breast-feed, I think, it was just automatically baby, bottle, formula. (Edel)

Bottle feeding was considered by most of the participants to be the prevailing norm in their neighbourhood, or locality. Breast feeding was construed by the women as 'still' having a lot of stigma attached to it:

It's just it's [breast feeding] not accepted yet. It's so natural and people still just look at it as disgusting. (Linda)

The interviewees distanced themselves from perceived negative societal attitudes towards breast feeding by declaring that they themselves had nothing against breast feeding and that it should not be seen as a 'bad' or 'unnatural thing'. The older generation was viewed as especially intolerant of breast feeding and although breast feeding was perceived as becoming more acceptable over time, there was a general consensus that a lot of stigma still remained. The women's beliefs about accepted means of feeding infants in their social context appeared to influence their feeding choice. The perceived bottle-feeding norm in Ireland was often compared by the interviewees, (especially those who had lived abroad) with the cultural acceptability of breast feeding in other countries and ethnicities. They noted that breast feeding is the automatic choice in many other countries:

My first one now it was born in Holland, and over there now they never really bothered saying anything, 'cos automatically over there now you just breast-feed, everybody over there just breast feeds kinda thing, so they just automatically assume that you'd be doing it. (Pauline)

A commonly held perception was that breast feeding was 'not really talked about' in Ireland, which limited women's knowledge about it and discouraged them from doing it. Breast feeding was perceived by many of the participants as a 'taboo' subject and 'not the done thing' in their locality. A mother, who bottle fed commented:

I don't mean to like come across bad but it's not a done thing in more lower class areas, I've noticed. But I think kind of the more educated you are about it [breast feeding]...or even the more educated the person is that, they kind of know that it is okay to do it like. (Susan)

Many of the women recommended that there should be more discussion and promotion of breast feeding in Irish society, as this would help to normalise it. A number of women also recommended that education about breast feeding should begin in school, to allow children and teenagers an opportunity to become accustomed to it and see it as normal. A mother who bottle fed her 3 children commented:

Maybe educate the younger girls, take the taboo off it, 'cos like I said, my two [teenagers] are appalled with it, so maybe if they start educating the younger girls around it, start getting them used to it. (Leanne)

Formal sources of knowledge

A number of the women perceived that the antenatal education about breast feeding was focused on the promotion of breast feeding and the benefits for the baby with little emphasis on the practical skills needed. It was also perceived that potential problems encountered during breast feeding and solutions for these issues were not discussed in antenatal classes.

Although the women frequently mentioned getting leaflets about breast feeding in the antenatal and postnatal period, these were perceived by some as difficult to understand. A leaflet alone was not enough, as women preferred an experienced person to provide them with practical knowledge during pregnancy about how to breast feed, so they can make an informed choice. Two mothers, who bottle fed commented:

I mean anyone can read a leaflet and not understand it like, you know what I mean. You want to be shown, you want to be taught, you want to be prepared for it. You don't want to be just saying – 'here you go, go in there for five minutes and read it over'. (Linda)

But, like even if you went to see your doctor in the hospital and you're pregnant if they talked about it, told you what it was about, maybe, rather than giving you a leaflet, 'cos I don't really read them you know what I'm saying. If someone actually....told me it was better, I'd be like yeah, right, I'm gonna do it and told me how it worked and stuff do you know like. (Áine)

Some of the women expressed the need for some kind of demonstration from a person with experience of breast feeding in pregnancy, rather than merely focusing on 'technical' issues.

Embarrassment

Embarrassment in public places

Embarrassment about breast feeding in public was commonly mentioned by the women as a barrier to breast feeding, regardless of their infant feeding choice. The women perceived that breast feeding in public places was not acceptable in Ireland and that women who violate this norm generally receive negative attention and reactions, such as tuts of 'disgust', or negative comments. The women felt a social pressure to keep breast feeding hidden from the public gaze. Taboos about exposing breasts in public seemed to underlie the stigma about breast feeding in public:

There is a taboo around it. Ah look at her with her diddy [breast] out feeding the baby. (Jacinta)

I wouldn't be getting my boobie [breast] out in public....'cos although I'd be like, if you want to do it that's fine, but I wouldn't do it. (Susan)

The breast has become increasingly sexualised in Ireland and other westernised societies; however this alone cannot explain the low levels of breast feeding in Ireland, as many westernised societies have very high rates of breast feeding. Additionally, values of sexual prudery in Irish society across successive generations may underlie Irish women's reluctance to feed with the breast:

Yeah, I think it's still a whole sex issue about your boob. (Imelda)

Eh, if I'm being honest I think it's a very twisted Catholic upbringing of some description. It's like, I've had people say, it's like breasts are for sexual things, you know, not for feeding babies. And when they associate...[the] breast with a sexual act, they don't think it's normal for a baby. (Lauren)

The Irish are prudes. (Jacinta)

And in an excerpt from a focus group discussion:

Angela: Look even at all the foreigners over here, it doesn't bother them to breast feed anywhere, and it doesn't.

Leslie: It's just our attitude; it's the way we were brought up really.

Many of the women were critical of the lack of good facilities in public for breast feeding mothers, which meant that breast feeding mothers often had to feed in locations perceived as unsuitable, such as toilets. Some of the women who breast fed were clear that they would not feed in public; however this made breast feeding harder, as they had to find private facilities when outside the house, or go back to their car:

Well I wouldn't like to do it [breast feed] sitting on a bench, so I found I was going back to the car to feed and everything like, which makes it harder. (Liz)

Many of the women who did breast feed in public places were careful to do it covertly and without bodily exposure, so as to draw as little attention to themselves as possible, as illustrated by this comment from a breast feeding mother:

I just find it easier like say if you go into a cafe, I find a quiet spot and keep my back to everyone, I was always comfortable, or if I get my husband to sit at one side of me if there's people that side, it just makes me feel better. (Erica)

Some of the women also found it embarrassing to breast feed on the hospital ward as they perceived it to be a public place, which you shared with many other patients and where hospital staff and visitors would come in and out of the ward on a frequent basis:

I think it was hard in the hospital at first you know with my first baby and then everyone's coming to visit you. So every time you go to feed someone's coming in and you can't do it....I think they should not let anyone in for a while when you're doing it, it's just really awful. (Tanya)

One of the women felt especially embarrassed on the ward. In spite of her intentions throughout pregnancy to breast feed, she initiated artificial milk-feeding in the hospital. She then tried to breast feed at home where she felt more comfortable, but she didn't know what to do, so she continued with artificial milk-feeding:

I wouldn't know how to breast feed now and I was embarrassed in the hospital. I kept saying no, like, I wouldn't breast feed, but when I got home I said ah well I'll just try it, but I didn't know what to do. (Miriam)

Embarrassment in the private sphere

Some of the mothers, who bottle fed mentioned that if they had chosen to breast feed, members of their family would have felt embarrassed, or uncomfortable about it (e.g., their parents or in one case their partner). A participant, who had studied childcare, perceived that some of her female classmates were disinclined to breast feed because they would feel embarrassed to breast feed in front of others, including even their mother:

They were still against it [breast feeding], and they, they couldn't get over, like, the embarrassing part of it. You know, and they didn't see the breast feeding as a natural thing, you know. Like to even do it in front of like their mother and stuff like that, you know. (Jenny)

Many of the women who breast fed described feeling comfortable feeding in front of their partner and their parents. In contrast, a single mother felt embarrassed about breast feeding in front of members of her family and because of this, she perceived breast feeding as socially isolating:

That's what I found really embarrassing after having her like, even going to my mam's, 'cos I don't live at home. And it was like, alright, I have to go upstairs, 'cos like your dad and your brother, you're not going to sit down and breast feed in front of them, like. (Róisín)

Well-being of mother and baby

The well-being of both mother and baby were weighed up by the women in making their feeding decisions. Almost all of the women who initiated breast feeding mentioned the health benefits for the baby, or doing what's 'best for the baby' as influencing their feeding choice. In the focus groups, many of the women who

bottle fed countered that their children were very healthy and they never had any problems with bottle feeding.

Some of the women also mentioned that they were motivated to breast feed as it facilitates the bonding process between mother and baby. Many women felt however that the bond developed with bottle feeding is just as strong as breast feeding and that it is unfair to promote the notion that breast feeding fosters a stronger bond.

Many of the women who successfully breast fed their babies described breast feeding as more convenient than bottle feeding, as they did not have to prepare bottles beforehand. In contrast, many of the women who initiated bottle feeding described breast feeding as difficult and inconvenient:

Yeah because like breast feeding would be kind of really demanding do you know 'cos it's not just like every four hours you give him a bottle, do you know, it's ongoing. (Lisa)

I know it's supposed to be more beneficial but, I just think, well after I have had him, I'd just be too sore and too tired. I find, it's just harder on yourself. (Susan)

The perceived pain of breast feeding put some of the women off initiating breast feeding, and reflects lack of knowledge about overcoming early problems with breast feeding. Exhaustion, or soreness after the birth, especially if the birth was difficult, also inclined some of the women to bottle feed. A few of the women noted that artificial feeding allowed their partner to bond with the baby and for the job of feeding to be shared by other members of the family. This sharing of feeds also allowed the mother to have some 'me time'. Although a small number of the women noted that their partners would not favour breast feeding (especially in public), decisions about feeding were seen as the mother's prerogative, with her decision then supported by her partner.

Worries about how much milk the baby receives from breast feeding was mentioned by a number of women as influencing their decision to bottle feed. They perceived that using a bottle made it much easier to measure the baby's intake of milk. In some cases, mothers initiated artificial feeding as they had an entrenched fear that they would not produce enough milk as they were 'flat-chested'.

Although, most of the women, who initiated artificial feeding acknowledged that breast feeding conveyed greater health benefits for the child, many other considerations were involved in their feeding decisions. The decision to bottle feed was often presented as a practical balance of the health and welfare needs of the baby, mother and family.

Early breast feeding difficulties

Difficulties with breast feeding, especially in the early postpartum period were frequently described by the women. As expected, difficulties were more acute for first-time mothers, or mothers new to breast feeding. These difficulties included not knowing how much milk the baby was getting, pain, tiredness, embarrassment, constant feeding and difficulties latching the baby on. Some of the women gave up breast feeding early because of one or more of these difficulties, while others continued to feed despite the difficulties. Lack of knowledge about coping with breast feeding difficulties, along with lack of help from an experienced person were clearly evident from many of the stories told by the women about stopping breast feeding early. A single mother living in a disadvantaged urban area described her feelings of isolation and exhaustion during her four weeks of breast feeding:

But, like that, you don't have anyone to talk to, because all my friends bottle fed, and you just feel like pulling your hair out

because you're so tired and if they're not feeding... But whereas if I'd known someone who could have given me advice, and for expressing, I never got a clue how to put that machine together, and I was like, what? (Róisín)

A number of the women who initiated breast feeding described being constantly worried about how much milk the baby was getting, especially at the early stages of breast feeding. In some cases the women were reassured by signs that their baby was thriving, while others changed from breast to bottle feeding to allay their fears.

Many of the women who breast fed successfully described having help from an experienced person, who encouraged them and gave them help with their difficulties:

I mean if my sister hadn't done it [breast fed] before me, I wouldn't have stuck it with my first child...because she had done it, she was like, oh just stick with it, another day and another day and then when I did...it was fine. (Tanya)

Talking with an experienced breast feeder, who could reassure them that they weren't the only one who had experienced problems with breast feeding, was perceived as more helpful than written material, or advice from health professionals:

Just you're not the only one going through that and, or even as well as all the leaflets, doctors, midwives, everybody giving you advice you know, to me there's nothing better than mums who have done it. (Erica)

Health professional support

The women's experiences of support from health professionals in relation to breast feeding were varied. Some of the women described receiving help and encouragement with breast feeding, while many of the women described receiving little or no support. Many of the women, who bottle fed recalled that the only time breast feeding was mentioned to them by a health professional was when they were asked if they were breast or bottle feeding after the birth. Some of the women described feeling they didn't have the option to breast feed, as the health professional presumed they would bottle feed:

I didn't get the option. They checked my notes that I bottle fed on his brother, now it's 11 years in the difference, so they just gave him the bottle, where I was planning it [breast feeding] and I had discussed it in the hospital and it was on the chart. (Jacinta)

It appeared that some health professionals may presume that certain mothers should bottle feed, as breast feeding would be too onerous for them (e.g., low-income mothers, young mothers and mothers who bottle fed previously):

Well when I was 16 having my young one [first child], they never said anything to me about breast feeding at all, breast feeding wasn't even mentioned in the hospital. Even when I went in on my [antenatal] visits, no, they never mentioned breast feeding. I think it was because I was so young they never mentioned breast feeding or anything. Just when I had her she was given the bottle. (Miriam)

In this excerpt from an individual interview, the participant was asked if she had discussed breast feeding with any health professionals during pregnancy:

Deirdre: yeah well they just said like, there was an option [to breast feed], but like...they didn't say it this way, but I took it up that way, that it would be more convenient to bottle feed

because if I was out on the street, people would be offended. Like I was thinking that's nature.

Interviewer: Yeah, and did you ask them anymore about it or?

Deirdre: No, because I felt like I was shut down straight away.

The power differential between the health professional and the patient may then make it difficult for the mother to resist the assumption of the health professional that they should bottle feed.

A number of women felt pressurised by health professionals to breast feed, and felt judged if they did not breast feed. Many of the women described being 'turned off' breast feeding by this pressure. Others felt that they were pressurised to breast feed, but then were not given any practical help with breast feeding:

I breast fed on my two but they force you, when you're going for your [antenatal] hospital visits, but then when you actually have the baby nobody will sit with you and explain what to do. It's just, 'okay, she's breast feeding, go to the next bed'. (Shauna)

It was perceived that breast feeding is not the 'normal' thing to do for many women and therefore they need to receive non-judgemental information about it during pregnancy and be prepared for it, instead of being pressurised to breast feed after the birth.

The need for practical support from health professionals was evident from the dialogues. The women described needing time from a health professional to sit with them after the birth and make sure they were feeding the baby correctly. The women also preferred health professionals not to touch their breasts when teaching breast feeding skills (see also Whelan and Lupton, 1998; Hoddinott and Pill, 2000; Dykes, 2005).

The women perceived that hospitals were under-staffed and therefore the staff did not have enough time to provide the support needed by breast feeding mothers. The women also described not liking to ask for help, as they perceived that the staff were very busy. Some of the women recounted receiving inaccurate or conflicting advice from health professionals, which some women ignored, while it put other women off breast feeding. It was also perceived that lack of time was responsible for some of the inaccurate, or conflicting advice received, as health professionals often wanted to find an 'instant fix' for problems, rather than thoroughly assessing an issue.

Self-determination

Some of the women who initiated bottle feeding with their infants were fearful of breast feeding. This fear seemed to derive from lack of knowledge about how to breast feed and the idea that breast feeding was very demanding and that they wouldn't be able to manage it. Many of the women who initiated bottle feeding, or gave up breast feeding early expressed a willingness to consider breast feeding in the future, if they had the support required. A few of the mothers however expressed little interest in breast feeding in the future. One of the women who initiated bottle feeding was adamant that nothing would have encouraged her to breast feed:

Nothing really would have changed my mind I think, so it wasn't the fact that the campaigns didn't work or I didn't believe in what they said, it was just, as I said, just not me. (Carol)

Many of the women who breast fed successfully were characterised by a strong determination to breast feed, which helped them seek out information about breast feeding for themselves

and to persevere in the face of problems. Others, who initiated breast feeding had low self-confidence in their ability to breast feed and but had decided to 'try' it and see how it goes. Most of these mothers gave up early when faced with difficulties, while other continued with breast feeding for a longer period, as they received strong support in the early postnatal period:

In the hospital they kept pushing and pushing it with me, 'cos I wanted to give up because I was in pain and whatever, I was knackered [exhausted], but they kept saying no just keep going, keep going, you'll get it, you know, it works, so I did. And then when I came home the baby nurse was there, 'cos I said to her I want to give it up as well and she was down nearly every day helping me out and saying you know, don't give it up. (Lesley)

Infant feeding choice appeared to be closely bound up with the women's sense of self. Some of the women, who initiated bottle feeding perceived that it 'wasn't in' them to breast feed, which highlights the pervasive belief that breast feeding is a highly demanding or difficult job, which only mothers with high determination to breast feed can manage.

Discussion

The findings extend the qualitative literature on breast feeding by exploring the infant feeding decisions of a sample of low-income women living in Ireland. The findings expose the perceived stigma about breast feeding in Ireland and the lack of practical and experienced support available for breast feeding in the family and the health-care system.

The findings depict a bottle feeding culture in low-income communities, in which breast feeding is rarely seen or mentioned. This has also been shown in previous qualitative studies in the UK (Hoddinott and Pill, 1999; Pain et al., 2001; Bailey et al., 2004). Furthermore, the perception that embarrassment about breast feeding discourages women from initiating breast feeding has been documented in both Ireland and the UK (Fitzpatrick et al., 1994; Kelleher et al., 1998; Scott and Mostyn, 2003). A recent survey found that 'embarrassment about breast feeding in front of others/in public' (31%) was the principal reason given by the Irish born mothers for not initiating breast feeding (Tarrant et al., 2010). Previous research also supports the finding that values of prudery in Irish society may underlie women's reluctance to breast feed (Ineichen et al., 1997). There is a clear need for promotional efforts to normalise breast feeding in Ireland. Television advertising may help to normalise breast feeding in Ireland. Previous research in Northern Ireland has found however that breast feeding promotional materials—showing semi-naked women breast feeding at home, are perceived to inadvertently portray breast feeding as unrealistic and isolating (Stewart-Knox et al., 2003). It is crucial therefore, that promotional advertisements portray breast feeding as a normal aspect of everyday life.

The women's dialogues also shed light on the common survey finding that the perceived inconvenience of breast feeding motivates women to bottle feed (Begley et al., 2009; Tarrant et al., 2010). The mothers perceived that breast feeding required high levels of determination and self-sacrifice for success. This deterred some women from breast feeding because they felt they did not have it 'in' them to breast feed. For these women, artificial feeding represented a practical balance of the needs of the mother, baby and family. These findings suggest that promotional efforts should not just emphasise that breast feeding is 'best for baby', but instead should present the benefits for the mother also (e.g., weight loss, the convenience of not preparing bottles and psychosocial benefits). Facilities in public for breast feeding

should also be improved and extended, so that breast feeding mothers have the freedom to go out in public and yet have ready access to private facilities.

The notion that support from an experienced person can be crucial in overcoming problems with breast feeding has been reported previously (Pain et al., 2001). This finding underlines the importance of providing low-income women (who may lack experienced family support) with information about breast feeding support groups, where they can meet experienced breast feeders.

A lack of support from health professionals for breast feeding was a common theme in the dialogues, although when appropriate support was provided, it was highly valued. Perceived barriers to breast feeding were time pressures on health professionals in the hospital, receiving conflicting, or inaccurate advice from health professionals and pressure from health professionals to breast feed; all of which have been documented in the literature from other westernised countries (McInnes and Chambers, 2008). Breast feeding is not 'normal' for many low-income women in Ireland and therefore health professionals should not pressurise women to breast feed. Some participants perceived that practical education during pregnancy about how to breast feed would enable women to make an informed infant feeding decision. In addition, the women wanted health professionals to take the time to sit with them after the birth and make sure they were feeding correctly. This help should be provided without the mother having to ask for it, as some of the women interviewed, especially younger mothers were fearful about asking health professionals for help.

An unanticipated finding was that some health professionals may consider breast feeding to be too difficult for certain mothers, so they provide them with a bottle of artificial milk without any discussion of breast feeding. This suggests that training for health professionals needs to emphasise the importance of providing information about the benefits and management of breast feeding to all mothers regardless of their age, social class, or previous feeding choice.

The vast majority of Ireland's 20 maternity units are participating in the UNICEF Baby Friendly Hospital Initiative (BFHI) and six of these units have BFHI accreditation (BFHI in Ireland, 2011). Previous research has documented that Baby Friendly accredited hospitals have higher breast feeding rates than non-accredited hospitals (Broadfoot et al., 2005; Bartington et al., 2006). Strategies to increase implementation of BFHI policies in Irish maternity units may help to address some of the issues raised in this paper.

The research had a number of limitations. The median age of the participants' youngest child was 13 months, which meant that recall difficulties may have limited the richness of the accounts given. The strength of feeling generally evident in the mothers' accounts however, suggested that infant feeding decisions resonated in their minds, which facilitated clarity of recall. In addition, the use of a convenience sample may have limited the range of participants recruited. However, the participants were recruited from a variety of urban and rural locations throughout Ireland and varied in terms of age, family size and infant feeding practices and therefore it seems likely that a broad range of views and experiences were elicited.

Implications for policy and practice

The research highlights a number of key implications for policy and clinical practice. Firstly, health promotion efforts in Ireland should aim to normalise breast feeding by presenting it as an everyday activity engaged in by women from all sectors of society. Secondly, promotional efforts should be more woman-centred and not focus solely on the benefits of breast feeding for

the baby. Thirdly, public facilities for breast feeding in Ireland should be improved and extended. Fourthly, health professionals need training in the provision of practical and non-judgemental breast feeding support to all mothers regardless of their background. Finally, breast feeding support groups should be fostered in low-income areas to provide access to support from experienced breast feeders.

Conflict of interest statement

The authors declare that they have no conflicts of interest.

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References

- Bailey, C., Pain, R.H., Aarvold, J.E., 2004. A 'give it a go' breast-feeding culture and early cessation among low-income mothers. *Midwifery* 20, 240–250.
- Bartington, S., Griffith, L.J., Tate, A.R., Dezateux, C., Millenium Cohort Study Child Health Group, 2006. Are breastfeeding rates higher among mothers delivering in baby friendly accredited maternity units in the UK? *International Journal of Epidemiology* 35, 1178–1186.
- Begley, C., Gallagher, L., Clarke, M., Carroll, M., Millar, S., 2009. The National Infant Feeding Survey 2008. The Health Service Executive, Dublin. <http://www.breastfeeding.ie/uploads/files/National_Infant_Feeding_Survey_2008.pdf> (last accessed 28 February 2012).
- BFHI in Ireland, 2011. Participants in BFHI Projects December 24, 2011. <<http://www.ihph.ie/babyfriendlyinitiative/participatinghospitals.htm>> (last accessed 28 February 2012).
- Braun, V., Clarke, V., 2006. Using thematic analysis in psychology. *Qualitative Research in Psychology* 3, 77–101.
- Broadfoot, M., Britten, J., Tappin, D.M., MacKenzie, J.M., 2005. The baby friendly hospital initiative and breastfeeding rates in Scotland. *Archives of Disease in Childhood (Fetal and Neonatal Edition)* 90, F114–F116.
- Buzan, T., Buzan, B., 2003. *The Mind Map Book*. BBC, London.
- Cattaneo, A., Burmaz, T., Arendt, M., et al., 2010. Protection, promotion and support of breast-feeding in Europe: progress from 2002 to 2007. *Public Health Nutrition* 13, 751–759.
- Centers for Disease Control and Prevention, 2011. Breastfeeding among US children born 2000–2008. CDC National Immunization Survey. <http://www.cdc.gov/breastfeeding/data/NIS_data/> (last accessed 28 February 2012).
- Dykes, F., 2005. A critical ethnographic study of encounters between midwives and breast-feeding women in postnatal wards in England. *Midwifery* 21, 241–252.
- Economic and Social Research Institute, 2011. Perinatal Statistics Report 2009. Economic and Social Research Institute, Dublin. <http://www.esri.ie/health_information/nprs/nprs_reports/Perinatal_2009.pdf> (last accessed 28 February 2012).
- Fitzpatrick, C.C., Fitzpatrick, P.E., Darling, M.R., 1994. Factors associated with the decision to breastfeed among Irish women. *Irish Medical Journal* 87, 145–146.
- Freeman, V., van't Hof, M., Haschke, F., the Euro-Growth Study Group, 2000. Patterns of milk and food intake in infants from birth to age 36 months: the Euro-Growth Study. *Journal of Pediatric Gastroenterology and Nutrition* 31, S76–S85.
- Hoddinott, P., Pill, R., 1999. Nobody actually tells you: a study of infant feeding. *British Journal of Midwifery* 7, 558–565.
- Hoddinott, P., Pill, R., 2000. A qualitative study of women's views about how health professionals communicate about infant feeding. *Health Expectations* 3, 224–233.
- Ineichen, B., Pierce, M., Lawrenson, R., 1997. Jewish and Celtic attitudes to breast feeding compared. *Midwifery* 13, 40–43.
- Kelleher, C., Nolan, G., Connolly, C., Rossnagel, K., McFarlane, A., 1998. Knowledge and Attitudes to Breastfeeding in the Eastern Health Board Area. Centre of Health Promotion Studies, National University of Ireland, Galway.
- Kelleher, C., Timoney, A., Friel, S., McKeown, D., 2002. Indicators of deprivation, voting patterns, and health status at area level in the Republic of Ireland. *Journal of Epidemiology and Community Health* 56, 36–44.

- Kitzinger, J., 1995. Qualitative research: introducing focus groups. *British Medical Journal* 311, 299–302.
- Lande, B., Andersen, L.F., Baerug, A., et al., 2003. Infant feeding practices and associated factors in the first six months of life: the Norwegian infant nutrition survey. *Acta Paediatrica* 92, 152–161.
- Lambert, S.D., Loiselle, C.G., 2008. Combining individual interviews and focus groups to enhance data richness. *Journal of Advanced Nursing* 62, 228–237.
- McInnes, R.J., Chambers, J.A., 2008. Supporting breastfeeding mothers: qualitative synthesis. *Journal of Advanced Nursing* 62, 407–427.
- Merriam, S.B., 2002. *Qualitative Research in Practice: Examples for Discussion and Analysis*. Jossey-Bass Publishers, San Francisco.
- NHS Information Centre, 2011. *Infant Feeding Survey 2010: Early Results*. The Health and Social Care Information Centre, UK. <http://www.ic.nhs.uk/webfiles/publications/003_Health_Lifestyles/IFS_2010_early_results/Infant_Feeding_Survey_2010_headline_report2.pdf> (last accessed 28 February 2012).
- Pain, R., Bailey, C., Mowl, G., 2001. Infant feeding in North East England: contested spaces of reproduction. *Area* 33, 261–272.
- Powell, R.A., Single, H.M., 1996. Focus groups. *International Journal for Quality in Health Care* 8, 499–504.
- Scott, J.A., Mostyn, T., 2003. Women's experiences of breastfeeding in a bottle-feeding culture. *Journal of Human Lactation* 19, 270–277.
- Stewart-Knox, B., Gardiner, K., Wright, M., 2003. What is the problem with breastfeeding? A qualitative analysis of infant feeding perceptions. *Journal of Human Nutrition and Dietetics* 16, 265–273.
- Tarrant, R.C., Kearney, J.M., 2008. Breastfeeding practices in Ireland: a review. *Proceedings of the Nutrition Society* 67, 371–380.
- Tarrant, R.C., Younger, K.M., Sheridan-Pereira, M., White, M.J., Kearney, J.M., 2010. The prevalence and determinants of breast-feeding initiation and duration in a sample of women in Ireland. *Public Health Nutrition* 13, 760–770.
- Twomey, A., Kiberd, B., Matthews, T., O'Regan, M., 2000. Feeding infants—an investment in the future. *Irish Medical Journal* 93, 248–250.
- Ward, M., Sheridan, A., Howell, F., Hegarty, I., O'Farrell, A., 2004. Infant feeding: factors affecting initiation, exclusivity and duration. *Irish Medical Journal* 97, 197–199.
- Whelan, A., Lupton, P., 1998. Promoting successful breast feeding among women with a low income. *Midwifery* 14, 94–100.