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“What I Hadn’t Realized is How Difficult it is, You Know?”: Examining the Protective Factors and Barriers to Breastfeeding in the UK

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“What I Hadn’t Realized is How Difficult it is, You Know?”

Examining the Protective Factors and Barriers to Breastfeeding in the UK

by

Cheyenne R. Wagi

A thesis submitted in partial fulfillment of the requirements for the degree of Master of Arts with a concentration in Applied Biocultural Medical Anthropology
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ABSTRACT

The international recommendation for breastfeeding is that a baby should be exclusively breastfed for six months. Breastfeeding should be continued for up to two years and beyond with complementary foods (WHO, 2016). The United Kingdom exhibits some of the lowest breastfeeding rates in the world (HSCIC, 2012). The percentage of mothers who breastfed in the United Kingdom falls below 34% at six months, with only 1% of mothers breastfeeding exclusively at this point (HSCIC, 2012:31). This study sought to examine the protective factors and barriers for breastfeeding in the UK. Mums (n=28), their partners (n=6), and facilitators at breastfeeding support services (n=3) were interviewed (n=37) to learn more about breastfeeding experiences and related factors. Mums (n=28) also completed the Breastfeeding Self-Efficacy Scale Short-Form. Factors related to individual knowledge and beliefs, support from partners, family, and friends, clinical experiences, formal support, and stigma all played central roles in the mum’s breastfeeding experience. Efforts should be made to address these factors at community, organizational, and policy levels to improve breastfeeding in the UK.
CHAPTER 1: INTRODUCTION

The international recommendations for breastfeeding are that a baby should be exclusively breastfed, meaning breastfed without other food, water, or supplements, for the first six months of their life. Breastfeeding should be continued after six months for up to two years and beyond with complementary foods (National Health Service (NHS), 2016; World Health Organization (WHO), 2016). For infants, breastfeeding is shown to reduce the risk of Sudden Infant Death Syndrome, and reduce asthma, obesity, and type 2 diabetes later in life (Hauck, Thompson, Tanabe, Moon, & Vennemann, 2011; National Institutes of Health (NIH), 2017). It is also important for cognitive development and may have emotional benefits (Britton, Britton, & Gronwaldt, 2006). For mothers, breastfeeding reduces the risk of breast and ovarian cancer and may reduce the risk of post-partum depression (Bascom & Napolitano, 2016; Groer, Davis, & Hemphill, 2002).

Breastfeeding rates in the UK are significantly lower than other developed countries, with fewer than one percent of mums breastfeeding exclusively at six months (Health and Social Care Information Center (HSCIC), 2012; World Health Organization (WHO), 2015). It is essential to learn more about what barriers and protective factors are in place that influence a mum’s breastfeeding experience. An exploratory study was conducted with mums, their partners, and facilitators at Baby Cafés across London to learn more about the factors that influence breastfeeding in the UK. Interviews, participant observation, and the Breastfeeding Self-Efficacy Scale Short-Form were conducted to learn more about experiences with breastfeeding and their
perceptions of organization and community influence on breastfeeding. Major themes emerged as playing the most central roles in a mum’s breastfeeding experience. These included expectations for infant feeding, partner support, the role of family and friends, clinical experiences, breastfeeding information, formal support, breastfeeding-related stigma, judgement mums experience, and policy awareness. These themes can be organized within the Social Ecological Model and be used to develop recommendations for programmatic interventions and policy development to improve breastfeeding in the UK.

Statement of the Problem

The United Kingdom exhibits some of the lowest breastfeeding rates in the world (HSCIC, 2012; WHO, 2015). For the first six months of an infant’s life, exclusive breastfeeding is recommended and breastfeeding should be continued with complementary solid foods between six months and two years (NHS, 2016; WHO, 2016). This recommendation is practically universal, however, the percentage of mothers who breastfed in the United Kingdom falls below 34% at six months, with only 1% of mothers breastfeeding exclusively at this point (HSCIC, 2012:31). Most mums in the UK choose to initiate breastfeeding, with 81% of mothers initiating in 2010. Of those mothers who initiated breastfeeding, 68% still breastfed their infant at six weeks, though only 23% of mums were breastfeeding exclusively at this point (HSCIC, 2012). Further, in a national breastfeeding survey in the UK, 60% of mothers stated they stopped breastfeeding before they wanted to (McAndrew et al., 2012). It is important to gain a better understanding of why mums who initiate breastfeeding are able to continue, or not, and the reasons for exclusive and non-exclusive breastfeeding. Multiple factors are cited as the cause of low rates of sustained breastfeeding, including stigma, lack of support, and attitudes about public breastfeeding (HSCIC, 2012; Thomas, 2014). Large gaps currently exist in the literature for the
role of partner support and self-efficacy in a mother’s experiences and willingness to breastfeeding in public, as well as a mother’s perceptions of public breastfeeding. Additionally, the literature also currently focuses on these factors individually. The *International Breastfeeding Journal* has put out a call for papers on breastfeeding in public, stating, “…there has been little qualitative research targeted at understanding the experience of this activity” (*International Breastfeeding Journal*, 2017). There is also a lack of anthropological literature focusing on breastfeeding stigma in developed countries and even fewer with applied outcomes.
CHAPTER 2: REVIEW OF THE LITERATURE

Breastfeeding

Breastfeeding and breastmilk provide immune-strengthening antibodies and maternal bonding in the first stages of an infant’s life. Breastfeeding provides infants with protection against illnesses in the form of antibodies in breastmilk (WHO, 2016). Infants who breastfeed have a reduced risk for hospitalization related to lower respiratory tract infections (Healthy Children, 2006). Breastfeeding, especially exclusive breastfeeding, is also protective against Sudden Infant Death Syndrome (Hauck et al., 2011; U.S. Department of Health and Human Services, 2014). Mothers also benefit from breastfeeding, as it is associated with a reduced risk of type-II diabetes and breast and ovarian cancer (WHO, 2016). Psychological benefits of breastfeeding for mothers include the reduction in reactivity to stress and stressors and decreased postpartum depression (Groer et al., 2002). In addition to improvements in overall physical health, there is evidence that breastfeeding serves as a protective factor against child abuse and maltreatment (Strathearn, Mamun, Najman, & O’Callaghan, 2009). There is growing recognition of the health benefits of breastfeeding and increased support for breastfeeding in the UK. The House of Commons notes that increasing breastfeeding in the UK could result in a reduction of health inequalities, but that current duration is “abysmally low” and exclusive breastfeeding “vanishingly rare” (House of Commons, 2009). The House of Commons is not as clear how they would plan to address breastfeeding from a policy or governmental level.
**Stigma**

Breastfeeding, as with any other practice, is culturally embedded. Stigma related to breastfeeding is the result of cultural connotations and norms related to breastfeeding in public and cultural conceptions of breasts. Both in the United States and the United Kingdom, breastfeeding in public is seen as “taboo” (Boyer, 2011; Mulready-Ward & Hackett, 2014). A study examining perceptions of public breastfeeding among 2075 New Yorkers found that breastfeeding was perceived to be a private act that should not be done in public by just over half of the sample (Mulready-Ward & Hackett, 2014). Stigma related to breastfeeding in public is often related to the sexualization of breasts (Johnston-Robledo, Wares, Fricker, & Pasek, 2007; Sayers, 2014). The lack of support for public breastfeeding has resulted in lower rates of exclusive breastfeeding and decreased breastfeeding duration (Sayers, 2014). Women are asked to cover up or leave public areas while breastfeeding because it makes others uncomfortable (Sriraman and Kellams, 2016). Partners may also exacerbate these feelings, as studies have found fathers did not feel comfortable with their partner’s breastfeeding in public (Mitchell-Box & Braun, 2012). This leaves women who are made to feel embarrassed about public breastfeeding to decide between staying home, breastfeeding in areas such as public restrooms, or supplemental bottle feeding (Sriraman and Kellams, 2016). Bottle feeding is problematic for mothers who wish to sustain breastfeeding as milk production is a supply and demand system (Brown, 2016). If milk is not being removed regularly, it will not be produced in as great of quantity as it would with on-demand feeding (Brown, 2016).

**Partner Support**

Partner support is shown to be essential in making the decision to breastfeed and to continue breastfeeding. It is an essential component of social support. Social support is widely
and historically evidenced to improve breastfeeding outcomes. Kaufman and Hall (1989) found that women without social supports were six times more likely to stop breastfeeding than those with social supports present. Examining partner support specifically, Hauck and colleagues found in their study across Australia, Ireland, and Sweden that partner support was a valued factor for continued breastfeeding in examining what women perceived assisted them in breastfeeding for six months (Hauck et al., 2016). Mothers reported partner practical assistance, acknowledgment of the importance of breastfeeding to the mother, and support in the face of opposition from others to assist in breastfeeding (Hauck et al., 2016). In Ecuador, partner support was found to be among the most important factors in a mother’s decision to breastfeed (Jara-Palacios, Cornejo, Pelayo, Verdesoto, & Galvis, 2015). Brown and Lee (2011) found in the UK that mothers with supportive partners were more likely to plan to breastfeed, initiate breastfeeding, and sustain breastfeeding. Conversely, a lack of partner support is significantly associated with the early cessation of exclusive breastfeeding (Ogbo et al., 2017). A study on how including fathers in breastfeeding education affects breastfeeding outcomes found including fathers improves rates of exclusive breastfeeding and increases overall breastfeeding duration (Su & Ouyang, 2016). A supportive partner is more likely to be a breastfeeding advocate, which may reduce some of the negative consequences of stigma (Hauck, Hall, & Jones, 2007).

**Self-Efficacy**

Self-efficacy related to breastfeeding is the measure of a mother’s confidence to breastfeed her child and it is predictive of breastfeeding outcomes (Blyth et al., 2002). Breastfeeding self-efficacy is most frequently measured by the Breastfeeding Self-Efficacy Scale and Breastfeeding Self-Efficacy Scale-Short Form. These scales measure a mother’s ability to determine if her baby is getting enough milk if she can manage to breastfeed, desire to continue,
and keep up with her baby’s breastfeeding demands (Dennis, 2003). Confidence in these abilities is predictive of sustained breastfeeding (Dennis, 2003). One study found that mothers who were not as confident in their breastfeeding ability were more likely to stop one week postpartum (Sriraman & Kellams, 2016). Further, the researchers found breastfeeding self-efficacy before birth was a significant predictor of breastfeeding duration (Sriraman & Kellams, 2016). High breastfeeding self-efficacy is also linked to exclusive breastfeeding (Blyth et al., 2004). Self-efficacy impacts the mother’s perceived insufficient milk supply, which also affects the ability to sustain breastfeeding (Blyth et al., 2004). Studies found that having a supportive partner was linked to a mother feeling more confident and that breastfeeding self-efficacy was positively correlated with having a partner who was supportive of breastfeeding, thus demonstrating the interconnected nature of these components (Hauck et al., 2007; Hinic, 2016).

**Public Breastfeeding**

Breastfeeding in public is a focal point for breastfeeding and stigma research. For breastfeeding to be supported, public breastfeeding must become more socially acceptable in the UK (Boyer, 2011; Brouwer, Drummond, and Willis, 2012; Grant, 2016). Research has been done with mothers, lactation activists, and lactation consultants, as well as Critical Discourse Analysis on public comments on new articles. These studies found that new mothers often feel uncomfortable while breastfeeding publicly (Boyer, 2011). Mothers often felt pressured to breastfeed, but doing so in public led to feelings of anxiety and embarrassment (Brouwer, Drummond, and Willis, 2012). These feelings are barriers to breastfeeding in public, which makes exclusive breastfeeding more difficult, as mothers may not be able to sustain breastfeeding while also running errands and completing tasks outside of the home (Brouwer, Drummond, and Willis, 2012). In the analysis of public opinion via news story comments, Grant
(2016) found that the majority, eighty-two percent, of comments contained negative views on public breastfeeding. While these views cannot be assumed to be representative, comments that demonstrate opinions that public breastfeeding is distasteful or for sexual exhibitionism must be considered and do play a role in social norms related to breastfeeding (Grant, 2016). Public breastfeeding demonstrates the intersection of stigma, partner support, and self-efficacy. This behavior can be used as a way to operationalize the above critical components of breastfeeding, as it is happening in the public sphere and incorporates a mother’s desire and confidence related to breastfeeding and their partner’s support of breastfeeding.

**Tongue-Tie**

Tongue-tie, or ankyloglossia, is a condition in which the lingual frenulum is unusually short, thick, or tight (Mayo Clinic, 2018). This causes issues with breastfeeding, as the infant is unable to stick out his or her tongue to properly latch onto the breast. Tongue-tie can cause nipple pain, difficulty with latch, and lack of continuous feeding (Edmunds, Miles, & Fulbrook, 2011). Tongue-tie is diagnosed by visually and physically examining the mouth and tongue, most commonly using the Hazelbaker Assessment Tool for Lingual Frenulum Function (Drazin, 1994). If it is determined that a baby has tongue-tie that is affecting their ability to feed, a frenotomy, is conducted and a baby may resume breastfeeding immediately (Mayo Clinic, 2018).

In the UK, the availability of tongue-tie services is inconsistent depending upon location (Fox et al., 2016). Having previously sought assistance with positioning and attachment from a breastfeeding service provider is a necessary step to getting a tongue-tie referral. In some parts of the UK, a mum must have a referral for NHS services in her area, while other NHS Trusts accept out of area referrals. Some NHS Trusts did not have tongue-tie services, and in these areas,
mums must follow referral pathways that may complicate or delay their ability to receive tongue-tie services (Fox et al., 2016).

**Breastfeeding: An Anthropological Perspective**

Breastfeeding in Western societies is promoted and identified as being superior nutrition for infants. However, the women in these societies face pressures that reduce their abilities to sustain breastfeeding successfully. Two methods that facilitate breastfeeding are breastmilk sharing and bed sharing for nighttime breastfeeding (Tomori, Palmquist, & Dowling, 2016). These two practices are highly debated, with mothers feeling shame and stigma for partaking in either practice (Tomori et al., 2016). Mothers who experienced insufficient milk supply, but did not want to use formula sought out milk from other mothers. Mothers who used shared milk found they were judged by family members and often resorted to secrecy to avoid stigmatization (Tomori et al., 2016). Mothers who co-slept with their infants to ease breastfeeding throughout the night faced further stigma and judgement. These mums were often questioned about their babies sleep and criticized for not using cribs self-soothing and sleep training techniques for their babies. Mums who chose to co-sleep found the medical professionals to be a central source of criticism, as the widely agreed upon message is that co-sleeping is dangerous and could be a source of SIDS (Tomori et al., 2016). Co-sleeping is also shown to enhance breastfeeding and increase sleep for both mum and baby (Gettler & McKenna, 2010; McKenna, Lee, & Gettler, 2010). Mums who co-slept with their babies breastfed significantly more often than those who did not co-sleep (Gettler & McKenna, 2010). Additionally, breastfeeding is found to be protective against SIDS (Hauck; 2011; NIH, 2017), therefore safe co-sleeping may not pose as significant of a risk as is presented (Gettler & McKenna, 2010; McKenna et al., 2010). These two practices ease difficulties of breastfeeding by providing mums with low milk supply with
more milk and making nighttime breastfeeding more convenient. However, both medical professionals and the friends and family of mums stigmatize these practices. This results in mums continuing these practices in secret or reducing the length of time they breastfeed (Tomori et al., 2016).

Extended breastfeeding is often considered unusual in Western cultures (Faircloth, 2010, Gribble, 2008). Women who had chosen to breastfeed reported feelings of disgust about breastfeeding beyond infancy (Gribble, 2008). Mums felt their friends and family did not understand why they wanted to continue breastfeeding and found medical professionals to be unsupportive (Tomori et al., 2016). Women who chose to breastfeed beyond six months said, while they felt comfortable to breastfeed in public, they felt others were more uncomfortable seeing them breastfeed (Tomori et al., 2016). These women also experienced isolation from other mothers who were not breastfeeding (Tomori et al., 2016).

Concepts of parenting practices are weighed as “good” and “bad” parenting. When mums chose to participate in practices that were not considered parenting norms, such as milk sharing, co-sleeping, and extended breastfeeding, they faced consequences. The mums were socially isolated, facing judgement from friends and family and also felt they did not have the support of medical practitioners, leading to their being more secretive about their breastfeeding-related decisions (Tomori et al., 2016).

Anthropologists have also discussed breastfeeding from a human history and evolutionary perspective. The biologically natural weaning period may be much later than what is considered the norm in Western societies. Children are adapted to breastfeed beyond infancy, as breastmilk provides a source of nutrients, calories, and immunological support (Dettwyler 2004). Weaning, from a human history and biological perspective, is directed by maternal age
and body weight, infant weight markers, and the eruption of permanent teeth (Dettwyler 2004). Culturally, weaning is directed by beliefs, return to work, and social norms. If culture did not influence weaning, breastfeeding would be continued for between 2.5 and 7 years (Dettwyler 2004). However, most mothers in Western societies do not continue breastfeeding beyond one year, though it is difficult to know how many women are breastfeeding beyond this period. Specifically, Dettwyler explained, “Duration of breastfeeding is the only life history variable that is subject to direct and substantial cultural intervention and the only one for which routine shortening or complete elimination has become accepted as the cultural norm in some populations” (Dettwyler, 2004, p.720). The evolutionary perspective of breastfeeding also informs medical practice. The practices of skin-to-skin, infant proximity, and the immediate establishment of breastfeeding after birth have been informed by applying evolution to postnatal practices in healthcare (Klingaman & Ball, 2009).

Anthropologists have also researched breastfeeding from Marxist production perspectives, examining breastfeeding as “work” and the production of resources. Anthropologists have also examined the political, economic, and gender aspects of breastfeeding. Breastfeeding has played a significant role in HIV and nutrition studies. Additional studies have covered breast versus bottle feeding, globalization, and the medicalization of birth. Many of the studies completed have taken place in developing countries or among a single cultural group (AnthroSource, 2019). However, there is a gap in the anthropological literature examining protective factors and barriers to breastfeeding and breastfeeding in Western societies.

**Baby Café Model**

Baby Café is a system of breastfeeding support that was developed in the UK. The services are community-based, free, and do not require the mums to sign up or make
appointments ahead of the Café meeting (Fox & McMullen, 2018). The Cafés are run by skilled facilitators who meet at least one of the following standards, a qualified health professional, a qualified Breastfeeding Counsellor with accreditation, or a local authority with post-18 education and specific training or professional development in breastfeeding (Fox & McMullen, 2018).

Baby Cafés aim to provide expert support to mothers regarding breastfeeding questions, experiences, or difficulties. Café sessions also aim to provide social support to mums and are held in informal environments where refreshments are served and play areas are provided for children who accompany mums. The Cafés are held in locations such as children’s centers or churches (Fox & McMullen, 2018). Funding for Baby Café includes NHS trusts, Children’s Centers, NCT branches, and community funds. Facilitators provide additional referrals for care when necessary, such as to health specialists. Baby Café’s vision is, “For a world in which women from all social groups feel motivated and supported to breastfeed by their friends, family, community, and professionals. Mothers are able to breastfeed for as long as they want to and feel empowered about their feeding decisions and experiences” (Fox & McMullen, 2018).

Policy Review

**Equality Act 2010.** The Equality Act 2010 provided protection for women to breastfeed in public in the UK. The Act encompasses multiple protections made to promote equality across socioeconomic statuses and genders while decreasing discrimination due to personal characteristics. Age, disability, gender reassignment, marriage/civil partnership, race, religion/belief, sex, and sexual orientation are among the topics covered in the Act.

Breastfeeding is mentioned twice in the Equality Act. The first mention is in Part Two, Equality, Chapter Two Prohibited conduct, Section on Discrimination. In this section, it is stated direction discrimination includes “If the protected characteristic is sex—less favourable treatment of a
woman includes less favourable treatment of her because she is breast-feeding” (Equality Act 2010, p.7). The second mentioned of breastfeeding is also in Part Two, Chapter Two under “Pregnancy and maternity discrimination: non-work cases.” It is stated that “The reference in subsection (3) to treating a woman unfavourably because she has given birth includes, in particular, a reference to treating her unfavourably because she is breast-feeding” (Equality Act 2010, p.9). The use of the word “unfavourable” leaves much of the protection this policy should provide open to interpretation. In theory, the Equality Act 2010 should provide “clearer protection for breastfeeding mothers” (Government Equalities Office and Equality and Human Rights Commission, 2015). However, the vague wording of the protections leaves women open to criticism when they are breastfeeding in public. In the years following the Equality Act 2010, women continued to be asked to cover up or leave when breastfeeding in public places (Grant, 2016). The Act does not specify if there is an age restriction for this protection, meaning it is not clear if women may continue to breastfeed their child beyond a specified age in public. Additionally, the Equality Act 2010 does not state to what extent a mother may be exposed while breastfeeding, leaving mums concerned about whether they are required to be covered.

**Summary of the Literature**

Stigma, partner support, and self-efficacy are essential components of the breastfeeding experience. These components need to be explored to gain an understanding of protective factors and barriers to breastfeeding. They are each intrinsically linked with breastfeeding outcomes. By looking at these factors altogether in a single study, results may demonstrate the importance of horizontal programming to address multiple breastfeeding-related concerns aside from physical barriers. However, these external factors should not be separated from physical complications, such as tongue tie. Tongue tie is a growing issue among women seeking lactation services. It is
important to address why tongue tie is becoming more common, and how it may impact other breastfeeding-related barriers, such stigma and hesitations around public breastfeeding in the UK. The Baby Café model is designed in way that these interconnected factors may be addressed during sessions with individual mums. Baby Café seeks to address the whole person, rather than acute issues, through person-centered counselling. Applying the anthropological lens to such issues within a Café setting would provide opportunities to address the value of care work, stigma, and perceptions of “good” and “bad” mothering. Additionally, an anthropological perspective could be used to guide recommendations for policy change. Changes to the current Equality Act 2010 are needed for long-term and wide spread impact on breastfeeding outcomes. An anthropological perspective could provide critical insight into the effectiveness of the currently policy and include women’s perspectives on ways to make improvements.
CHAPTER 3: THEORY

Social Cognitive Theory

Bandura’s Social Cognitive Theory provides a method to examine motivation, thought, and behavior (Ahmed, 2008; Bandura, 1968). It can be used to examine culture as a mental phenomenon with shared conceptual domains. A change in the behavior or a group, community, or society occurs through changes in beliefs, attitudes, or perceived norms. This theory lends itself to an applied approach in which education through individual learning or beliefs has the ability to create a shift in social norms (Trotter, Schensul, & Kostick, 2015). Social Cognitive Theory can be used to understand the complicated decision process for deciding to breastfeed and deciding to breastfeed in public (McKinley & Turner, 2017). Each of the following constructs can be used to understand an aspect of breastfeeding (Bandura, 1968). Self-efficacy may be used to address the mother’s confidence in her breastfeeding ability and willingness to stand up for her right to breastfeed in public. Observational learning is important, as it can be used to address if the participant's mother or friends breastfed, which plays a role in desire and confidence to breastfeed (Entwistle, Kendall, & Mead, 2010). Expectations can examine the perceived outcomes of breastfeeding and breastfeeding in public. Expectancies provide space for a discussion on why the mother values breastfeeding. Behavioral capacity may be used to discuss whether the mother feels aptly prepared to breastfeed. Reinforcement will touch on the reactions and feelings the mother has experienced while breastfeeding and breastfeeding in public. Finally, the locus of control may assess how much control the mother feels she has over her infant
feeding decisions and experiences (Bandura, 1968). Social Cognitive Theory has been successfully applied to promote and increase breastfeeding (Ahmed, 2008; McKinley & Turner, 2017). Further Bandura’s Social Cognitive Theory is used as the theoretical basis of the Breastfeeding Self-Efficacy Scale that will be used in this study (Tuthill, McGrath, Graber, Cusson, & Young, 2016).

In this study, Social Cognitive Theory will be applied to examine how breastfeeding behavior, including breastfeeding in public, extended feeding, and mixed feeding, are influenced by cultural norms (Environmental Factors), and personal factors such as knowledge about breastfeeding and confidence in the ability to breastfeed. The model allowed for the examination of interactions between individual factors, environmental or social factors, and their behavioral outcomes. These interactions can help to explain why some mums struggle to sustain breastfeeding, even if they have personal protective factors, such as knowledge and confidence, in place.

Social-Ecological Model

The social-ecological model (SEM) is a five-level theoretical model that demonstrates the interconnectedness between individual, interpersonal, organizational, community, and public policy levels (UNICEF, 2010). The framework is useful in demonstrating how these layers of factors play a role in behaviors and health outcomes. The model can be used as a framework for introducing intervention points to achieve targeted health behaviors. Interventions based on the SEM may include advocacy, social mobilization, social change, and behavior change (UNICEF, 2010). The literature demonstrates that many of the issues that women face in breastfeeding are socially-related. Breastfeeding issues fall within the social-ecological hierarchy. With individual self-efficacy, interpersonal partner support, organizational support, community stigma, and
breastfeeding policies, the SEM provides a framework to organize protective factors and barriers to breastfeeding. Separating these factors into the hierarchy provides a systematic approach to developing interventions to improve breastfeeding outcomes. To use the SEM as a theoretical framework for intervention, it is important to understand the health problem and potential pathways to address the issue. The next step is to prioritize goals to address multiple facets of the issue or make sustainable changes to the environment (UNICEF, 2010). The SEM has been applied to breastfeeding (Bentley, Dee, & Jensen, 2003; Dunn, Kalich, Henning, & Fedrizzi, 2015). The findings of these efforts demonstrate that the SEM can be used to develop opportunities and support systems to support breastfeeding by challenging social norms and establishing policies that promote breastfeeding. This is accomplished by using the SEM to link micro and macro level factors along the hierarchy to develop a holistic understanding of breastfeeding in a certain area.

In this study, the SEM was used as the primary model used to organize findings. Results from interviews were organized into the individual, interpersonal, organizational, community, and policy levels. The results are further divided within these categories into protective factors and barriers. The SEM provides a way to discuss breastfeeding from a holistic perspective, including a wider context for the environment in which breastfeeding occurs. This will lend to the discussion on implications of breastfeeding programs and policies and to crafting recommendations that can benefit breastfeeding women in the future.

**Feminist Theory**

Feminist theory assumes gender organizes and shapes culture and cultural practices and that power shapes lived experiences and meaning (Gailey, 2015). These assumptions lead to questions about how gender has shaped social norms, policy, and economics. Feminist theory
links history, economics, cultural beliefs, and agency to discuss issues at both an individual and societal level. Feminist theory lends itself to an applied approach as it informs social engagement and provides a space to collaborate with participants (Gailey, 2015). Breastfeeding can be examined through a feminist lens to provide a framework for the context and environments in which breastfeeding occurs. Penny Van Esterik is an anthropologist whose work has focused primarily on breastfeeding. She uses feminist theory in her breastfeeding research to frame poverty, female empowerment, infant formula corporations, policy, and advocacy. As Van Esterik explains, “Breastfeeding and women’s work cannot be examined independently of the economic and political context of maternity entitlements, health insurance, wages, and child-care arrangements” (Van Esterik, 2002). Research into why women breastfeed and why they do not require a discussion about the division of labor and policy related to maternity leave and breastfeeding/pumping at work (Van Esterik, 1994). Further, breastfeeding in the public sphere includes issues such as breasts as sexual objects and conceptualizing women’s role in production (Van Esterik, 1994). Breastfeeding challenges many of the “traditional” roles of women and their bodies, therefore Van Esterik argues that feminist theory is necessary to frame and understand such challenges (Van Esterik, 1994). This argument is particularly pertinent for work done in “developed” societies, as the shift from productive personhood to motherhood and breastfeeding is starker. Van Esterik argues that feminist theory can be used to reposition breastfeeding to include women in policy decisions, develop new strategies to promote breastfeeding and address workplace issues. Finally, feminist theory provides a space for reflexivity and the discussion of researcher bias, which is important in applied and advocacy work in which the researcher is personally invested in the topic (Van Esterik, 1994).
In this study, feminist theory will be applied to examine the sexualization of women’s bodies in regards to their comfort with breastfeeding in public and norms around women and modesty. Further, partner support in regards to “traditional” gender roles and paternity leave policies are important to consider within the feminist framework. Examining to what extent women fit into traditional roles when they are breastfeeding and how society views the role of the partner during this period is important in discussing breastfeeding policies and protections.

**Linking Theories**

The Social Cognitive Theory, Feminist Theory, and the Social Ecological model are complementary in examining breastfeeding in the UK. The Feminist Theory frames the research study, as breastfeeding is entrenched into a deeper context of expectations and norms surrounding women’s behavior and their bodies. The SCT then provides a method to examine how behavior is influenced by environmental and personal factors at an individual level to see what helps mums to meet their breastfeeding goals. This feeds into the SEM’s provision of a wider context including policy, organizational support, and the community in describing what aspects of society promote breastfeeding and which are detrimental to sustaining breastfeeding. The factors that are examined within the SCT and SEM can help to build evidence for recommendations. These three models, taken together, provide a philosophy, an individual perspective, and a holistic perspective to examine breastfeeding in the UK.
CHAPTER 4: RESEARCH DESIGN

Overall Approach

This exploratory study aimed to gain further understanding of protective factors and barriers to breastfeeding in the UK and examine what helps mothers meet their breastfeeding goals. The study employed a mixed-methods design. Semi-structured interviews, participant observation during peer support groups, and a psychometric scale were used to examine the research questions. All names used in this document have been changed.

Site. The research took place through the National Childbirth Trust at eight Baby Cafés across London. Baby Café is a free drop-in group for mothers and their families that provides information and support on breastfeeding. Baby Cafés are open to all mums from pre-to post-natal and also welcome mums regardless of whether breastfeeding is their sole feeding method. Health professionals are available to mothers for one-on-one help and provide information on breastfeeding. Mothers may also meet other mums, enjoy refreshments, and feed their babies in a comfortable setting, which may assist in the transition to public breastfeeding (Baby Café, 2017). The mission of Baby Café is, “to provide a social model of community-based support for breastfeeding mothers in a café-style environment, with access to expert breastfeeding practitioners and prompt referral for additional care when needed” (Fox & McMullen, 2018, p.12). The Cafés are each run according to 12 quality standards including having a welcoming environment, providing a combination of social and clinical support, promotion and support of breastfeeding at every stage, serving the whole community, ensuring accessibility, and providing
high-quality information (Fox & McMullen, 2018). The three key measurable outcomes that Baby Café seeks to improve are increasing the number of women having a positive experience of breastfeeding, increasing the number of women breastfeeding at 6-8 weeks, and decreasing the number of women who give up breastfeeding before they intended (Fox & McMullen, 2018).

Breastfeeding and lactation professionals lead Baby Cafés in community centers. Each meeting takes place for approximately two hours once a week, with multiple Cafés on each day across London. There are currently 46 Cafés in the United Kingdom, with 11 in the London area (Fox & McMullen, 2018). Baby Cafés were chosen as the recruitment site due to the presence of mothers who have chosen to breastfeed for at least part of their infant’s feeding. Breastfeeding is not the most common feeding method in the UK, therefore, it was important to choose a field site where breastfeeding mothers would be present. Baby Cafés take place in informal settings such as children’s centers and churches. Mums are offered refreshments and are able to socialize with other Café attendees. Baby Cafés offer opportunities to talk with mothers in a relaxed setting where professional help is available in the case that a mother becomes distressed during an interview when talking about breastfeeding stress and difficulties or has questions about breastfeeding.

Sample. I used targeted sampling to identify participants for this study through the identification of geographically focused sampling areas (Watters & Biernacki, 1989). Participants included mothers at Baby Café sessions, partners of mothers when present, and facilitators of Baby Cafés. Inclusion criteria for mums were that they must be currently breastfeeding for at least a portion of their infant feeding, UK natives, and speak English as a primary language. For significant others, they must have a partner who participated in the study and speaks English as a primary language. Partners and mums would be excluded if they did not
speak English or were from a country outside of the UK. Café facilitators must be UK natives who speak English as a primary language. For the semi-structured interview component, I interviewed 28 mums across seven Baby Café locations, six partners of mum participants, and three Café facilitators were interviewed. For the BSES-SF component, all 28 mums who completed interviews also completed the scale. Observational data were collected during each Baby Café meeting and observations were conducted across eight Cafés, including all participants present. The average number of mums present at an observation ranged from two to twenty-five with a mean of twelve.

**Methodology**

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**Participant Observation**

Observations (n=22) were conducted at Baby Cafés (n=8). Conducting participant observation during support group meetings is a common method used in anthropological research in maternal and child health, especially that on topics such as stigma and experiences. This type of research is often used to find participants, gain knowledge about social norms, and current discourse surrounding the topic of interest (Ellison, 2003; Pivnick et al., 1991; Van Hollen, 2011). I sat with mums during their groups and took notes of any relevant conversations
or information related to protective factors and barriers to breastfeeding. I also assisted facilitators in handing out, explaining, and collecting paperwork as well as preparing tea and snacks for the mothers and their partners. Baby Cafés are based on group instruction and conversation. It was here that mums could discuss with both breastfeeding professionals and other mums the barriers and issues they experience related to breastfeeding, therefore it was important to listen to concerns mums were raising in these settings. Notes were systematically taken on the number of mums present, the atmosphere of the Café (was there socialization, were mums keeping to themselves, did people appear to know one another), and on the questions and issues presented by mums during their meeting with the facilitators. This method was primarily used to augment the one-on-one semi-structured interviews and provide insights into how women talk about breastfeeding experiences and issues amongst themselves (Small, 2011).

**Semi-Structured Interviews**

Semi-structured interviews (n=37) were completed with three sample groups, mums (n=28), partners (n=6), and Café facilitators (n=3) (Appendices C-E). Interviews took place during Café sessions across seven Café locations in London between May and July 2018. Interviews were designed to allow me to gain a deeper understanding of experiences and opinions related to breastfeeding, while also allowing participants an opportunity to provide their input on recommendations for best practice (Bernard, 1988). For mums, interviews aimed to obtain information on how they perceive others feel about breastfeeding and breastfeeding in public, why they have chosen to breastfeed, experiences with public breastfeeding, partners support, perceived self-efficacy, and awareness of a public policy protecting their right to breastfeed in public. These interviews were also used to guide applied outcomes, as ways they believe the stigma surrounding public breastfeeding can be addressed were discussed. For
partners, interviews aimed to obtain information on how they perceive others feel about breastfeeding and how they feel about breastfeeding. Specific questions about their experiences of their partner breastfeeding in public and reactions to this were also asked. Additionally, they were asked about the breastfeeding policy and ways they think discomfort around public breastfeeding can be reduced. For Café facilitators, questions or concerns they hear from mums were asked, as well as questions about the types of advice they give to mums. The facilitators were also asked about their awareness of the breastfeeding policy and ways they believe the stigma surrounding public breastfeeding can be addressed.

**Breastfeeding Self-Efficacy Scale-Short Form**

The Breastfeeding Self-Efficacy Scale-Short Form (BSES-SF) was completed with mums (n=28) at the end of their interviews. The BSES-SF consists of 14-questions with a 5-point Likert-type scale and is the short version of the original 33-question Breastfeeding Self-Efficacy Scale. The scale is a self-report instrument that measures confidence in new breastfeeding mothers (Dennis & Faux, 1999; Dennis, 2003). This is done through the assessment of breastfeeding behaviors and confidence in a mum’s ability to access support (Dennis, 2003). Questions on the survey were framed as “I can always…” followed by a statement in which a mother noted how confident she was, on a scale of 1-5, to always meet that criteria. Questions include topics such as feeling you could cope with and be satisfied with your breastfeeding experience, could manage to breastfeed during difficulties and could ensure breastfeeding was going well while feeding. This scale was used in combination with questions from the interviews to assess a mother’s self-efficacy related to both confidences in breastfeeding and the ability to stand up for the right to breastfeed in public. The scale is widely validated for use with mothers of a variety of ages and cultures (Dennis, Heaman, & Mossman, 2011; Margotti & Epifanio,
2014; Tuthill et al., 2016; Ip et al., 2016; Wutke & Dennis, 2007). I received permission from the creator of the BSES-SF, Dr. Cindy-Lee Dennis, to use the BSES-SF for my research on November 28, 2017 (Appendix B).

**Analysis**

Interviews were recorded and transcribed verbatim. Data from the interviews were analyzed using both deductive and inductive techniques to identify themes. The deductive analysis used interview guides and findings from the literature, specifically on public breastfeeding, stigma, partner support, and self-efficacy to delineate themes. Inductive analysis of the interviews was conducted by a careful reading of the interview transcripts to develop a list of codes. These pertained to topics such as treatment in clinical settings, tongue-tie, and breastfeeding information. Codes were combined and organized into larger code groups and used to develop a codebook. ATLAS.ti 8 software was used for data management and coding for interviews.

BSES-SF and demographic data were input into SPSS 24 for analysis. Questions were analyzed individually for mean, standard deviation, and variance. All question scores were compiled to find the mean score. Data were not normally distributed and the sample size was less than 30, therefore non-parametric tests were used to analyze the data. Spearman’s rank-order correlations were conducted to examine the relationship between BSES-SF score, babies age, number of children, as well as correlations between questions. Spearman’s rank-order correlations were chosen for analysis, as this method measures the strength and direction of the association between two variables. This allowed for the comparison of individual BSES-SF questions to one another, to babies age, and the number of children within a non-normally distributed dataset.
CHAPTER 5: CASE STUDIES

Two case studies have been written to demonstrate different breastfeeding experiences of mums in the UK. Components of the profiles have come from the stories told to me by mums, partners, and facilitators during interviews. The cases are representative of the participants in this study as a whole, rather than representing a single individual. Names from the study have not been used. The first case, Freya, was designed to demonstrate how some mums succeed in meeting their breastfeeding goals, within a supportive environment. Freya, who faces some challenges, has protective factors in place to support her throughout her journey. The second case, Gabriella, was designed to demonstrate how, even when a mum wants to breastfeed, she may be faced by a variety of challenges that limit her ability to succeed. Gabriella faces similar challenges to Freya but experiences more of the barriers.

**Freya.** Freya is a first-time mum who gave birth two weeks ago to a boy named James. Freya had taken a few breastfeeding courses, one of which her partner attended with her, before giving birth and decided she wanted to breastfeed her baby. She learned that breastfeeding has a lot of great benefits for both the baby and herself and thinks it will help her save money and time, compared to formula. Freya discussed her decision with her partner, Oliver, who said he will support whatever she wants to do and is happy to help in any way he can. Freya also spoke with her mum about breastfeeding and found out that her mum was able to breastfeed her and her siblings for about three months each, but did not feel like she had the support to continue. Freya’s mum is happy she has decided to breastfeed and tells her all about her own breastfeeding
experiences and difficulties. Freya also talks to a couple of her friends who recently had babies. They both tried breastfeeding and one is still currently feeding her one year old. They tell Freya about Baby Café, which helped them both when they had issues. They also tell her about a few Cafés in their neighborhood where they would always go to feed because of how nice the employees were to them while they fed. When Freya goes into labor, she arrives in hospital and is prepped for birth. After giving birth, Freya is handed James and given time to have skin-to-skin contact with him directly after birth. The clinical staff is patient while Freya and James try to figure out breastfeeding together. When one nurse stops by and attempts to move James and put him onto Freya’s breast, Freya’s partner Oliver steps in and asks the nurse to give them more time. Freya is able to get James latched, but needs help with positioning, as he won’t stay latched for more than a minute before squirming away. The next morning, a lactation consultant team visits Freya in the hospital and helps her find a more comfortable way to breastfeed that helped James stay latched.

Over the next week, Freya is having some difficulties with breastfeeding. She feels James is feeding very often and she is experiencing some nipple pain. Oliver tells her she is doing a great job and commends her for continuing to breastfeed. He has been helping around the house, cooking, and changing diapers to give Freya time to rest between the frequent feeds. She remembers that her friends suggested Baby Café, which she looks up and discovers a session will be offered near her in a couple of days. In the meantime, she speaks with her mum and her friends about her difficulties. One of her friends also had nipple pain and suggests a nipple cream that worked well for her. Her mum says she hates that Freya is struggling, but tells her she is doing a great job and that James looked like a happy healthy baby. Freya and Oliver take James to Baby Café to see if there is anything they could do to make breastfeeding more comfortable.
and to have some of their questions answered. At the Café, a facilitator suggests a new position lying down while breastfeeding and temporarily using nipple shields to give Freya’s nipples time to heal, in addition to using the cream her friend suggested. The facilitator also lets Freya know that the high frequency of feeding is completely normal for a newborn and that James is getting enough milk, but is probably sucking for comfort as well. Freya leaves feeling more confident that she is doing the right thing for her baby.

A positive breastfeeding experience does not have to be perfect. Mums may still experience difficulties and doubts, but having a supportive environment is essential to ensuring they are able to meet their breastfeeding goals.

**Gabriella.** Gabriella is a first-time mum who gave birth to her daughter Ava three weeks ago. She had attended a couple of breastfeeding courses before giving birth and thinks breastfeeding is probably the best option for her baby, so she will give it a try. Her partner, Leo, was unable to attend the courses with her, but also said that since breastfeeding is natural, she will just be able to do it when the time comes. Gabriella had a mildly complicated birth and was exhausted afterward. A midwife immediately attempted to put Ava to her breast, causing Ava to cry and not latch. The midwife commented that she was always able to get a baby to latch, so she did not know what was wrong. Gabriella was able to get Ava to latch the next morning and was released from the hospital. Upon arriving home, Gabriella was not able to get Ava to latch again for some time, which made Ava fussier, which resulted in more difficult in latching. Gabriella was able to successfully feed Ava a few times the first day and felt she was starting to get better at it. Her mum said it was difficult to see Gabriella struggling so much, so she went to the store and brought back formula, “just in case.” Over the next week, Gabriella had some days that she was able to breastfeed and some when she continued to struggle. Leo said he didn’t understand
why breastfeeding was so hard if women have been doing it for thousands of years and that Gabriella should just use the formula her mum bought since she was having a hard time. Gabriella, wanting to continue breastfeeding and make it a part of her usual routine decided to meet up with some friends for tea at a Café. Her friends were surprised she brought Ava along and asked why she couldn’t leave her at home for a few hours. When Ava said she would need to feed her while they were having tea, her friends, embarrassed, asked if she planned to do it at the table. They said they were afraid they would be kicked out of the Café is Gabriella fed Ava at the table and Gabriella wondered if this may happen. To avoid conflict, Gabriella cut her tea short with her friends so that she could return home to feed. After struggling for about two weeks, Gabriella had severe nipple pain and sought help for breastfeeding from her general practitioner. She learned that Ava had tongue-tie. She got a referral but discovered it would take four weeks to get an appointment. Gabriella did not have the money to seek private services and was resigned to waiting a month before Gabriella’s surgery. The physician who diagnosed Ava’s tongue-tie suggested Gabriella use formula if the pain of feeding was too severe. After three weeks of struggling with breastfeeding, without the help of her partner, friends, and family, Gabriella reluctantly started using formula for about half of Ava’s feeds to relieve some of her pain and give her a chance to rest. Her mum, happy that Ava could now be left with her for a few hours, said Gabriella should be happy with her decision, but Gabriella felt guilty that she was not trying harder. As Ava continued on the bottle, Gabriella breastfed less often and found her milk supply could no longer meet Ava’s needs. She made the decision to use formula only since it would allow Leo and her mum to take some of the responsibility for feeding. She was happy that Ava was getting fed, as that was what was most important, but frustrated that she was not able to meet her breastfeeding goals.
Gabriella should not feel guilty about her inability to continue breastfeeding. Mums should not feel pressured to continue breastfeeding if it is causing them severe pain or emotional distress. However, Gabriella should have had the opportunity to meet her breastfeeding goals with the appropriate support networks. All mums should have the environment to give them a chance to successfully breastfeed and should not have to stop for reasons beyond their control. If mums like Gabriella were given proper support in hospital and were referred to breastfeeding specialists, they may be better able to not only achieve their breastfeeding goals but educate their partner and family about why they want to breastfeed. Partners and family members should be included in breastfeeding education so they may have a better understanding of how to support the mums when they experience challenges without immediately offering formula as the most suitable solution. If given the tools and a positive environment, mums would have the knowledge and skills to sustain breastfeeding and meet their breastfeeding goals.
CHAPTER 6: RESULTS

Participant Observation

I visited eight Baby Café locations across Greater London. The Cafés were diverse in size, format, and the participants they drew. Some Cafés are run by health visitors, or those with other health practitioner training, such as nursing. These Cafés tend to be more clinic-like in nature. The facilitator has one-on-one meetings with mothers, there is generally less talking between the parents that are present, and the “café” part of Baby Café is less of the focus. In visiting this type of Cafés, I usually saw about 4-8 mums. The health visitor who ran one of the clinic-like Cafés I visited noted that she would not be able to assist any more mothers than that, as she generally had longer in-depth one-on-one sessions with the mothers and always ran out of time. Other Cafés are run by NCT trained breastfeeding counselors. These Cafés tend to be more boisterous, with mums talking to each other and relaxing while enjoying tea and snacks. I usually saw about 10-30 mums in these Cafés. The first time I visited a café like this, I was unable to complete any interviews until the very end of the café session once quite a few people had left and the noise had died down. These Cafés are more like social meetings for many of the mothers. At one of the Cafés run by a breastfeeding counselor, other NCT employees would come in to speak with mothers about babywearing and demonstrate different available products. The facilitators at these Cafés would have one-on-one chats with some mums but were sure to ask who needed to have a chat and who was just there for a social visit.
At the Cafés, mums are free to drop in anytime during the session. The general process in that a mum comes in, drops her pram or carrier in a designated space, and has a seat with her baby. The café facilitator, peer supporter, or volunteer comes by and has them fill out some paperwork. For first time mums, this includes information on who they are, how old their baby is, where their baby was born, where they live, and other demographics. Beyond the initial visit, most Cafés have mums sign in and many Cafés have mums fill out a small questionnaire on why they are visiting that day. Once a mum has settled in, she is offered tea and snacks or is welcome to serve herself. Cafés run in some child centers were not allowed to serve hot beverages and would provide water and biscuits. Cafés run in churches and community halls often served a variety of teas, cocoa, and occasionally coffee. One Café relied on mums to organize and rotate who was responsible for bringing snacks, while a facilitator at another café was an avid baker and always brought home-baked cakes for the Café sessions. Depending on the number of mums present, they would wait anywhere between a couple of minutes and an hour to be seen by the Café facilitator. To assist the facilitators, many Cafés had peer counselors who had been to Baby Café and been trained through NCT on basic counseling. Chats with facilitators lasted between a few minutes for simple issues or for mums just seeking a bit of reassurance to 15-20 minutes for more severe issues. When a mum seemed to be in crisis or particularly struggling, such as when she was crying or saying she was distraught and did not know if she could carry on breastfeeding, often times the facilitator would speak with her more than once during the session.

While mums visited the Cafés for a variety of breastfeeding-related assistance, the reasons I observed for visiting were helped with positioning, latch, pain, and tongue-tie. These reasons were primarily for mothers of newborn babies between a few days to a month old. The reasons for visiting Baby Cafés that I observed are also reflected in the findings of Baby Café’s
Annual Report (Fox & McMullen, 2018), which listed positioning/latch, tongue-tie, and sore nipple to be among the top four reasons mums attended Baby Cafés, with social support as an additional cause for seeking services (Fox & McMullen, 2018). Further, tongue-tie as a primary reason for visiting a Café has increased significantly from 20% in 2014 to 65% in 2017 (Fox & McMullen, 2018). I observed mothers of older babies often coming in for help with pain, expressing, and weaning. When a mum came in with questions about latch and positioning, facilitators would often use dolls to demonstrate positions that may work better for mum and baby. When a mum came in with questions about tongue-tie, most facilitators would put on gloves and do a preliminary tongue-tie check on the baby. If the facilitator determined that the baby likely had tongue-tie, she would refer the mum to a service for further checks and surgery.

Pain, namely sore nipples, was often a result of positioning, latch, and tongue-tie issues. Facilitators would help the mum address these potential causes and if it was determined that these factors were not the cause of the pain, nipple shields were often suggested.

When I was visiting the Cafés, I helped the facilitator with anything they needed to have done. This ranged from setting up materials in the café before they started, directing mums to their seats, and handing them the paperwork as they came in, getting teas and snacks made for parents as they waited, to cleaning up after the sessions. I found that when I interacted with the mums when they came in, helped them get settled, and brought them snacks, they were more relaxed and willing to chat during the interview.

**Interviews**

I interviewed twenty-eight mums, six partners, and three Baby Café facilitators. Twenty-two of the twenty-eight mums were first-time mothers, four had two children, one had three children, and one had four children. The average age of participants’ babies was just over 12
weeks ($M=12.5$, $SD=14.6$, $Mdn=7$, mode=2). All partners were male and were in a relationship with the mum they accompanied. Further, all male partners were the fathers of the babies they brought. Café facilitators included two breastfeeding counselors and one health visitor who is an International Board-Certified Lactation Consultant (IBCLC).

Research themes fall along the Social Ecological Model levels, individual, interpersonal, organizational, community, and policy. Themes can be further organized into protective factors and barriers to breastfeeding. Figure 3 has applied the themes found in the research to the Social Ecological Model and organized them into protective factors and barriers. Themes at the individual level include why a mum has chosen to breastfeed, expectations related to breastfeeding, and babies having tongue-tie. At the interpersonal level, partner support, partner presence in Cafés, and the role of family and friends are discussed. Themes at the organization level include a mum’s clinical experiences, experiences with tongue-tie correction, experiences with breastfeeding information, and formal support. At the community level, themes of breastfeeding in public, extended breastfeeding (feeding beyond one year), and judgement mum’s experience related to infant feeding are included. Finally, at the policy level, awareness of the Equality Act 2010.
Research themes can be also categorized with the Social Cognitive Theory model. Figure 4 has applied themes from the research to the Social Cognitive Theory model. For examining positive breastfeeding outcomes as the outcome expectation, behavioral factors of ability to breastfeed, sufficient breastfeeding frequency, and support seeking behaviors each play a role. These behavior factors are bidirectionally influential with environmental factors including partner, friend, and family support, accepting cultural norms, the presence of formal support, and positive clinical experiences. Behavioral and environmental factors are bidirectionally influenced by personal factors such as perceptions and expectations about breastfeeding. Personal factors
influence knowledge and self-efficacy related to breastfeeding. Self-efficacy is specifically influenced by confidence in the ability to meet breastfeeding goals, initiating breastfeeding successfully, and having knowledge of support. Environmental factors are influenced by social supports with the social network and within the community. These factors, taken together, create a positive environment in which breastfeeding may succeed.

Figure 2. Application of the Social Cognitive Theory model.

Adapted from Chin & Mansori, 2018
Mums discussed concerns related to why they had chosen to breastfeed, their expectations related to breastfeeding, and issues associated with their babies having tongue-tie. These experiences directly affected a mum’s ability to sustain breastfeeding.

**Expectations for infant feeding.** When asked how they planned to feed their baby before they were born, every woman stated she planned to at least try breastfeeding. Many mums had the “breast is best” attitude and felt that breastfeeding was the best option for their baby. One mum stated, “…they're getting the best, and sort of the best nutrition from doing it that way [breastfeeding].” This attitude was common among mums, as women saw this idea of “breast is best” in their prenatal classes, research, and other information. Mums were aware this was the common health message, as another mum stated, “All the messaging is breastfeeding is the best possible thing, and you should try to do it if you possibly can.” A few mums felt that breastfeeding was the only viable option for infant feeding and did not want to consider formula, even as a backup plan, though this was not the most common opinion. One mum stated, “I planned to breastfeed exclusively, which is why I think I haven't done research on anything else.” The most common expectation mums had was that they would try breastfeeding, but if it did not work, they would be willing to mixed feed or use formula. An example of this mindset was a mum who said, “I always wanted to at least try breastfeeding, but I also didn't have any real kind of restrictions on myself about bottle-feeding either. It was very much just whatever he needed.” Other statements such as, “I planned to breastfeed, but I was, you know, I was flexible, and sometimes it doesn't work out.” and “I sort of went thinking we would give breastfeeding a shot if it didn't work out for any reason then we were happy to consider going onto formula” were very common among participants. In commenting on this quick transition from breast to bottle, a Café facilitator stated:
I think it’s probably quite, ‘give breastfeeding a go, but when breastfeeding doesn’t work there’s formula and formula feeding is fine.’ I think women are set up to fail by the fact that we’re not very positive or pro breastfeeding.

**Why breastfeeding?** When asked what contributed to their decision to breastfeed, mums provided answers including health benefits, bonding, convenience, cost, recommendations, and pressure as for why they decided to try breastfeeding. Breastfeeding has proven benefits to the health of both baby and mum (Bascom & Napolitano, 2016; Britton et al., 2006; Groer et al., 2002; Hauck, et al., 2011; NIH, 2017). Mums most often cited the health benefits as their primary reason for deciding to breastfeed. One mum stated, “Probably the main thing is the health benefits that baby is supposed to get from being breastfed.” The specific health benefits that mums mentioned included reduced risk of cancer, reducing allergies, improving immunity, provision of antibodies, meets nutritional needs, and it providing good bacteria. All mentions of health benefits were benefits to the baby. Mums did not mention health benefits they may receive as a reason to breastfeed. Six mothers said they wanted to breastfeed because they knew it was a way to bond with their baby, stating breastfeeding was closest to the baby and a part of the bonding process. Many mothers said breastfeeding was more convenient than formula/bottle feeding. One mum explained, “…it [breastfeeding] also comes down to convenience and things like that and just thinking that it's always on it's always there, on demand rather than we were finding the whole bottles and sterilizing a pain.” Some mothers mentioned the high cost of formula or that breastfeeding is free as a contributing factor in their decision to breastfeed. Many mothers were recommended breastfeeding by family, friends, and health information, which contributed to their choice to breastfeed. One mum stated all of these factors played a role in her decision to breastfeed stating, “I had heard from our NCT class, the internet, books, my mum,
and friends that it was the best option if I could do it.” There was an agreement among about half of the mothers that there was pressure to breastfeed from others and society in general. One mum explained:

I think there is quite a lot of pressure to do it. I can imagine if I hadn't been able to or if I can't in the future, I think that would be hard to deal with… the strong message is your child would be healthier if you can breastfeed, so of course, you're going to feel terrible if you can't.

In regards to pressure, another mum said, “I think there is a bit of peer pressure around that is what is normal and that is what is natural, it's what you should do.” Even among mums who stated they had not felt pressured to breastfeed; some their friends or family members have certainly felt pressured to do so.

*Tongue-tie.* Mum’s often mentioned that their babies tongue-tie caused them severe pain, made them dread breastfeeding, and made it difficult for their baby to latch while feeding. Many mothers at Baby Café had babies who had either been diagnosed with tongue-tie or they were seeking a diagnosis. They cited tongue-tie as one of the reasons for their difficulties breastfeeding. One mum explained,

He started out the first three weeks just doing breastfeeding. I found it quite painful because he's got quite a high palate and a posterior tongue-tie. So, I went on to just using solely nipple shields just so I can carry on breastfeeding because I found it so painful that I didn't enjoy breastfeeding.

Even once tongue-tie is corrected, some mums continue to experience resulting difficulties. One mum described this process, “She had a tongue-tie, which was diagnosed at the hospital and snipped at two days old, but it did affect my supply and I didn’t have enough [breastmilk].”
Interpersonal

Themes at the interpersonal level include partner support, partner’s presence in Café's meeting, and the role of family and friends in a mum’s breastfeeding experiences. These are ways in which other people in a mum’s life affect her ability to sustain breastfeeding.

Partner support. Many mums explained that their partners were the most beneficial support systems they had. Partners assisted mums with tasks that need to be done with the baby and around the home. Partners filled in the gaps of formal support. Providing general support was the most common type of partner support that mums mention. One mum explained,

He [my partner] has been very, very supportive so it's brilliant. And that helps a lot as well because the hardest times are probably at 3:00 in the morning when it's just the two of you. You can't really pick up the phone to anyone else at 3:00 in the morning so that’s probably the biggest support you need.

Partners commend their significant others on their breastfeeding efforts, remind them that they are doing something incredible for their baby, and acknowledge that the mother has made sacrifices for their child. One mum said of her partner,

He's always been supportive and he knows it's the best by [my baby] and if anything, he'll say, almost like commend, and say you have been very selfless, you have given up your evenings your time out and everything else to make sure [our baby’s] needs are met so yeah without him I wouldn't have been able to do it.

Many mums said their partners have helped with other household chores such as helping with older children, cleaning, and helping with the baby aside from feedings. One mum, who had a particularly traumatic birth, explained:
He was very supportive. He got up and did loads of things like he would bring her to me because of my delivery, I had lots of stitches and I couldn’t sit straight so he was propping me up with pillows and making me drinks, helping me in any way. He obviously couldn’t breastfeed her, so he helped me in every way apart from the actual feeding.

Mums explained this made them feel that not only did their partners support their decision to breastfeed in theory, but also in practice. They also said that having their partner’s assistance made them feel like a team. One mum explained:

Yeah, it feels like a team rather than just me, which is been a bit of a surprise actually because I thought I would feel like this was the thing that only I could do. He tries to help position her and be the third arm.

When partners were asked how they felt they helped the mums to meet their breastfeeding goals, most answers centered on chores and assisting with the baby. One partner explained how he felt he assisted the mum and his answer was representative of other partners in the study:

I would just try and help as much as possible really. That’s what you do for a baby…Um, but yeah just sort of make tea and placate him when he’s upset. More nappies, that sort of stuff, just being helpful. Doing what you can really.

Though not as common, a couple of partners also mentioned that in addition to household help, they helped with looking for feeding cues. One partner said:

So, I guess I see my role as being as supportive as I can. So, I’ve been cooking, and cleaning, and tidying, and all that sort of stuff so that my partner can focus on making sure this little one is fed. I think I’ve also been the one who’s been saying look she’s doing the thing with her hands in her mouth
It is important to note that the partners who helped to look for feeding cues also mentioned attending prenatal classes with the mums. Mum’s whose partners were present in prenatal classes and other breastfeeding sessions felt their partner was better able to help by reminding them of what was said in classes. One mum explained:

I did a breastfeeding class…and my husband came along and I think that helps because when I was really tired after the birth, like when he was a few weeks old, my husband was like why don't you try that other position that they showed us at the class and it was great because he knew what to suggest and how to help me accomplish what I was trying to do

However, not all mums felt their partners knew how to support them in their breastfeeding journey. When a mum was struggling, some partners were unsure of how to recognize the difficulties without undermining the mother’s efforts. One mum said, “I know that my husband didn't mind and wanted to be helpful but he kept on saying ‘just put him on formula’.” Some partners struggled to understand the difficulties mums were having with breastfeeding. One mum explained:

I think he found it hard to understand what difficulties are because I think he just sort of thought it's just a natural thing and you should be able to do it. It was difficult for him to understand that it was really painful and he kept saying it's normal, it's normal and that was quite hard because I had to kind of solve the problem myself rather than him supporting me.

When asked if they felt their partners’ presence in a prenatal class or breastfeeding class would have beneficial, most mums agreed that it would have made it easier to navigate difficulties if their partners were more informed.
**Partner presence in Cafés.** Most mums did not bring their significant others with them to the Café sessions. Some mums said they brought them in the beginning while their husbands were on paternity leave and they have since returned to work. When partners asked if they felt comfortable attending the Baby Café sessions, they reported they were not sure if they would be welcome to attend. Some came by the Café, intending to drop the mum off, but stayed once they saw other fathers present. One significant other explained, in a sentiment common among partners in the study:

Yeah [I was wondering] if women would feel comfortable with me here. We turned up and there was another chap sat there and so I was like let’s see…Yeah, I was wondering whether it would be, I don’t know, whether partners would be welcome. Thinking about it now, it seems a bit ridiculous, but I wasn’t sure.

Another partner thought it would be a “women-only thing” so he did not know if he would stay for the session. Partner presence varied greatly between the different Café locations. In some Cafés, about one-third of the mums would bring their partners, whereas, in other Cafés, I never saw mums bring their significant others.

**Role of family and friends.** Friends and family played a variety of roles in a mother’s breastfeeding journey. For some women, their families and friends promoted and supported breastfeeding. Oftentimes, having friends going through similar experiences would play a large role in a mum’s breastfeeding experience. For other women, their families and friends were not supportive of breastfeeding and would dissuade them from continuing on, especially in the case of difficulties. For first time mothers, the infant feeding decisions of friends and family often influenced them in their choices. One mum said, “My friends did it and I don't know because he's my first baby I sort of just went with what my mum did and what my friends did.” Other mums
who had a midwife or doula in their family would mention that this person helped support them throughout the process and gave them information about breastfeeding. Having a maternal figure who had breastfeed was also helpful to mums. One mum said, “My mother-in-law has been really supportive, she had four boys and she breastfed two of them…so I knew she would be there to support me if I needed it. She is really easy to talk to.” Mums who had family members who had breastfed were more likely to mention that these women played a role both in their decision to breastfeed and ability to sustain breastfeeding. When confronting a breastfeeding problem, mums often turned to friends who were currently or recently breastfeeding. One mum explained:

Yeah, lots of my friends have breastfed. Some of them have breastfed successfully and some of them have breastfed and had problems or issues and I think that knowing actually it can be very hard and lots of my friends are very realistic and they've had good experiences and not-so-good experiences, but yeah being able to talk to people and say they are doing this or they're not doing that and what do you think about this

In other cases, mums did not feel supported by their families or friends. One mum explained:

During the difficult times, their answer is always to bottle feed because they are a bit ignorant you know. And I actually did have to say to them, my mum, please stop saying that because I need your support to breastfeed it's what I want to do and so I had to tell her to stop.

A Café facilitator explained that the mothers of mums who struggled to breastfeed often suggest formula because that was the only way they knew how to help their daughter. She said that they see their child struggling and know that they will be able to help out more if they can bottle feed.

Organizational
At the organizational level, a mum’s clinical experiences throughout her pregnancy, delivery, and postnatal with health professionals, experiences with tongue-tie correction for their babies, experiences with and access to breastfeeding information, and access to formal support emerged as key themes. These factors shape whether a mum is able or willing to seek assistance with breastfeeding difficulties to continue onward in her breastfeeding journey.

**Clinical Experiences.** One topic that consistently came up in interviews was a mum’s experiences in clinical settings. This includes prenatal services, labor and delivery, treatment in the hospital, and post-natal services. Mums often considered their clinical experiences as playing a role in their breastfeeding outcomes and included these experiences in the narrative descriptions of their breastfeeding journeys. These experiences included topics of traumatic birth, poor treatment by health practitioners, midwife issues and care, lack of support, and positive breastfeeding support.

Traumatic births often played a role in a mum’s initiation of breastfeeding. Traumatic births left mums feeling disoriented and unsure of how to handle initiating breastfeeding. One mum said:

I had a really quick birth, like from start to finish it was only a couple of hours and I was feeling quite traumatized, to be honest. I think we both were traumatized. I was just trying to regain a little bit of consciousness myself and she's trying to put the baby on [my breast] and I think it was just a little bit too soon for both of us.

Traumatic births also caused long periods of recovery, which made it difficult for the mums to find comfortable positions for feeding. One mum explained, “I had a forceps delivery I haven't felt very comfortable anywhere.” Mums with traumatic births often using this as the starting point for the breastfeeding narrative, explaining they began from a disadvantaged position.
Mums frequently brought up poor treatment by health practitioners. In these scenarios, practitioners often did not support a mother’s infant feeding decisions or help her when she was struggling to breastfeed. One mum explained,

I think that support in the hospital, the post-natal support, when breastfeeding doesn’t go right instantly, it just, I felt let down by them and I had to do a lot myself while dealing with emotions and hormones and no sleep

Mums who struggled to breastfeed often felt the health practitioners were not prepared for a situation in which a mum wants to breastfeed, but is struggling to do so.

Beyond the delivery staff, support among general practitioners varied greatly. One Café facilitator explained,

We have one GP at our local practice and when he sees thin babies, he prescribes formula. He has been known to look at a woman, look at her literally through her clothing and go, ‘You won’t ever make enough milk.’

The Café facilitator said postcode was the most important factor in having a breastfeeding supportive GP.

While midwives are health practitioners, due to the frequency of specific comments about midwives, I have separated them into another category. Mum’s often felt their midwives were not knowledgeable about breastfeeding and were not prepared to support them. One mum explained, “…the Midwife in the hospital, they were really trying to force, like grab the baby and force it [my breast] in his mouth.” This was a common theme across interviews. Midwives often resorted to physically putting the baby to breast in ways that sometimes caused damage to the mother’s breast. Many mums felt the midwives did not have the expertise necessary to support breastfeeding. Some midwives would refer mums to outside sources and many would attempt to
latch the baby themselves, which left mums feeling like they could not breastfeed successfully on their own. A few of the mums did have midwives that were very helpful to them. One mum explained,

We have a lot of support from the midwives in the hospital who on day three were really intensively training us how to do it and that's fantastic, that's what I needed, I needed one on one support

Often the mums who had positive experiences with their midwives found them to be particularly helpful in recognizing signs that breastfeeding was not going well. The midwives would suggest formula in the meantime and this took pressure off mums who said they were frustrated and exhausted.

Some women experienced a complete lack of support, particularly in hospital. Mums said they felt the doctors, nurses, and midwives were too busy and rushed. One mum explained, “…in Hospital they didn't really show me many ways of attaching, they only showed one. I couldn't even manage that with the doll they gave us, let alone with a wriggling baby.” This was common among the majority of mums, who felt that they were rushed both in attempts to breastfeed and in their breastfeeding education in hospital.

A few mums said they were abandoned after delivery and had a difficult time finding someone to help them. One mum described her experience after her baby was born

A midwife tried to help me to try to get him on the breast, but then just essentially abandoned us for about 12 hours...We basically had to beg and find somebody who would help us feed him because no one would help us.

While abandonment was less common than health practitioners who were unhelpful, it is serious enough that even a few mums experiencing abandonment in hospital is a serious issue.
Some mums said the services they were supposed to receive, such as a health visitor or breastfeeding team in hospital never reached them. One mum said, “No lactation consultant came, which I'm fairly sure in the hospital they say they do that, but it was just so busy. I think we just sort of got missed out, but that would have been really helpful.” Another mum stated, “The only thing I haven't got is, well I don't know about my health visitor, I texted somebody who I thought was my health visitor, but she never got back to me I don't really know what to do.” The mums in these situations often did not know who to contact to see why they did not receive these services and were left accepting exclusion from helpful programs.

Some mums did have very positive experiences and support for breastfeeding in their clinical experiences. One mum described the benefits of a lactation team in hospital,

There were some breastfeeding support people and they came and they were amazing…They gave me confidence, they helped me understand how to hold my baby how to support the back of his neck and without holding his head, what a good latch looks like and feels like, but it shouldn't be painful

While not all mums received these services, those who did generally stated it was helpful.

A café facilitator explained that when it comes to support, “We’re back to this Lottery again, it depends on what postcode you live in or what hospital you deliver in, it depends on what GP you see and what health visitor you get.”

**Tongue-tie.** Tongue-tie, an issue at the individual level, was also an issue at the organizational level. Some Café facilitators are trained to check for tongue-ties and could provide a preliminary exam and referral. When a mum is able to get her baby diagnosed with tongue-tie, it often provides relief that there may be a solution for her breastfeeding challenges. One mum explained,
A lactation consultant who looked at [my baby] and said yes, he has an anterior tongue-tie, which made me feel a lot better because I felt like I must have been doing it wrong to be in so much pain and everyone kept telling me the latch looked okay, but it did not feel okay.

Mums whose babies had tongue-tie often said they felt relief at getting a diagnosis, especially if previous providers said there was no issue. However, getting a tongue-tie diagnosis is often not the end of complications for some mums. Some mums experience difficulties in getting an appointment for a frenotomy. If tongue-tie is inhibiting the mum’s ability to breastfeed, waiting weeks for an appointment could cause a significant drop in her milk supply, therefore it is important to address tongue-tie very quickly. However, getting an appointment with the NHS can take quite a while. This results in many mums looking to private options for the tongue-tie surgery. One mum explained,

I phoned the NHS and they have to see you a second time before they refer you to someone in the NHS, which would mean I’d have to wait another week and then a possible 3 to 6 weeks wait to see someone and I was in so much pain I couldn't wait, so I chose to go private. He had his tongue-tie snipped at 10 days and I honestly think if he hadn't had it done then I would have had no choice but to give up.

Almost all mums in this study whose babies were diagnosed with tongue-tie sought private services to have the tongue-tie snipped. Each of these mums commented they were lucky to be able to afford the procedure in private practice and they could not imagine those without this luxury being able to sustain breastfeeding.

Mums felt tongue-tie was just another stressor related to breastfeeding that they had to work through. Many mums wished that tongue-tie checks would be routine in hospital so that
they would not have to go through the process of taking their infant to different specialists for diagnosis and surgery.

**Breastfeeding information.** Many parents felt the information provided to them about breastfeeding through different channels did not address potential challenges, made it seem like there would not be complications, and had many inconsistencies. Breastfeeding is positioned as a natural, uncomplicated process; therefore, many mothers felt they are personally responsible for any challenges they faced. One mum explained that she assumed breastfeeding would come naturally, but the reality was much different. She explained, “What I hadn’t realized is how difficult it is, you know? You hear about ‘oh yeah breastfed babies,’ you think it’s the most natural easy thing in the world but it’s really not, you know.” This was a widely common sentiment. Over 75% of participants used the word “natural” to describe breastfeeding at some point during their interview. The statement “It’s the most natural thing in the world,” was said, verbatim, 17 times by 14 different participants. Information provided about breastfeeding made parents feel like it would be easy. One partner explained,

> Through this class [NCT prenatal course] you’re made to feel...I think it was positioned like it would be really easy. I did feel like that, but I think the reality of it is very different because I think we came out of that class thinking we’ll be able to do it, it will be fine.

Potential breastfeeding challenges were also not addressed during courses meant to prepare parents for breastfeeding. One mum explained, “No one tells you how hard it is, unfortunately. Nobody tells you about cracked bleeding nipples and baby not latching and engorged breasts when baby doesn’t latch. And no one tells you about this, nobody talks about that.” Almost every mum explained she did not feel prepared for challenges and felt almost deceived by the prenatal classes she had attended. Parents also felt frustrated by inconsistencies in breastfeeding
information. Information and advice varied between prenatal courses, hospital staff, lactations consultants, and Baby Café. One partner stated, “…the issue comes from there seeming to be a massive difference of opinion, so we’ve come here today and it’s basically saying just completely disregard what we were told in hospital.” Parents would often come to Baby Café to clarify information they had received from a variety of sources.

Additionally, some parents explained that while there may have been sufficient information to prepare them for breastfeeding, they did not internalize the information before they began breastfeeding. One mum explained, “I did go to the class [prenatal NCT breastfeeding course] but I don't think, it wasn't a reality for me, I didn't really take on with it.” Café facilitators agreed with this statement, stating that some of the difficulties were covered, but mums ate generally more focused on learning about labor and delivery to pick up on those messages. Parents did demonstrate agency in seeking out helpful information once they experienced setbacks. Some mums found Facebook groups for breastfeeding mums where information and sharing with others in the same position was particularly helpful to them. Many mums stayed in touch with the cohort they completed the prenatal NCT courses with and found this group to be a great source of support and advice. Other mums sought out information from the NHS website and NHS breastfeeding helpline. Additionally, all of the mums in the study have sought help from Baby Café.

**Formal support.** Mums felt formal supports for breastfeeding were central to their ability to successfully sustain breastfeeding. Services were sought from a variety of professions. Some mums visited private lactation consultants, while others used free services such as Baby Café. They use these supports to answer questions, talk through concerns, and develop mum-to-mum networks that provide social support. Mums explained that having access to weekly support
allowed them to check-in and get advice, whether they were experiencing significant setbacks or had minor concerns to address. Support is useful from initiation to sustainment of breastfeeding and ultimately helped mums to meet their breastfeeding goals.

Formal supports are useful at the beginning of a mother’s breastfeeding journey to help her find a way to breastfeed that works for both her and her baby. One mum explained, “…having people with experience to kind of just show you the ropes is valuable.” All mums agreed formal supports were important for sustaining breastfeeding. One mum stated, “…you do need a lot of support I think, and it's Baby Cafés like this that are absolutely crucial.” Another mum described why support is necessary for sustaining breastfeeding:

[I thought] maybe I'm really not designed to breastfeed, maybe I'm failing, maybe I'm doing it wrong, maybe it’s not right. And you do question yourself, so I think having the support, I honestly think having these groups like Baby Café, and other people that are there that have been through it, they are sort of invaluable, really.

Mums go to these supports for reassurance, which helps them persevere when breastfeeding is difficult. Mums felt that seeking out support made them feel like everything would be okay. One mum said of Baby Café, “…it was really my lifeline.” Many mums state their reason for visiting the café as, “a bit of reassurance.” One mum, explained that formal supports would be essential in meeting her breastfeeding goals, saying, “Cafés where you can come in and have a chat and just get some advice, because it's [breastfeeding] an activity you do by yourself sometimes it's quite challenging to know [if you’re doing it right].”

Having these supports available frequently is useful to mums, as they know if they are having a problem, they will not have to wait long before another Café session or meeting with a lactation consultant. One mum explained:
Things change so much that having one [Baby Café] on a Monday and one on a Friday is really good, I think. If you didn't manage to get out of the house on a Monday and you had to wait another full week before you saw anyone that would be really difficult. Some mums would travel outside of their local areas to attend more than one Baby Café session a week.

At Baby Café, mums frequently formed friendships with one another, bonding over similar issues. Some mums continue to visit Baby Café beyond the time when they need breastfeeding support. One mum, who continued her Café visits for almost a year explained,

We like to come [to Baby Café], and if I have little issues, I'll have a chat with [the Café facilitator], but mostly just meeting and seeing other mums. That's what the Café is for, isn't it? It's not just support in terms of one-to-one advice, but the network that you build. This social network was commonly mentioned in reasons for attending Baby Café, especially for mums who had visited more than once.

One Café facilitator explained that when mums return with older babies, it helps to reassure mums with newborns that it is possible to continue breastfeeding, even for those who struggled.

Private appointments were often booked for specific reasons. The most common reasons mums gave for seeking private care was tongue-tie checks. NHS appointments can take time to get and then a longer wait period is required for surgery if it is determined that the baby has tongue-tie. Mums would seek out private services for these checks, and would also often choose private services for the surgery.

Ultimately, formal supports help mums to meet their breastfeeding goals. One mum explained, “I can genuinely say if it wasn't for the Baby Café, I would definitely be just exclusively bottle feeding, no question.” Another mum said:
I can honestly say that if it wasn't for this [Baby Café] I wouldn't have been able to do it, I would have given up. I would have had to. So, I am a huge believer in the breastfeeding Cafés, the expert advice that they provide, and the environment that they provide it in. This demonstrates how access to these supports is central to the breastfeeding experience for many mums, for whom these services are vital.

**Community**

At the community level, themes of breastfeeding in public, extended breastfeeding (feeding beyond one year), and judgement mum’s experience related to infant feeding were the primary factors discussed by participants. These factors establish whether a mum is able to feel comfortable and support by those around her and if she is able to make breastfeeding part of her normal routine.

**Breastfeeding in public - stigma.** Mums experienced stigma while breastfeeding in public and often felt hesitant to feed in front of others for fear of being criticized. Many mums stated that while people think you should breastfeed, there is still a bit of stigma about feeding in public. One mum explained, “I think it's kind of difficult because everyone thinks you should do it [breastfeed], but it's actually difficult to find places for you to be like it's okay for me to do this here.” Some cited “British prudishness” and others the “older generations,” but almost every mum felt that the public did generally have issues with public breastfeeding. As one Café facilitator described:

I think women are set up to fail by the fact that we’re not very positive or pro-breastfeeding, and we’re still, I think our culture is still quite anti-breastfeeding because we’ve still got a bit of a problem with boobs in public.
This was an idea that most mums agreed with, leaving them to feel uncomfortable about breastfeeding in public, especially before they had established breastfeeding. Mums discussed getting nasty looks from passersby and wondering if whispers were about them. However, very few mums experienced direct confrontation when breastfeeding in public. One mum described a situation where a man in a pub told her breastfeeding was disgusting and she should go to the toilets to do it. In another situation, a mum was asked to not breastfeed in a changing room in a department store. Many mums felt concerned about these types of situations happening to them. Though few had experienced it themselves, almost all mums said they had a friend or family member who had bad experiences while breastfeeding in public. One mum explained, “I’ve never had any problem [breastfeeding in public], but then I’ve heard some stories.” Some mums take precautions to avoid uncomfortable situations by covering up more, sitting in the back corner of a restaurant, or only feeding in “family friendly” places. Partners were also aware of this stigma. One partner stated, “You get some idiots who still think women should hide away and shouldn’t do it in front of them and it’s disgusting.” Another partner said, “…I think there’s still a taboo of it, so people, they’re focused on being embarrassed about it.” Public breastfeeding stigma adds another layer of difficulties for mums who are already facing challenges. One mum explained, “It takes a lot of courage for mums to go out there and breastfeed in public in a world where a lot of people don't support it.” Mums did report that as they became more confident in their ability to breastfeed, specifically the ability to keep their baby latched, the more confident they felt breastfeeding in public.

**Extended breastfeeding – stigma.** Women who were further along in their breastfeeding journey, or those who had breastfed previous children, said they felt there was a significant stigma around extended breastfeeding. Extended breastfeeding in these cases includes
breastfeeding a child beyond six months, and especially beyond one year. A Café facilitator explained how pervasive the stigma surrounding extended breastfeeding can be:

What is interesting is when you meet parents antenatally, if you show them a photograph with a baby with hair who is breastfeeding, they are really kind of confronted with this idea of breastfeeding an older baby and it really puts them off. I think antenatally that’s big opinion to have, so you’ve lost half of them before you start. So that’s something that’s in their head and has been in their head since, I don’t know, school maybe

Mums experienced a loss of support from those who previously helped them through breastfeeding difficulties. One mum explained,

I couldn't have gotten through the difficulties without their [my family’s] support and their help, especially my husband as well. But I feel as babies get older, people don't seem to understand as much why you want to continue to breastfeed

This left mums in social isolation from friends and family who did not understand why they wanted to continue to breastfeed beyond six months.

Additionally, mums explained friends would make comments like, “…oh you’re still breastfeeding” and “…just give it [breastfeeding] up, why are you still doing it, give yourself a break.” With this loss of support from friends and family, it is important for mums to still have a source support in the community. A Café facilitator described that Baby Café is a safe place for mums to do extended breastfeeding, as it is not the norm in the UK. She mentioned a mum’s experience saying, “One mum said she just stopped feeding her baby and he’s 18 months old and her mother-in-law calls her Mother Earth in a not very kind sort of way.” Mums feel stigmatized for their decision to breastfeed beyond six months or a year. One mum explained:
A lot of my friends now are like, oh you're still breastfeeding, and I'm like he's only just one, he still a baby and actually that's quite normal. But our society and our culture has made it strange and weird. Not a lot of people have an understanding of breastfeeding into toddlerhood. It's seen as you're a bit of a weird, weird person who is wanting to do it. Mums lose the support of friends and family and know that society, in general, does not support extended breastfeeding, therefore feel pressured from multiple angles to quit breastfeeding before they are ready.

Extended breastfeeding was not supported by all study participants. A few participants made comments about how long their friends breastfed their babies. One partner said, “One friend who is still breastfeeding what feels like her 18-year-old child.” Another partner said, “There’s kind of an assumption that it [breastfeeding] stops at nine months, a year. It would, knowing two-year-olds and what they are like, it would just seem weird.” One mum said, “There’s a different way you can get a nutritious diet into them at that age [after one].” Even among mums who plan to breastfeed, many have planned to breastfeed to six months and then quit.

**Judgement of mums.** Mums commented that they felt judged no matter what decision they made related to infant feeding. Mums were stigmatized for breastfeeding for too long, not long enough, and too often. Mums felt judged for their decision to breastfeed. One mum said, “There's a sort of also slight stigma attached to it, that if your breastfeeding you're some sort of Earth mother goddess, but then equally on the other side if I hadn't been able to breastfeed.” Another mum said, “I think people say women who are breastfeeding are doing it for attention. They think women who are breastfeeding toddlers and things, it’s for them, it’s not for the child.” Mums who breastfeed are also subjected to comments about how and how often they
breastfeed. There is a general lack of understanding of breastfeeding, especially around how often a newborn will feed, which brings about issues for mums. One mum said, “I didn't want my father-in-law to be there and lots of comments about ‘oh he's feeding again’.” Comments on feeding frequency were widely discussed by mums, as feeding on a schedule was considered the norm, rather than feeding on demand.

Other mums were stigmatized for their decision to mixed feed or use formula. When asked what she thought would have happened if she had chosen to not breastfeed, one mum explained:

I think I would have been feeling quite guilty about that choice, to be honest. I only have one friend out of all of my friends who never tried and used formula from the beginning.

I think I would have felt quite judged, probably.

Another mum, who was able to successfully breastfeed, shared a story about her sister-in-law who struggled to get breastfeeding initiated. Her sister-in-law lived in an area with fewer breastfeeding supports but was judged for her inability to breastfeed. The mum described:

My sister-in-law physically couldn't breastfeed. She really struggled with that because she felt that she was a failure, and she almost got treated like that by some midwives. They had that kind of attitude that she had just given up and she didn't try long enough when she actually really didn't want to give up. But then at the same time, she didn't have the support to get through that and she just got on with formula feeding because that was the next thing to go to.

Mums feared that friends, family, and medical professionals would judge decision to breastfeed or not and judge how and how often they breastfeed.
One mum, who was unable to initiate breastfeeding while in hospital said, “In the hospital, they were very anti-formula, I just wanted to feed my baby… so I needed not only support to breastfeed, but also support in the interim to feed my baby formula and to know that's fine.” Mums felt like they had to get permission to bottle feed or use formula. They would put themselves through a lot of pain and stress before they would be willing to try formula or expressing. One mum explained:

I just had a lot of problems really with fitting in sleep, and in the end, it was day one when we got home and the Midwife just took one look at me because I have been without sleep for two to three nights and she just said to express so that's what I did. When he [my baby] continued to cluster feed, we replaced one feeding with a bottle and it was like I had permission to do that.

One mum smartly summed up the issue, stating:

Everyone is quick to jump on a public photo of a mum breastfeeding…try and breastfeed and someone will say something…But then if you bottle feed, I know people get funny looks for that, so it’s kind of like you can’t win basically. You really can’t win because people judge you, which again doesn’t help the whole breastfeeding thing.

Among the participants in this study, many felt like either way there would be people who judged their decisions about infant feeding.

Policy

At the policy level, participant awareness of the Equality Act 2010 was the defining theme. Mum’s awareness of the policy, and confidence to cite this policy to protect their rights to breastfeed in public influenced breastfeeding experiences.
**Awareness.** Equality Act of 2010 provides protection for women who are breastfeeding. According to the Act, a woman cannot be treated “unfavourably” because she is breastfeeding. When asked if they knew about the Equality Act of 2010, there were three levels of awareness among study participants. First was completely unaware, second was aware, but unsure of what the policy stated/covered, and third was aware and had knowledge of what the policy stated/covered. Most mums fell into the second level and were vaguely aware that there was some protection for public breastfeeding, however, very few mums knew the name of the Act or exactly what is included. One mum explained her views on the policy, which was common among participants, “Yeah, I think I'm vaguely aware, I don't know exactly what it is or what it says, but I would love to be able to reference it.” Another mum stated, “I know they can't ask you to leave, but I don't know what the situation is about how exposed you can be while feeding. I'm not really sure about that.” Quite a few mums said they had not heard that there were any protections for public breastfeeding, and were happy to hear there was a policy. Though the exception, a few mums were very confident in their knowledge about the Equality Act 2010. One mum explained:

I was quite worried about taking her out and breastfeeding in public, but I was also quite excited about possibly swearing at a couple of old men and saying ‘have you not read the Equality Act 2010’ or maybe quoting parts of it to, which I've not had to do yet.

Partners were generally less aware than the mums about the policy. Most stated that they did not know any policy or protections existed. One partner said, “I’m not quite sure what the rules are about places allowing breastfeeding or if there’s a catchall policy.”
Even among the participants who knew about the policy and what it stated, there was a consensus that there was no general awareness of the policy, especially among those who are not parents.

**Marketing the policy.** All participants were asked how they think the Equality Act 2010 could be marketed to increase awareness among both parents and business owners. Participants described a variety of ways to improve knowledge of the Act. Suggestions included featuring information about the Equality Act more prominently on the NHS and NCT websites, including the Equality Act in sensitivity and diversity training for businesses, and mums also said putting information about the Equality Act on the back of toilet stall doors. This would be helpful for women who felt they had to resort to feeding in the restroom to avoid criticism. Mums said including information about the Act in pamphlets/leaflets would be the least helpful, as they receive so many of these handouts during their pregnancy, that they often go unread. Further, for businesses to demonstrate their awareness of the policy and demonstrate their support for breastfeeding, they could post a notice on their website saying they are breastfeeding friendly and a sticker on their door to let breastfeeding mums know they are welcome.

**Breastfeeding Self-Efficacy Scale-Short Form**

The Breastfeeding Self-Efficacy Scale-Short Form (BSES-SF) was completed by all mums who took part in the interviews. An exploratory data analysis was conducted to examine question responses (n = 28, M = 47.7, SD = 11.9, Mdn = 50.0). There were fourteen questions on the BSES-SF and questions follow a five-point Likert scale, with 1 being least confident and 5 being most confident in breastfeeding. This results in a possible range on scores for the BSES-SF
of 14-70. Lower scores indicate lower breastfeeding confidence and higher scores indicate higher breastfeeding confidence. Scores for this sample ranged from 24 to 66. The question with the overall lowest score ($M = 2.6$) was, “I can always ensure that my baby is properly latched on for the whole feeding.” The two questions with the highest scores ($M = 4.0$) were, “I can always keep wanting to breastfeed” and “I can always continue to breastfeed my baby for every feeding.”

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<th>Std. Dev.</th>
<th>CV %</th>
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n= 28, $M = 47.7$, $SD = 11.9$, Mdn= 50.0

A Spearman’s rank-order correlation was conducted to examine the relationship between BSES-SF score and baby’s age. There was a significant moderate, positive correlation, at an alpha level of 0.05 and 95% CI, between BSES-SF score and age of the mum’s baby ($r_s = .407$, $p = .031$, CI [.014, .694]). A Spearman’s rank-order correlation was also conducted to examine the relationship between BSES-SF score and the number of children. There was not a significant correlation found between these factors ($r_s = .197$, $p = .316$, CI [-.203, .536]).
Spearman’s rank-order correlations were conducted to examine the relationships between each question of the BSES-SF to determine how breastfeeding experiences and challenges are related. Correlations were conducted at an alpha level of 0.05 and 95% CI. A total of 91 question pairs were analyzed for correlation. Of the 91 analyses, 60 were determined to have a significant correlation, with 17 of these being significant at the 0.05 level and 43 at the 0.01 level. All significant correlations were positive correlations. Thirty of the 91 correlations were found to be non-significant, but positive, leaving a single non-significant negative correlation. The single non-significant negative correlation was between “I can always manage to breastfeed even if my baby is crying” and “I can always deal with the fact that breastfeeding can be time-consuming.”
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n=28 for each question

**. Correlation is significant at the 0.01 level (2-tailed)
*. Correlation is significant at the 0.05 level (2-tailed)
CHAPTER 7: DISCUSSION

Breastfeeding in the UK is shaped by a variety of factors that come together to create positive or negative environments for breastfeeding.

Breastfeeding in the UK

The most common expectation for infant feeding among mums in this study was that they would try breastfeeding, but if it did not work, they would be willing to mixed feed or use formula. All wanted to give breastfeeding a chance, but they did not want to put too much pressure on themselves to succeed in breastfeeding. A Café facilitator explained that the hasty switch to formula when breastfeeding is difficult is due to breastfeeding not being well-promoted in the UK. The ‘give it a go’ attitude is common and leads to the early cessation of breastfeeding (Bailey, Pain, & Aarvold, 2004). The women who approach breastfeeding expecting it to be difficult and expecting to fail were more likely to readily switch for formula in the early days of breastfeeding (Bailey et al., 2004). This negative approach is largely informed by the cultural context in which breastfeeding occurs. As the facilitator described, the UK has not historically promoted or protected breastfeeding as much as other countries (House of Commons, 2009).

In regards to breastfeeding education, parents were made to feel like breastfeeding would be easy and natural. This resulted in frustration and early cessation of breastfeeding (Graffy & Taylor, 2005). Many parents took part in an NCT antenatal course, in which one class session was focused on breastfeeding. It seems that prenatal courses and other breastfeeding information are successful in educating mums about the health benefits of breastfeeding, resulting in many
mums naming this as their primary reason to breastfeed. However, parents said the class did not bring up potential issues with tongue-tie, nipple and breast pain, or latching issues (Fox, McMullen, & Newburn, 2015). When considering this in the context of the Social Cognitive Theory, mums were not provided with the necessary support to gain knowledge about breastfeeding or confidence in their ability to continue breastfeeding after facing challenges (Ahmed, 2008). These lead to unsustainable breastfeeding patterns, resulting in a reduced duration of breastfeeding (Ahmed, 2008). As breastfeeding rates are so low in the UK, there is a recent push to promote breastfeeding (House of Commons, 2009). There is fear that discussing all of the potential challenges may dissuade mums from initiating breastfeeding. However, parents wanted a more realistic understanding of breastfeeding. This sentiment is common in other Western societies, as women note they did not expect many of the physical and emotional challenges they faced during the early stages of breastfeeding (Kelleher, 2006). Receiving information on engorgement, treatments for sore nipples, and reassurance that the difficulties they experienced were normal were among the most helpful types of support mums could receive (Graffy & Taylor, 2005). As seen in the SCT, knowledge influences self-efficacy, therefore it is important that women are given a complete picture of the breastfeeding experience so they may persevere through difficulties (Ahmed, 2008). Additionally, parents were frustrated by the lack of consistency in breastfeeding information (Berridge, McFadden, Abayomi, & Topping, 2005; Graffy & Taylor, 2005). Information provided by one source would be contradicted by another. This is difficult to correct for two primary reasons. First, breastfeeding is highly individual and every person’s experience and needs are very different. Solutions that work for one mum are not guaranteed to work for another, therefore no set guidelines for breastfeeding assistance can be made. Second, many different entities provide information on breastfeeding in the UK, including
the NHS, NCT, private lactation consultants, midwives, etc. Having these different perspectives means that each group may have their own set of policies, information, priorities, and guidance they provide to mums.

**Formal Breastfeeding Support**

Baby Café’s atmosphere is informal and relaxed, which allows mums to spend time drinking tea and chatting with other mums before and after their one-on-one session with the Café facilitator. Mums are given time to relax and are provided with tea and snacks. This is particularly important for new mums that may not have had a moment to relax since coming home from the hospital. Baby Café facilitators make a point to greet new mums and ask how they are doing before asking about the baby. This is notable, as new mums are rarely asked how they are doing since the focus is generally on their newborn. For a mum to be successful in breastfeeding, she needs to be healthy and feels supported. Receiving encouragement for self-care and relaxation is found to be most helpful to women in regards to breastfeeding support (Graffy & Taylor, 2005). Facilitators are trained in person-centered-counseling and the social model of care. The social model of care provides a wider scope for support. Rather than focus on a single issue, facilitators are trained to address the whole person, the family, and the environment (Fox & McMullen, 2018). The person-centered approach ensures listening is at the forefront of one-on-one sessions. Feeling they are not being listened to is considered by mums to be the least helpful for breastfeeding support (Graffy & Taylor, 2005), therefore this person-centered approach ensures mums feel heard. Facilitators take as much time with each mum as needed, never rush through conversations, and are not solely focused on seeking solutions for issues. This separates Baby Café from other breastfeeding support models (Fox & McMullen, 2018; Williams & Pardoe, 2003). Such ongoing formal support for breastfeeding fulfills the
organizational level of the Social Ecological Model, but also provides a structure in which interpersonal and community levels can be addressed (UNICEF, 2010).

Baby Café trains peer breastfeeding supporters to assist in Cafés. Peer support programs have been shown to be successful in increasing the number of women who breastfeed in the UK (Berridge et al., 2005; NHS, 2000). Baby Café fosters an environment of social relationships between mums (Fox, McMullen, & Newburn, 2015). Mums develop relationships with other mums, which promotes social, mental, and emotional wellbeing. Mums provide day-to-day support for one another and share advice, which is especially important if the mum feels isolated from other family and friends (Fox, McMullen, & Newburn, 2015). This interpersonal support between mums, as well as between mums and peer supporters, provides mums with individuals they can go to for advice, questions, concerns, and to build a network of breastfeeding supportive people (UNICEF, 2010). Finally, as babies grow older, mums are able to breastfeed without fear of judgement for feeding an older baby at the Café. Baby Cafés becomes a safe place for mums throughout their breastfeeding journey. Another unique characteristic of Baby Cafés is they are ingrained in the community, taking place in child and community centers or churches (Fox, McMullen, & Newburn, 2015; Fox & McMullen, 2018). This led to mums feeling the service was not only convenient but also familiar. This also promotes normalizing breastfeeding at a community level (UNICEF, 2010). Additionally, due to the drop-in relaxed nature of Baby Café, mums feel they are able to seek advice even for small issues and reassurance. If an appointment was required, mums may not feel their small issue is “worth” making an appointment for one-on-one assistance (Fox, McMullen, & Newburn, 2015; Williams & Pardoe, 2003).

Many mums noted the dual mum-to-mum and professional support was what separated Baby Café from other forms of breastfeeding support (Fox, McMullen, & Newburn, 2015).
Other services that only address breastfeeding issues may be helpful in solving an acute problem, but the Baby Café model addresses the mental, emotional, and social health of the mum, as well as breastfeeding issues. This draws upon the Social Cognitive Theory in which social support and positive environmental factors influence self-efficacy, behavior, and ultimately outcomes (Ahmed, 2008; Entwistle, 2010; McKinley & Turner, 2017).

**Role of Social Norms and Society**

Some mums felt a societal pressure to breastfeed. It is difficult to find a balance between promotion and pressure (Fox, McMullen, & Newburn, 2015). There are recent articles in the UK about how women are put under too much pressure to breastfeed and feel guilty when they choose not to or are unable to breastfeed. As a response, the Royal College of Midwives published a statement that midwives must respect mothers who decide not to breastfeed (Embury-Dennis, 2018). One café facilitator explained how others are reacting too severely to articles on pressuring mums by calling for breastmilk and formula to be presented as equal options.

Mums often felt judged, regardless of their infant feeding decision (Thomson, Ebisch-Burton, & Flacking, 2015). Mums who breastfed felt they were being judged for breastfeeding in public, breastfeeding too often, and breastfeeding for too long (Thomson et al., 2015). Women feel shame from negative feedback received from friends, family, and even strangers (Thomson et al., 2015). People feel that they can comment on women’s child-rearing decisions openly. Women were told their babies were “spoiled” and they were “making a rod for their own backs” by “giving in” to their babies’ demands to be fed more often. The biological and historical reality, however, is that babies, especially newborn babies, are fed frequently (Brown, 2016; Gray, 1995). Babies following feeding schedules is an accepted reality of developed countries. So
much so, that some mothers have been told to cut back on their frequency of breastfeeding by their physicians. Called ‘on-demand’ or ‘baby-led’ breastfeeding, this practice of non-scheduled feeding is disputed in Western societies. Scheduled feeding results in higher wellbeing scores for mothers, but lower test scores for babies (Iacovou & Sevilla, 2013). Mums face the brunt of the judgement from others if they choose this style of feeding for their child. However, mums who use formula are judged as being selfish and not making the best choices for their newborn (Thomson et al., 2015).

Breastfeeding in public, and the stigma surrounding public breastfeeding was a concern for many mums. Breastfeeding in public is not widely accepted, or seen, in the UK (Boyer, 2011), though a policy to protects mums’ rights to breastfeed in public was implemented in 2010 (Equality Act 2010) While very few mums in the study had personal experiences with being called out or asked to leave while breastfeeding in public, almost every mum knew someone who had a bad experience. Mums would tell each other about these stories and experiences, which continually reconstructed the narrative that breastfeeding in public is not accepted. New mums were the most worried about breastfeeding in public, which often was related to the breastfeeding difficulties they were experiencing. The perception that public breastfeeding is not the norm and that is open for disparaging comments creates anxiety for new mums who have to feed while out in public (Boyer, 2011). Mums fear judgement and criticism, they may face if they breastfeed in public (Sayers, 2014). This is largely due to the sexual connotations of breasts and women’s bodies (Sayers, 2014; Van Esterik, 1994, 2002). While women’s bodies are widely shown in advertisements and the media, few women feel it is appropriate to portray breasts in the context of breastfeeding (Johnston-Robledo et al., 2007). From a Feminist theory perspective, this is due to the manipulation of women’s bodies as sexual objects through the patriarchal lens.
Breastfeeding, or rather breasts, are sexualized in the UK through (Boyer, 2011; Van Esterik, 1994). Breasts are viewed as sexual, rather than maternal, and through exposing breasts in public, the act of breastfeeding is sexualized and politicized (Boyer, 2011; Johnston-Robledo et al., 2007; Morris, de la Fuente, Williams, & Hirst, 2016; Van Esterik, 1994). Women who choose to breastfeed in public are viewed as making a statement, trying to show off, or being eco-warriors (Morris et al., 2016. Mums who choose not to cover up using a muslin or other cloth are viewed as obscene (Morris et al., 2016). Mums who had trouble getting their baby latched and those who had to use nipple shields were more concerned about their baby not staying latched and exposing them in public. As mums grew more confident in their breastfeeding abilities, they became more confident in their ability to breastfeed discretely, making them feel more comfortable to breastfeed in public.

Extended breastfeeding is typically considered breastfeeding beyond the age of three (Dettwyler, 2004). However, as breastfeeding in the UK is uncommon, some believe breastfeeding beyond the age of one, or even six months is considered extended breastfeeding (Tomori et al., 2016). Even among breastfeeding mums, there are feelings that extended breastfeeding is weird or abnormal and that there are other ways to feed your baby a healthy diet (Gribble, 2008). If breastfeeding is sexualized, breastfeeding older babies or children is even more so. When babies are older, the idea that the mum is being selfish or is receiving some sort of sexual gratification from breastfeeding grows (Galupo & Ayers, 2002). Public disapproval for breastfeeding beyond infancy stems from a lack of understanding of the benefits of breastmilk and the sexualization of women’s bodies (Van Esterik, 1994). Thinking there are more acceptable ways to provide a child with nutrition beyond six months leads people to believe that mums are breastfeeding for perverse reasons, whether that be sexual gratification or because they
are exhibitionists. Mums in the study who planned to breastfeed often planned to stop after six months. It is common for most mums who chose to breastfeed in the UK plan to wean around six months (Tomori et al., 2016). Mums with babies around four to five months began seeking information on weaning at Baby Café and were in the process to switch entirely to solid foods or solid foods and expressed milk or formula.

With little acceptance for breastfeeding at a community level, there are gaps in the SEM for breastfeeding support in the UK (UNICEF, 2010). Incorporating this into the SCT, a lack of social support and unaccepting environment for breastfeeding influences personal factors (Chin & Mansori, 2018). Personal factors such as vicarious experience, or hearing about negative public breastfeeding experiences, and verbal persuasion, or mums choosing to not breastfeed in public after hearing many people shame women who have breastfed publicly influence breastfeeding outcomes. Mums who have negative personal experiences from an unsupportive environment are less likely to be able to sustain breastfeeding (Johnston-Robledo et al., 2007).

**Partner Support**

Partners were often described as the most essential support system (Kaufman & Hall, 1989). Partners fill in the gaps of formal support. While formal support can provide technical assistance for breastfeeding, the lived reality of breastfeeding includes managing the household, chores, and potentially other children while breastfeeding (Su & Ouyang, 2016). Partners who are willing to cover these other responsibilities, provide a positive environment for breastfeeding (Hauck et al., 2016; Su & Ouyang, 2016). Mums said partners assisting with household/baby chores and providing verbal reinforcement, made them feel like they and their partner were working as a team to make breastfeeding successful (Hauck et al., 2016). Commending the mum on her breastfeeding efforts and advocating for her in situations where others make disparaging
comments was found to be helpful (Hauck et al., 2016). Partners play an important role in the interpersonal level of the SEM (Dunn et al., 2015). As partners provide ongoing support to create a positive environment for breastfeeding, they influence other levels of the SEM related to breastfeeding. Additionally, partners serve as advocates for mum’s breastfeeding goals, therefore mediating other negative interpersonal interactions (Dunn et al., 2015).

Partners were not always as sure of the role they played in the mum’s breastfeeding journey. When first asked what they felt they did to help, many partners had to take a moment to think. Changing diapers and household help were the most common answers. Some partners struggled to support the mums in meeting their breastfeeding goals. Partners, wanting to help the mum with her stress, would suggest switching to formula, as they often believed it would be easier and more convenient (Mitchell-Box & Braun, 2012). Mums felt this was dismissive of their efforts and desires to breastfeed. The literature suggests that partners play a role in infant feeding method decisions, with mums stating if their partner had not supported breastfeeding, it would have caused difficulties (Hauck et al., 2016; Kaufman & Hall, 1989). Some mums said when they switched to mixed feeding, their significant others were happy to have the opportunity to be involved in the intimate and bonding action of feeding their baby (Mitchell-Box & Braun, 2012; Rempel & Rempel, 2011). Other partners were not understanding of the difficulties and pain the mum was experiencing. The mums explained their partners felt like breastfeeding was natural, so it must be easy. The mums said they did not feel like their partner said these things out of callousness, but rather it came from either a loving or ignorant place.

**Role of Family and Friends**

Family and friends played a role in many mums’ infant feeding decisions and breastfeeding experiences (Hauck et al., 2016). Women whose mums had breastfed often
mentioned this as a reason for their decision to breastfeed. When breastfeeding was the norm in a family, breastfeeding seemed like the natural choice and the mum received familial support (Negin, Coffman, Vizintin, & Raynes-Greenow, 2016). Mums who had family members, especially mothers and mothers-in-law, who breastfed were able to go to them for assistance and encouragement throughout their breastfeeding journey (Negin et al., 2016). There is a positive impact when maternal figures have positive attitudes towards breastfeeding from the decision to breastfeed through sustaining breastfeeding (Negin et al., 2016). Friends who breastfed provided support, advice, and a social group in which the mum could feel comfortable breastfeeding.

For those mums whose family did not breastfeed, felt there they had no intergenerational support for breastfeeding. When breastfeeding is not the norm, support and the passing of breastfeeding skills from one female family member to another are reduced (Berridge et al., 2005). Many mums explained that when they experienced breastfeeding difficulties, their own mothers would suggest switching to formula (Ekstrom, Widstrom, & Nissen, 2003). These grandmothers often saw this as the only way they could provide support for their daughters who were experiencing difficulties with breastfeeding (Ekstrom et al., 2003). Additionally, the grandmothers of mums in the study were giving birth during a period of low breastfeeding and promotion of infant formula. This resulted in many grandmothers never having breastfed, or having negative experiences breastfeeding with little support (Ekstrom et al., 2003). This juxtaposition demonstrates how increasing breastfeeding among one generation can influence the next and have a wider reach. Mums whose friends did not breastfeed often mentioned their friends felt uncomfortable with their breastfeeding in public, which led them to spend less time with these friends. Some mums would categorize friends into breastfeeding friends and other friends, choosing to adjust their breastfeeding behaviors around friends who did not breastfeed.
Similar to partners, family and friends are essential to considering the interpersonal level of the SEM. These individuals, their perceptions and knowledge of breastfeeding, and willingness to support the breastfeeding mum all play into whether a mum has a supportive social network she can rely on while breastfeeding (Dunn et al., 2015).

**Clinical Experiences**

All mums in the study brought up their labor and delivery experiences, using this as the starting point for their breastfeeding narrative. Mums who experienced difficult births, including quick births, forceps deliveries, emergency cesarean sections, or blood loss had less control over how and when they initiated breastfeeding (Beck & Watson, 2008; Smith, 2007). These mums were more likely to be heavily drugged or exhausted, making initiating breastfeeding immediately after birth very challenging (Beck & Watson, 2008). Mums who had traumatic births also had longer healing periods, making movement difficult and traveling to seek specialist help nearly impossible (Smith, 2007). When a baby experienced health complication, this further complicated breastfeeding, as it was unlikely that the mum would have consistent access to her baby to establish breastfeeding (Smith, 2007).

Once a mum had given birth, the support for breastfeeding, or lack thereof, received in hospital shaped initiation (Declercq, Labbok, Sakala, & O’Hara, 2009). Many mums felt they had to consistently advocate for themselves and their infant feeding choices while in hospital. For some, this meant forging ahead with breastfeeding regardless of physicians doubt and for others, demanding formula (Declercq et al., 2009). Those who had support in hospital, whether it be their partner, doula, or parent, felt these people helped them to advocate for what they wanted. They explained that without their support team, they would have given in to what doctors and nurses were saying.
Mums whose health practitioners intervened and physically initiating breastfeeding felt it impacted their ability to breastfeed in the future. They often described the experience as traumatic and it has negative consequences for breastfeeding (Declercq et al., 2009). Many mums felt they left hospital knowing that breastfeeding had not been established, which is a critical period in sustaining breastfeeding (Declercq et al., 2009). The literature demonstrates that midwives physically intervening, rather than teaching, leads to mums not having the necessary skills when they leave hospital (Berridge et al., 2005). Mums felt rushed to show they could get their baby latched and sent on their way. Some women had not been visited by lactations teams that were supposed to visit mums after delivery. Women who had positive experiences while in hospital, whether from lactation consultants, midwives, or physicians, noted this as a reason they were able to successfully initiate breastfeeding. They said their positive experiences gave them the confidence to continue breastfeeding once they got home.

Tongue-tie was the most commonly mentioned physical issue with breastfeeding (Fox & McMullen, 2018). While latch and positioning were something a mum could seek advice for and learn how to improve, tongue-tie required medical intervention to correct. Mums felt that due to their babies’ tongue-tie, they were unable to establish breastfeeding. What mums found the most frustrating about tongue-tie was that even once their baby was diagnosed, they could not seek immediate correction for the issue (Fox et al., 2016). Due to NHS guidelines, there was a need for referrals and wait times for appointments. Mums said if they were to have waited on NHS appointments, they would have to give up breastfeeding because it was too painful and difficult for the mum (Fox et al., 2016). Because of this, many mums chose to seek out private surgery for tongue-tie correction. At the organizational level of the SEM, it is important to consider how NHS practices shape breastfeeding outcomes for women of differing socioeconomic statuses.
(UNICEF, 2010). For some women, the prohibitive costs of private surgery would result in their having to give up breastfeeding before they were ready.

**Equality Act 2010**

There was moderate awareness that the Equality Act of 2010 provides protection for women who are breastfeeding. However, many mums were unsure of what the policy did not and did not cover. Mums felt that while they had the right to breastfeed in public, they did not know if the policy covered private businesses, extended breastfeeding, or choosing not to cover up while breastfeeding. There have been cases of women being asked to stop breastfeeding or leave in public the UK since the enactment of the Equality Act 2010 that demonstrate the ambiguous nature of the policy (BBC, 2018; Cripps, 2018; Hartley, 2018). Protective policies are important to ensuring mums are able to breastfeed without fear of repercussion. At the highest level of the SEM, policies have the ability to affect the entire breastfeeding environment. Working closely with the SEM, the SCT demonstrates that environmental factors directly influence personal and behavior factors (Chin & Mansori, 2018; UNICEF, 2010). Taken together, these theories demonstrate the value of having policies to promote positive breastfeeding outcomes.

**BSES-SF**

The highest two scores on the BSES-SF were on “always wanting to keep breastfeeding” and “continuing to breastfeed for every feeding.” This demonstrates that mums, regardless of other challenges, often want to persevere and continue to breastfeed and demonstrate their initiative to sustain breastfeeding. That there is a significant positive correlation between BSES-SF score and age of the mum’s baby demonstrates that as a baby gets older, mums who sustain breastfeeding become more confident in their breastfeeding abilities. Once breastfeeding has been established, it is more likely a mum will be able to successfully carry on with breastfeeding.
Examining the results from the Spearman’s rank-order correlations, the majority (60 of 91) analyses were significant positive-correlations. This means that mums who reported more confidence in one question were more likely to report higher confidence on another question. Questions were, on average, correlated with 8.5 other questions. Since the majority are correlated, it is more revealing to examine those question pairings that are not correlated. Question 10, “I can always deal with the fact that breastfeeding can be time-consuming” had the fewest correlations with other questions. Question 10 was only correlated with one other question. Interestingly, the average score for question 10 was 3.6 out of 5, placing it among the upper quartile of question averages. Many mothers did address the time-consuming nature of breastfeeding during their interviews but did not consider it a priority issue, as evidenced by the average score on the question.
CHAPTER 8: CRITICAL REFLECTION AND APPLICATION

Critical Reflection

Baby Cafés were chosen as the only site for research for two reasons. The primary reason is that breastfeeding is not as common in the UK, and to conduct interviews, it was necessary to be located where I would be guaranteed to find mothers who breastfed for at least a portion of their infant feeding. Secondly, after visiting multiple Baby Cafés and conducting interviews, it became clear that breastfeeding can be a sensitive and emotional topic for many mums. If I were to have interviewed mums outside of Baby Café settings, it is possible the interviews could have caused emotional distress and no breastfeeding counsellors would be present to assist the mum.

All Baby Cafés that I visited were NCT-run Cafés. While I was initially scheduled to visit three NHS-run Cafés, this became impossible due to unexpected circumstances. Upon my arrival and contact with the NHS Café facilitators, my recurrent presence at the NHS Cafés would require the completion of an ethics review of my research. It was estimated this process would take five to six weeks. As my stay in the UK was limited to eight-weeks, completing the ethics process would have taken too much time away from visiting other Cafés that did not have this requirement. I made the decision, along with my Baby Café mentor, to find other NCT Café locations to substitute for the NHS Cafés I would no longer visit.

Each facilitator handled my presence at their Café differently. Some facilitators were happy to have an extra pair of hands and put me to work with signing in attendees, passing out teas and snacks, and making sure everyone was settled. Some facilitators would announce my
presence in the Café and tell the attendees about my project and make sure they were comfortable with my being there, which they always were. Some would ask each mum they met with if they would like to volunteer to be a part of the study, introducing me to each person individually. One facilitator even posted on her Baby Café Facebook page that I would be visiting later in the week and asked if anyone interested in the study would come to the Café meeting that week to be interviewed. Some facilitators chose not to announce my presence and, in these settings, I was responsible for introducing myself to potential participants. Each method had its own benefits and drawbacks, but I felt like the participants who were informed about me and my study by the Café facilitator, even if only very briefly, generally felt more comfortable during the interview. Another factor that influenced the comfort of the participant was their familiarity with research. Participants who were recently in University often made remarks about having to work on their own research and wanting to help me with mine because they remembered what it was like. I found that these individuals were the most likely to approach me to learn more about what I was doing, especially if they saw me do an interview with another mum. While Cafés were usually during a two-hour window, facilitators would often arrive early and stay as much as two hours beyond the end of the Café session to ensure all mums had been seen that day. The facilitators urge mums to show up at least fifteen minutes before the session is over, but multiple mums said that facilitators stayed after when they showed up late. Some Cafés are not open year-round, but the facilitators continued to provide support any way they could. One mum explained she reached out to a facilitator over Facebook about a concern while the Café was closed and the facilitator responded immediately with a thorough response and information resources.
Another challenge included determining when it was most appropriate and beneficial to interview parents at Baby Café. Interviewing participants before their chat with the facilitator poses a couple of issues. First, when a mum or couple comes it, they often have to wait to have a chat with the facilitator and judging whether the wait will be ten minutes or forty-five is difficult. If I chose to interview the participant before they met with the facilitator, it was likely our interview would be interrupted. Additionally, speaking with them before they had a chance to speak with the facilitator often meant they were preoccupied with what issues they had come in for that day. This meant I was unlikely to have their full attention or that their answers would be more anxiety-filled than if I waited until after they were seen. Interviewing participants after their chat with the facilitator posed its own challenge. The issue was that some people would leave straight away after being seen by the facilitator, which would mean they would not be willing to stick around for an interview. Ultimately, it depended on how busy the Café was if I knew there were quite a few people waiting to be seen before the participant, if they seemed particularly anxious or upset, or if they approached me, which happened occasionally. An additional challenge was that sometimes people would come to socialize. This was particularly common among couples. I often chose not to interrupt groups of people engaged in conversation to ask if they would be willing to participate in the interview.

Limitations

All study participants were part of the Baby Café network. This means that these parents had already accessed some services related to breastfeeding. Accessing services demonstrates their knowledge of available resources and the ability to attend such services, including having transportation. Additionally, because Baby Café is a service to help mums with breastfeeding
challenges, this may mean the study population has a higher likelihood of breastfeeding issues and challenges than the general population.

Another limitation of this study is the low number of partners represented in the interviews. Many mothers did not bring partners with them to Café meetings, making it difficult to include more in this sample. Partners are vital to a mum’s ability to meet her breastfeeding goals, therefore their opinions and experiences related to breastfeeding are necessary to develop a complete understanding of protective factors and barriers to breastfeeding. Future studies should seek to include more partners in their sample.

A third limitation is that the majority of mothers in the study had very young babies. It is not possible to see how protective factors and barriers a mum experiences affects her ability to sustain breastfeeding long-term when her baby is still only a couple of weeks old. Including more mums who have breastfed to six months and beyond would provide a deeper understanding of how mums manage challenges over time, as well as develop confidence and find support.

If I were to conduct further research, I would address the limited population by expanding the study beyond Baby Café participants. Having participants who had not accessed Baby Café services would provide a more representative view of issues faced by breastfeeding mums. Mums could be recruited from other breastfeeding services for comparison, as well as from health clinics and mum groups. I would also seek to include more partners in the study by recruiting these individuals directly, rather than relying on the presence in a Café. This could be achieved by having GPs and hospitals provide information about the study to couples with infants. I would address the age limitations by visiting other child-centered groups, such as mum groups and play groups, where mums with older babies may be more likely visit. This limitation
could also be addressed with a longitudinal study, following mums from their babies’ births through their decision to wean to learn about how challenges change over time.

**Application**

Moving forward, I am taking steps to ensure that my research findings can be used to make positive changes for breastfeeding mums in the UK. I am writing a report for the National Childbirth Trust and Baby Café on my findings, with a focus on how Baby Café and formal supports play a role in a mother’s ability to meet her breastfeeding goals. This report can be used to secure funding for Baby Café locations to stay open and to be open year-round. Demonstrating the positive role Baby Café plays in these women’s ability to sustain breastfeeding is essential to continued funding for each Café location. There has been an increase in the number of Baby Café closures over the past six years (Fox & McMullen, 2018). In 2010, there were 104 Cafés. That number has been steadily dropping, with only 46 Cafés remaining in 2017. Baby Café states the reason for the closings is linked with funding (Fox & McMullen, 2018).

**Recommendations**

Recommendations are made to improve the education, social environment, and knowledge related to breastfeeding. Targeting prenatal courses and breastfeeding support, breastfeeding policy, and breastfeeding data collection are thought to have the largest impact on breastfeeding outcomes. Prenatal courses and breastfeeding support will reach the widest audience of mums, partners, and families. The breastfeeding policy will shape social acceptance for breastfeeding and breastfeeding data collection will provide a more accurate understanding of the current state of breastfeeding in the UK. Finally, recommendations for future studies are developed from topics discovered through conversations with study participants.
Prenatal courses and breastfeeding support. Courses should seek to include more information on the practical reasons for breastfeeding including convenience and cost. Including a section in courses about formula could address the price of formula and sterilization process. This would achieve two goals. First, this may encourage some mothers, who felt breastfeeding was too much of a hassle, to try breastfeeding. Second, it would provide mothers with information on how to safely use formula if they are ultimately unable to successfully breastfeed. During prenatal courses, information on potential breastfeeding difficulties should be presented. Presenting this information would provide knowledge and preparation for some potential problems that may occur and let mums know that these difficulties are normal (Fox et al, 2015; Graffy & Taylor, 2005). However, simply presenting the information prenatally may not be sufficient. Some parents explained that while they did receive adequate information on breastfeeding and challenges, they were not yet at a stage where they internalized this information. As a Café facilitator explained, prenatally, the mums are more concerned with labor and delivery, so some of what is presented is not taken in by the mums. It is important to reiterate breastfeeding information at multiple stages perinatally.

Breastfeeding and prenatal support should seek to include significant others. Educating partners on the realities and difficulties of breastfeeding, as well as ways to support their partners through these difficulties is an important step towards ensuring mums have a supportive home environment for breastfeeding (Mitchell-Box & Braun, 2012). Additionally, there is evidence that partner presence in breastfeeding education programs increases exclusive breastfeeding and decreases formula use (Su & Ouyang, 2016). Partners, in general, are less aware of the benefits of breastfeeding and educating them could have a positive effect on breastfeeding sustainment (Shepherd, Power, & Carter, 2000). Partners should be specifically addressed during these
courses to discuss how they can help to support breastfeeding mums. Partners could be told how to help out around the house, assist with the baby’s other needs, and provide verbal praise for mums trying to breastfeed (Hauck et al., 2016). For partners to take part in prenatal classes and breastfeeding support, it should be made clear they are welcome, and encouraged, to attend. Partner attendance should be promoted on breastfeeding course and Café websites, so partners feel confident they are welcome.

It is important to mobilize all social supports for promoting breastfeeding. Teaching family members how to be supportive of breastfeeding is essential in promoting a positive breastfeeding environment (Negin et al., 2016). Including grandmothers in breastfeeding education is valuable for providing them with an understanding of why breastfeeding is important and how it benefits both mum and baby (Ekstrom et al., 2003). This would allow grandmothers to both foster a positive environment for their daughters’ breastfeeding experience. Further, they would be educated on how to support their daughter if she experiences difficulties instead of suggesting formula (Ekstrom et al., 2003; Negin et al., 2016).

**Equality Act 2010.** The Equality Act 2010 provides protection for mums to breastfeed in public, but many mums are unaware of the policy and what it covers. When asked how to market the Equality Act 2010 to spread awareness, participants described a variety of ways to improve knowledge of the Act. The methods fell into two primary categories. The first was providing information about the policy to business owners and employees through included the Equality Act in preexisting diversity training in the workplace. The second was publicly displaying information about the policy in restaurants and shops to help boost a mum’s confidence in her ability to breastfeed in public. This would be accomplished through stickers on business and restaurant doors to show that businesses promote breastfeeding and posters on the inside of
restroom stall doors so that if a mother has relegated herself to feeding in a bathroom stall, she will see she is within her rights to feed in public. This two-pronged approach would increase the mum’s confidence to breastfeed in public and increase awareness of the policy among businesses to ensure they follow the protections laid out in the Equality Act. Beyond promoting and educating about the Equality Act in its current state, the policy, while a great step in the right direction, is vague. It states that women who are breastfeeding must not be treated “less favourably,” but does not expand upon private versus public businesses, exposure while breastfeeding, or extended breastfeeding. It is important that these topics are explicitly covered to ensure mums feel within their rights to breastfeed their children in public.

**Infant feeding data collection.** The UK is no longer systematically collecting data on breastfeeding beyond hospital initiation. The Infant Feeding Survey was a national survey used to collect data on a myriad of breastfeed-related topics. It was conducted every five years for thirty-five years (NHS, 2012) The survey was sent out to mums at three stages, the first when the baby is 4-10 weeks old, the second at 4-6 months, and the third at 8-10 months. The most recent survey in 2010 had a total of 10,768 mums complete all three stages (NHS, 2012). The survey has been canceled, and there is no longer any national-scale data collection on breastfeeding. A large number of organizations in the UK are dismayed by the canceling of the survey and have spoken out against the decision, stating that the canceling is, “…a move that is shocking and disappointing” (Doula UK, 2014). A coalition of Doulas in the UK posted a statement from Lindsey Middlemiss, the Doula UK spokesperson (Doula UK, 2014). She said

The cancellation of the 2015 Infant Feeding Survey has huge implications for the provision of evidence-based support in the area of infant feeding, and so for the health of the UK. It is symptomatic of how far down the government’s agenda infant feeding has
slipped, despite the huge body of evidence that raising breastfeeding rates is vital to both the NHS and the economy.

The Baby Milk Action network (2016) says it difficult to understand the current rates and challenges associated with breastfeeding after the canceling of the survey. These organizations joined together to urge the UK government to continue the IFS but failed to get them to conduct the survey in 2015 (Doula UK, 2014). Without the valuable data provided by the Infant Feeding Survey, there is no way to know if breastfeeding rates have improved or if the issues mums find challenging have changed over time. To see improvements in breastfeeding outcomes, the UK needs to resume collecting data on breastfeeding. Not only should the original Infant Feeding Survey be recommenced, but the collection of data should be extended to two years post-partum to capture data on extended breastfeeding.

**Future studies.** Future studies on breastfeeding in the UK should seek to include clinical experiences as a central topic. Clinic experiences, such as traumatic births and treatment by medical professionals played a significant role in a mother’s ability to initiate breastfeeding. Additionally, having supportive midwives, health visitors, and GPs helped mothers to sustain breastfeeding. Mums would discuss their delivery experiences as the starting point of their breastfeeding journey, demonstrating how essential this experience is to breastfeeding outcomes. Extended breastfeeding continues to be stigmatized, even among mums who choose to breastfeed. Studies should examine why extended breastfeeding is stigmatized in the UK and develop recommendations for reducing stigma around this topic. Future studies should also seek to compare the breastfeeding experiences of mothers with and without access to Baby Café. For mums without formal support, the breastfeeding experience may be significantly different and cause her to rely on other forms of support to meet her breastfeeding goals.
Public Health Implications

Breastfeeding provides a myriad of benefits to mums and babies; therefore, it is important to consider the implications of factors that decrease breastfeeding in the UK (WHO, 2016). Access to formal support, the presence of stigma against breastfeeding, and the management of tongue-tie in the UK each have social and health implications for breastfeeding mums.

Formal support. Professional breastfeeding support is associated with prolonged breastfeeding and exclusive breastfeeding (McFadden et al., 2017). Mums in this study had access to Baby Café and many stated they used other breastfeeding support services throughout the week. However, in some areas of the UK, there is a significant lack of breastfeeding support sources (Baby Café, 2017). Baby Cafés are largely centered in London and outside of London, Baby Cafés may be as great as three hours distance apart (Baby Café, 2017). In these areas, traveling outside of the local community would be required to find support. Traveling in London is less of a burden due to widely available public transportation, however, traveling with a baby decreases the mum’s ability to seek services outside of her immediate area. Outside of London, public transportation is not as widely available, thus transportation may become an issue for women without local support. Baby Cafés have been closing, with over half of Cafés open in 2010 having been closed by 2017 (Fox & McMullen, 2018). With fewer Baby Cafés, fewer mums have access to ongoing formal support. It is important that funding is directed for breastfeeding support services so that mums continue to have access to services such as Baby Café.

Stigma. Breastfeeding in public is still viewed as taboo in the UK (Boyer, 2011). Ensuring women feel comfortable to breastfeed in public is important because being able to breastfeed outside of the home help mums to sustain breastfeeding. If a mum feels she cannot
breastfeed while running errands, she may decide to switch to a bottle while in public (Boyer, 2018). While mums should be free to make the infant feeding decision that works best for their family, they should not be pressured into making these decisions based on stigma and pressure from the community. Over half of mums in the UK stated in a national survey that they quit breastfeeding before they wanted to (McAndrew et al., 2012). This has serious implications for not only stress and guilt associated with failing to meet breastfeeding goals, but also a loss of the health benefits that could be gained from breastfeeding (Groer et al., 2002; Hauck et al., 2011; U.S. Department of Health and Human Services, 2014; WHO, 2016).

**Tongue-tie.** Tongue-tie is a growing concern for mums in the UK (Fox & McMullen, 2018). While a frenotomy is a routine and quick procedure, many issues surrounded the process of diagnosis and referral. Mums felt frustrated that tongue-tie was not diagnosed earlier and that it was not a part of a routine check before leaving the hospital. Mums felt they would have been able to better establish breastfeeding, had tongue-tie been diagnosed earlier. Receiving a tongue-tie diagnosis required seeking formal assessment, which can be performed by trained lactation consultants or Café facilitators. Mums without access to formal breastfeeding support may be unaware of where to seek a diagnosis outside of waiting for an appointment with the NHS. After a diagnosis is received, the wait time for a frenotomy through the NHS can be too burdensome. This procedure is not considered to be an emergency procedure; therefore, mums may be left waiting to weeks for their baby’s tongue-tie to be corrected. During this time, breastfeeding may become too difficult or painful, leaving the mum with no other option but to switch to pumping or formula (Fox et al., 2016). Private services for frenotomies are available, but this comes at a cost. For some mums, the surgery was a financial burden on their family. While many mums in the study said it was worth the cost to be able to continue breastfeeding, this would not be an
option for every family. This could result in inequalities among mums of varying socio-economic statuses and their ability to sustain breastfeeding. Currently, frenotomies are performed by the tongue-tie division of the UK NHS (Fox et al., 2016). This division is not present in all regions of England (Fox et al., 2016). Frenotomies should be reclassified as a semi-urgent procedure, with maximum waiting times in place. NHS England states, “…the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities” is at the center of the development of their policies (NHS, 2015). However, current policies and practices related to tongue-tie divide women who are financially able to seek private services and those who are not. Tongue-tie checks should become routine in hospital, with immediate referral for cases to be scheduled for the procedure within a maximum wait time period.

**Conclusions**

Mums who breastfeed in the UK are faced with many barriers. The UK is currently promoting breastfeeding but is not giving women the support needed to successfully sustain breastfeeding. Mums who plan to breastfeed are responsible for seeking their own information and must pay hefty sums to attend some breastfeeding courses. In these courses, they are not informed about potential difficulties. Many mums, when they do experience breastfeeding challenges, feel they are responsible for the issues and felt guilt at not being able to provide for their baby as planned. Information should more consistently educate mums on breastfeeding, how it works, what challenges may arise, and where to seek help for issues. Included with this breastfeeding advice should be information on the Equality Act 2010 so that mothers know their rights. This sets mums up, before they even give birth, to be better prepared to breastfeed. When a mum has knowledge about the benefits of breastfeeding, a positive attitude towards
breastfeeding, and determination to succeed, she is more likely to try to overcome difficulties and continue to breastfeed. She is also more likely to advocate for herself if put into situations with partners, friends, family, or clinicians who try to persuade her to stop breastfeeding.

In the hospital, it is essential for mums to get positive, caring, and patient support from health professionals to initiate breastfeeding. Having health professionals who are trained to support breastfeeding can help the mum to achieve her breastfeeding goals by setting her on a path towards sustained breastfeeding. If a mum does not get the help she needs from the very beginning, it is likely breastfeeding will not be successfully initiated and unlikely she will carry on breastfeeding after leaving the hospital. Once a mum is at home, her partner will play the largest role in her breastfeeding experience.

Partners play a significant role, not so much in a mum’s decision to breastfeed, but in her ability to sustain breastfeeding. Therefore, it is important that partners are included in breastfeeding education. It is important that partners are patient and supportive and assist mums with other chores to make breastfeeding possible. The support of friends and family members ensures a positive environment where a mum can stay socially connected while breastfeeding and not feel she has to hide away while feeding her baby. Further, it is even more helpful if these friends and family members have breastfed, so they may provide information about their experiences, empathy for struggling mums, and advice.

For a mum to meet her breastfeeding goals, she should be linked with community resources so she knows where to go if she experiences challenges. Mums without formal support may have to reach out to general practitioners or health providers who are not trained in ways to support breastfeeding. A mum who has access to formal support is able to not only receive technical advice to help her navigate breastfeeding difficulties but also form social networks with
other mums. Armed with a positive individual knowledge and attitudes towards breastfeeding and a supportive partner, friends, and family, the mum is more likely to be confident in her ability to breastfeed, which is linked with sustaining breastfeeding. A positive breastfeeding experience does not have to be perfect. Mums may still experience difficulties and doubts, but having a supportive environment is essential to ensuring they are able to meet their breastfeeding goals. Taken together, the provision of these factors creates a positive breastfeeding environment where a mum is able to overcome difficulties, armed with confidence, knowledge, and the help of a strong supportive network.

Even with each of these challenges addressed, the most significant challenge remains, changing public opinion. For breastfeeding in the UK to improve, the most important change that needs to be made is the stigma around breastfeeding. Breastfeeding must become more socially acceptable. Mums should feel welcome to feed out and about and should be able to feed their older babies without fear of being harassed and receiving negative comments. Shifting public perception requires both significant time and focus. Efforts would be required at every level, from individuals to marketing campaigns, to policy amendments. As one mum smartly described, it will not be until there is a generation who is completely unaware of the stigma that was once associated with breastfeeding, that breastfeeding will become normalized and acceptable.
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Appendix A: University of South Florida Institutional Review Board Approval Letter

2/23/2018

Cheyenne Wagi,

RE: Expedited Approval for Initial Review

IRB#: Pro00032945

Title: Good Mother, Bad Citizen: The Breastfeeding Paradox Experiences of Stigma and Support for Breastfeeding in the UK

Study Approval Period: 2/22/2018 to 2/22/2019

Dear Dr. Wagi:

On 2/22/2018, the Institutional Review Board (IRB) reviewed and APPROVED the above application and all documents contained within, including those outlined below.

Approved Item(s):

Protocol Document(s):

Study Protocol

Consent/Assent Document(s)*:

There are no items to display
*Please use only the official IRB stamped informed consent/assent document(s) found under the "Attachments" tab. Please note, these consent/assent documents are valid until the consent document is amended and approved.

It was the determination of the IRB that your study qualified for expedited review which includes activities that (1) present no more than minimal risk to human subjects, and (2) involve only procedures listed in one or more of the categories outlined below. The IRB may review research through the expedited review procedure authorized by 45CFR46.110 and 21 CFR 56.110. The research proposed in this study is categorized under the following expedited review category:

(1) Clinical studies of drugs and medical devices only when condition (a) or (b) is met: (a) Research on drugs for which an investigational new drug application (21 CFR Part 312) is not required; (b) Research on medical devices for which (i) an investigational device exemption application (21 CFR Part 812) is not required; or (ii) the medical device is cleared/approved for marketing and the medical device is being used in accordance with its cleared/approved labeling.

(2) Collection of blood samples by finger stick, heel stick, ear stick, or venipuncture as follows: (a) from healthy, nonpregnant adults who weigh at least 110 pounds. For these subjects, the amounts drawn may not exceed 550 ml in an 8 week period and collection may not occur more frequently than 2 times per week; or (b) from other adults and children, considering the age, weight, and health of the subjects, the collection procedure, the amount of blood to be collected, and the frequency with which it will be collected. For these subjects, the amount drawn may not exceed the lesser of 50 ml or 3 ml per kg in an 8 week period and collection may not occur more frequently than 2 times per week.

(3) Prospective collection of biological specimens for research purposes by noninvasive means.

(4) Collection of data through noninvasive procedures (not involving general anesthesia or sedation) routinely employed in clinical practice, excluding procedures involving x-rays or microwaves. Where medical devices are employed, they must be cleared/approved for marketing.

(5) Research involving materials (data, documents, records, or specimens) that have been collected, or will be collected solely for nonresearch purposes (such as medical treatment or diagnosis).

(6) Collection of data from voice, video, digital, or image recordings made for research purposes.

(7) Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.
Your study qualifies for a waiver of the requirements for the informed consent process as outlined in the federal regulations at 45CFR46.116 (d) which states that an IRB may approve a consent procedure which does not include, or which alters, some or all of the elements of informed consent, or waive the requirements to obtain informed consent provided the IRB finds and documents that (1) the research involves no more than minimal risk to the subjects; (2) the waiver or alteration will not adversely affect the rights and welfare of the subjects; (3) the research could not practicably be carried out without the waiver or alteration; and (4) whenever appropriate, the subjects will be provided with additional pertinent information after participation.

Your study qualifies for a waiver of the requirements for the documentation of informed consent as outlined in the federal regulations at 45CFR46.117(c) which states that an IRB may waive the requirement for the investigator to obtain a signed consent form for some or all subjects if it finds either: (1) That the only record linking the subject and the research would be the consent document and the principal risk would be potential harm resulting from a breach of confidentiality. Each subject will be asked whether the subject wants documentation linking the subject with the research, and the subject’s wishes will govern; or (2) That the research presents no more than minimal risk of harm to subjects and involves no procedures for which written consent is normally required outside of the research context.

Your study qualifies for a waiver of the requirement for signed authorization as outlined in the HIPAA Privacy Rule regulations at 45CFR164.512(i) which states that an IRB may approve a waiver or alteration of the authorization requirement provided that the following criteria are met (1) the PHI use or disclosure involves no more than a minimal risk to the privacy of individuals; (2) the research could not practicably be conducted without the requested waiver or alteration; and (3) the research could not practicably be conducted without access to and use of the PHI.

As the principal investigator of this study, it is your responsibility to conduct this study in accordance with IRB policies and procedures and as approved by the IRB. Any changes to the approved research must be submitted to the IRB for review and approval via an amendment. Additionally, all unanticipated problems must be reported to the USF IRB within five (5) calendar days.

We appreciate your dedication to the ethical conduct of human subject research at the University of South Florida and your continued commitment to human research protections. If you have any questions regarding this matter, please call 813-974-5638.
Sincerely,

John Schinka, Ph.D., Chairperson
USF Institutional Review Board
Appendix B: Verbal Informed Consent Form

Script for Obtaining Verbal Informed Consent

Overview: Researchers at the University of South Florida (USF) study many topics. To do this, we need the help of people who agree to take part in a research study. We are asking you to take part in a research study that is called: Good Mother, Bad Citizen: The Breastfeeding Paradox - Experiences of Stigma and Support for Breastfeeding in the UK.

Study Staff: This study is being led by Cheyenne Wagi, who is a graduate student at the University of South Florida. This person is called the Principal Investigator. She is being guided in this research by Drs. Jaime Corvin and David Himmelgreen. Other approved research staff may act on behalf of the Principal Investigator.

Study Details: This study is being conducted at Baby Cafe and is supported by the University of South Florida and the National Childbirth Trust. The purpose of the study is to examine the roles of stigma, self-efficacy, and partner support in infant feeding decisions and outcomes. Your participation will require 1 session lasting a total of 30-45 minutes of your time. You will complete a 30-minute interview in which you will be asked about your opinions and experiences related to breastfeeding. Mothers will also complete a short survey about your feelings related to breastfeeding.

Participants: You are being asked to take part because you are a mother who is currently breastfeeding for at least a portion of her infant feeding/you are the partner of a mother who is currently breastfeeding for at least a portion of her infant feeding/you are a breastfeeding professional.

Voluntary Participation: Your participation is voluntary. You do not have to participate and may stop your participation at any time. There will be no penalties or loss of benefits or opportunities if you do not participate or decide to stop once you start. Alternatives to participating in the study include: not participating.

Benefits, Compensation, and Risk: We do not know if you will receive any benefit from your participation. There is no cost to participate. You will not be compensated for your participation. This research is considered minimal risk. Minimum risk means that study risks are the same as the risks you face in daily life. You may face some discomfort in some of the questions I will ask related to breastfeeding.

Confidentiality: Even if we publish the findings from this study, we will keep your study information private and confidential. Anyone with the authority to look at your records must keep them confidential.
We will not pay you for the time you volunteer while being in this study.

We must keep your study records as confidential as possible. We may publish what we learn from this study. If we do, we will not let anyone know your name. We will not publish anything else that would let people know who you are. However, certain people may need to see your study records. By law, anyone who looks at your records must keep them completely confidential. The only people who will be allowed to see these records are:

- The research team, including the Principal Investigator, the Advising Professors, and all other research staff.
- Certain government and university people who need to know more about the study. For example, individuals who provide oversight on this study may need to look at your records. This is done to make sure that we are doing the study in the right way. They also need to make sure that we are protecting your rights and your safety.
- The University of South Florida Institutional Review Board (IRB) and the staff that work for the IRB. Other individuals who work for USF that provide other kinds of oversight may also need to look at your records.
- The Department of Health and Human Services (DHHS).
- The National Childbirth Trust

If you have any questions about this study, you can contact the investigator Cheyenne Wagi at crwagi@mail.usf.edu or +1 336-337-9579. If you have question about your rights as a research participant please contact the USF IRB at (813) 974-5638 or by email at RSCH-IRB@usf.edu.

Would you like to participate in this study? [PI will record if verbal consent is given]
Appendix C: BSES-SF Permission of Use

BSES-SF Request

Cindy-Lee Dennis <cindy.lee.dennis@utoronto.ca>
To: Cheyenne Wagi <crwagi@mail.usf.edu>
Cc: "Himmelgreen, David" <dhimmelg@usf.edu>, "Corvin, Jaime" <jcorvin1@health.usf.edu>

Dear Cheyenne,

Thank you for your email and interest in my Breastfeeding Self-Efficacy Scale. Attached is the short-form that you can use in your research project. Good luck with your studies. Please let me know if you have any questions.

Warm regards,

Cindy-Lee Dennis

Cindy-Lee Dennis, PhD
Professor in Nursing and Medicine, Dept. of Psychiatry
Canada Research Chair in Perinatal Community Health
Women's Health Research Chair, Li Ka Shing Knowledge Institute, St. Michael's Hospital
University of Toronto
155 College St
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www.cindyleedennis.ca

Mothering Transitions
RESEARCH

From: Cheyenne Wagi [mailto:crwagi@mail.usf.edu]
Sent: October 26, 2017 6:20 PM
To: Cindy-Lee Dennis <cindy.lee.dennis@utoronto.ca>
Cc: Himmelgreen, David <dhimmelg@usf.edu>; Corvin, Jaime <jcorvin1@health.usf.edu>
Subject: BSES-SF Request

https://mail.google.com/mail/u/1?ui=2&ik=d50f7a5ac5j&isonboard=1&oi=fwin&sa=m&rs=None&pli=1&fs=1&source=icon&chld=IN&mv=1&shd=1&ssel=1&spell=0&itabloid=1606509dd59532956&q=cindy.lee.dennis%40utoronto...... 1/1
Appendix D: Interview Guide – Mum

Introduction
1. Can you tell me a little bit about yourself (where you’re from, how many children you have, in a relationship, etc.)
2. How old is your youngest child?
3. How did you plan to feed your baby before they were born?
4. How do you feed them now?
5. What contributed to your decision?
6. What do you think will be helpful to you in meeting your breastfeeding goals?
7. Are you aware of if your mother breastfed you or your siblings?
8. How do you think other people in the UK feel about breastfeeding?
   i. How about your friends and family? Is there an expectation that mothers will breastfeed?

Specifics
9. How do people feel about breastfeeding in public?
   i. Why do you think that is?
10. Have you ever breastfed in public?
    i. If no, what discouraged you from breastfeeding in public?
    ii. Would anything make you change your mind about public breastfeeding?
    iii. If yes, what was that experience like?
    iv. What contributed to your decision to/not to breastfeed in public?
    v. When would you breastfeed in public/when would you not breastfeed in public?
    vi. Would you breastfeed in public in the future?
11. How does your significant other feel about your infant feeding decision?
12. How does your significant other feel about breastfeeding?
    i. How does your significant other feel about breastfeeding in public?
13. How you have you felt about breastfeeding in front of your partner? Family? Strangers/in public?
14. Have you ever been asked to leave a restaurant, shop, movie theater, or other public places because you were breastfeeding?
    i. Could you tell me about that experience?
15. How would you react if you were asked to leave a restaurant, movie theater, shop, or other public places because you were breastfeeding?
16. Are you aware of any policies that protect your right to breastfeed in public?

Recommendations
17. What do you think about the public breastfeeding policy? Do you think there is a general awareness of this law?
18. What would be most helpful to you in terms of standing up for your right to breastfeed in public?
19. What do you think would help reduce stigma or discomfort surrounding breastfeeding in public?
20. Are there any types of support you wish you had?
Appendix E: Interview Guide – Partners

Introduction and general
1. What do you think is the general expectation for infant feeding in the UK?
2. How do you think people in the UK feel about breastfeeding?
3. Is there any stigma or discomfort associated with breastfeeding in the UK?
4. How did you and your significant other decide how you were going to feed your baby?

Public Breastfeeding
5. Does the general public think it okay for mums in the UK to breastfeed in public?
6. Has your significant other ever breastfed in public? Were you with them at the time?
   i. Could you tell me about that experience?
   ii. What were the reactions of those around you?
   iii. How did you feel during this experience?
7. Has your significant other ever been asked to leave a restaurant, shop, movie theater, or another public place because she was breastfeeding?
8. How would you respond if your significant other were asked to leave a restaurant, movie theater, shop, or another public place because you were breastfeeding? How likely would you both be to leave?
9. Are you aware of any policies that protect the right to breastfeed in public? Are you aware of what the policy states?
   i. Do you agree with what this policy states?
   ii. Do you think there is a general awareness of this law?

Recommendations
10. What do you think would help your significant other to meet their breastfeeding goals?
11. What do you think would help reduce discomfort surrounding breastfeeding in public?
Appendix F: Interview Guide – Café Facilitator

Expectations and Stigma
1. What do you think is the general expectation for infant feeding in the UK?
2. How do people in the UK feel about breastfeeding?
3. How do people in the UK feel about breastfeeding public?
4. Is there stigma or discomfort associated with breastfeeding in the UK?
5. How often do you hear mums’ express concerns about breastfeeding stigma?
   a. What are these concerns?
   b. What advice do you give to mothers who express these concerns?
6. How often do you hear mums’ express concerns about their partner not supporting them in breastfeeding?
   a. What are these concerns?
   b. What advice do you give to mums who express these concerns?

Recommendations
7. Are you aware of any policies that protect the right to breastfeed in public?
8. What do you think about this policy?
9. Do you think there is a general awareness of this law?
10. What do you think helps mums to meet their breastfeeding goals?
11. What do you think would help reduce stigma/discomfort surrounding breastfeeding in public?
12. What do you think would be most beneficial to mums to help them feel comfortable to breastfeed in public?