Research Report:

Exploratory Research Regarding Infant Feeding Attitudes and Behaviours

Prepared For:
Department of Health & Ageing

Contacts:
Dale Osborne
Lucy Economus
Liz Sparham

May 2009
Contents

Acronyms .......................................................................................................................... 1
Definitions ............................................................................................................................ 1
1. Executive Summary ........................................................................................................ 2
   1.1 Background ................................................................................................................ 2
   1.2 Research Design ....................................................................................................... 2
   1.3 Project Objectives .................................................................................................... 3
   1.4 Key Findings ............................................................................................................ 3
   1.5 Recommendations .................................................................................................. 11
Background and Methodology ............................................................................................ 14
2. Background and Objectives ............................................................................................ 15
   2.1 Research Objectives ............................................................................................... 16
3. Research Design ............................................................................................................. 18
   3.1 Pregnant Women, Mothers, Partners and Grandmothers ........................................ 19
   3.2 Health Professionals and Influencers ...................................................................... 22
Detailed Research Findings from Mothers, Pregnant Women, Partners and Grandmothers ..................................................................................................................... 24
4. Top of Mind Associations with Infant Feeding ............................................................... 25
4. Top of Mind Associations with Infant Feeding ............................................................... 25
5. The “Journey” - Pregnancy to Infancy ......................................................................... 26
   5.1 Pre-natal/Pregnancy Stage ....................................................................................... 26
   5.2 Birth/In Hospital Stage ............................................................................................ 29
   5.3 At Home Stage – The First Two Weeks .................................................................. 34
   5.4 One to Three Months Stage .................................................................................... 38
   5.5 Three to Six Month Stage ....................................................................................... 41
   5.6 Over Six Months ..................................................................................................... 43
6. Cultural Differences ........................................................................................................ 45
7. Summary of Key Differences Between Committed and Non-Exclusive / Lapsed Breastfeeders .................................................................................................................. 47
8. Summary of Perceived Benefits of Breastfeeding & Formula Feeding ....................... 49
9. Awareness and Perceptions of the ABA ...................................................................... 51
10. Awareness and Reactions to the Guidelines ................................................................. 52
10.1 Reactions to Exclusive Versus Non Exclusive Breastfeeding ............ 52
10.2 Knowledge of Guidelines ................................................................. 52
10.3 Reactions to Presented Benefits of Exclusive Breastfeeding ............. 54
Detailed Findings from Health Professionals ........................................ 58
11. Interaction with Health Professionals Regarding Feeding ................... 59
11.1 GP Involvement .................................................................................. 60
11.2 Midwives/Antenatal/Maternity Nurses’ Involvement ............................. 61
11.3 Child Health Nurse Involvement ......................................................... 63
11.4 Lactation Consultants’ Involvement .................................................... 65
11.5 Family Support Nurses’ Involvement .................................................. 67
11.6 Indigenous Health Workers’/CALD Workers’ Involvement .................... 68
11.7 ABA Involvement ................................................................................ 70
12. Health Professionals’ Awareness of and Reactions to Guidelines ............ 72
12.1 Knowledge of Guidelines .................................................................... 72
12.2 Understanding of ‘Exclusive’ Breastfeeding ......................................... 72
12.3 Goals/Target Rates for Breastfeeding .................................................. 73
13. Health Professionals’ Reactions to the Presented Benefits ...................... 75
Conclusions and Recommendations ....................................................... 77
14. Conclusions and Recommendations .................................................... 78
Appendices .................................................................................................. 88
15. Appendices ............................................................................................ 89
15.1 Detailed Research Design ................................................................. 89
15.2 Infant Feeding Topic Guide - Mothers .................................................. 94
15.3 Health Professional and Influencer Topic Guide .................................... 101
15.4 Infant Feeding Topic Guide – Partners (Existing dad/parent) ............... 105
15.5 Infant Feeding Topic Guide - Partners (of pregnant women – with no other children) ................................................................. 112
15.6 Infant Feeding Topic Guide - Pregnant Women, First Child ................. 117
15.7 Infant Feeding Topic Guide - Pregnant Second or Subsequent Child .... 122
15.8 Infant Feeding Topic Guide – Grandmothers of Children Under Two. 128
15.9 Show cards ....................................................................................... 136
15.10 Screener questionnaire ................................................................. 137
Acronyms

ABA    Australian Breastfeeding Association
BFHI   Baby Friendly Health Initiative
PND    Post Natal Depression
GP     General Practitioner

Definitions

The following terms have been used in this report:

Family Support Nurse including Tresillian, Karitane, Ngala, Torrens House and Child and Family Health Service Nurses

Child Health Nurse including Early Childhood Centre Nurse (NSW), Maternal and Child Health Nurses (VIC), Child and Youth Health Nurses (SA) and Child Health Nurses (WA)

Exclusively or fully breastfed Breastfed with no other food or milk given
1. Executive Summary

1.1 Background

Breastfeeding brings a range of long and short-term health benefits for both mother and baby. Australia’s dietary guidelines\(^1\) recommend exclusive breastfeeding until six months of age with continued partial breastfeeding after the introduction of solids until 12 months - and beyond if the mother and infant wish. Although 92% of mothers start breastfeeding immediately after the birth of their baby, there is a steep decline in breastfeeding thereafter with only 80% of infants fully breastfed at one week of age. At three months of age only 56% of infants are fully breastfed and this reduces to 28% at five months of age and 14% at six months of age\(^2\).

Therefore, the Department of Health and Ageing saw a need to further explore infant feeding attitudes and experiences, in order to understand how decisions about infant feeding are made and what barriers and enablers influence breastfeeding initiation, continuation and cessation.

1.2 Research Design

The research design consisted of 30 mini-groups and 32 depth interviews with pregnant women, mothers, partners and grandmothers, six paired depths with couples, 52 depth interviews with health professionals and one mini-group with Australian Breastfeeding Association (ABA) counsellors. The fieldwork took place in New South Wales, Victoria, Western Australia and South Australia.

---


1.3 Project Objectives

The fundamental objectives of the research were to:

✔ explore the attitudes and experiences of breastfeeding amongst pregnant women, mothers, partners, grandmothers and health professionals,
✔ identify the enabling factors and barriers that contribute to decisions about initiation, continuation and cessation of breastfeeding,
✔ explore the support strategies and advice that women obtain,
✔ explore the attitudes of health professionals, the advice they provide and their level of confidence in providing this advice, and
✔ investigate the levels of training available to/attained by health professionals advising on breastfeeding.

1.4 Key Findings

Attitudes and Experiences, Enablers and Barriers

The research has indicated that whilst the majority of women intend to breastfeed prior to birth, and many in fact do succeed, women’s attitudes, expectations and experiences understandably change and evolve, as they move from pregnancy through to the time that the child is around six months old.

This report describes in full the ‘journey’ from pregnancy to infancy, and the attitudes and experiences of the mothers and those around them, and this is summarised on the following pages.
Pregnancy

Whilst pregnant, almost all of the women interviewed had a high expectation that they would like to breastfeed and that they would at least “give it a go”. There was a general perception that “breast is best” without any real understanding of what the benefits were. A small number had decided they would not breastfeed before giving birth, with barriers to initiating breastfeeding being more present in younger mothers. These younger women were concerned about changes to their breast shape, breastfeeding not being “sexy”, and not being able to leave the baby with others when they went out.

Birth/Hospital

Whilst as mentioned, most wanted to try to breastfeed, and many were successful, the barriers to continuing breastfeeding in hospital were mainly physical – pain, difficulties latching on, inverted nipples or the baby having a physical problem such as a tied tongue. A small number did not start breastfeeding at all in hospital, mainly due to medical reasons.

There was a high degree of hands on help available in hospitals, from Midwives and Lactation Consultants, however it seemed the mother’s own prior level of commitment to breastfeeding and firm belief in it as the best and most natural option often played a strong role in overcoming the initial physical problems.

However, for those who were initially committed and found they still simply could not achieve it, there was a high level of disappointment, as well as feelings of failure as a mother.

First Two Weeks at Home

Many mothers experienced further difficulties on leaving hospital, some having returned home after only two or three days, before breastfeeding could be established. The physical difficulties, combined with lack of sleep, inexperience
and anxiety were difficult to cope with for the mother. This resulted in some of the partners and other family members such as grandmothers also feeling stressed and concerned for both mother and baby.

It was at this time of weakened resolve that the mother could be encouraged to try formula by partners or family members, as it was perceived to offer a solution to the problems with breastfeeding, and which to many did not have a major downside.

Some acknowledged that formula might not be quite as good for the baby as breast milk, but felt the trade off in relieving the stress was worth any small disadvantage.

**One to Three Months**

Whilst most had settled into a routine after a month or so, others still needed some help and encouragement to keep going; particularly the less committed who were not enjoying the experience of breastfeeding.

Many of those lapsing between one and three months did not know what the benefits of exclusive over partial breastfeeding were, and they therefore tended to easily lapse into a mix of formula (perhaps at night to "settle" the baby), and a bit of breast milk during the day when it was more convenient, feeling that they were still providing the child with some benefit from breast milk.

**Three Months and Over**

After three months of feeding mothers were generally in a routine, and if still breastfeeding would continue to do so unless it became inconvenient due to a change in lifestyle such as a return to work or simply wanting to get out more and socialise. Often a change in perceived feeding needs for the baby was an influence on breastfeeding continuation, such as the introduction of solids or the baby teething.
As the baby grew older, external factors became a greater influence, with some mothers lapsing because they did not like breastfeeding in public. They felt there was often a lack of facilities such as feeding rooms they could use, and sometimes the workplace made expressing breast milk difficult.

In addition, the lack of awareness and confusion about how long to exclusively breastfeed led some to believe they had done enough to give the baby a good start in life and it was time to move on.

**Differences in Commitment**

Whilst this study was qualitative and therefore not definitive in a proportionate sense, our observations suggest that the more committed breast feeders were more likely to be slightly older, have achieved higher levels of education, and from higher socio-economic areas. They tended to have prepared themselves to a greater degree, reading more and sourcing information online.

Mothers committed to breastfeeding seemed prepared to try much harder than others when there were physical difficulties. They had also built up better support systems amongst friends and family or had educated themselves about where to go for help and advice.

Their commitment seemed to be more often based on the strong general belief that a "natural" approach was best, and whilst they were not all aware of the detailed health benefits of breastfeeding, they did tend to believe that it helped "boost the immune system" of the baby. The benefits to the mother were seen to be more about the better nurturing/bonding aspect, rather than the specific health aspects.

The less committed were more likely to be in the lower socio-economic group, and younger. Some of the less committed were openly concerned about body appearance issues, but the majority reported physical difficulties in the first few
weeks that had been too hard to overcome. To these people formula feeding offered a very appealing option, sometimes in fact being suggested to them by their mothers or partners.

Formula was seen to offer advantages in that it allowed the father and others to also have that feeding/bonding experience. It was seen to enable baby, and subsequently the mother, to have longer sleep periods, which allowed for a more relaxed relationship between the mother and those around her. It was convenient in that it could be administered anywhere and was socially widely accepted. Mothers also felt more certainty in "knowing how much" the baby was getting.

However there were many mothers who were initially very committed, but who had simply not been able to overcome physical difficulties or access the sort of help they might have needed.

Awareness of the Guidelines and Specific Health Benefits

Most mothers and partners were not aware of any set guidelines about breastfeeding, but there was overall understanding in a general sense that "breast" was thought to be "best".

There was also little awareness of the range of specific health benefits which were shown as stimulus in the research, with the exception of ‘breastfeeding helps protect against diarrhoea, respiratory and ear infection in babies’, which some mothers admitted a vague awareness of. They specifically mentioned the breastfeeding benefit of strengthening “immunity” or giving “antibodies”, and associated this with the respiratory aspect, and the impact on asthma prevention.

This was also the most motivating benefit out of the three shown, as it was believable and offered a short-term, more tangible reason to breastfeed their baby exclusively.
Support and Advice Sought

The type of information, advice and support used also varied according to the stage the mother was at in the “Journey” from pregnancy through to toddler stage, as follows:

Pregnancy

Whilst pregnant, most women were very focussed on the birth rather than how they were going to feed their baby. Therefore detailed information about breastfeeding was not generally sought out during pregnancy. They did obtain some information from antenatal classes, however there was not a great deal of specific feeding information given in these classes and many mothers and partners could not recall many details.

Most had simply an idea that “breast is best”, but they did not necessarily know where they had heard or read this, and assumed it had come by word of mouth through friends or relatives.

Birth/Hospital

Mothers received a lot of advice and hands on practical help with trying to breastfeed during their time in hospital. Hospital Midwives were crucial in being a source of understanding and help, however there was evidence that often their advice was contradictory and sometimes insensitive. Some mothers were also referred to Lactation Consultants in hospitals if there were serious problems with breastfeeding.

In hospital mothers did have some time to read magazines, pamphlets and in particular the ‘Bounty Bag’ information, which could be used to give advice, help build commitment and also provide some hints about where to go for help on their return home.
First two weeks

The first couple of weeks after the birth was a crucial time in the continuation of breastfeeding, and one in which there were many problems as the mother tried to cope with life back at home without the level of help available at hospital. Hands-on external advice from visiting Midwives, Child Health Nurses or in a few cases Lactation Consultants was an important element in helping the mother keep going with breastfeeding, but not all could access these at the time they were needed most.

One to three months

Many mothers had a check up for their babies at six to eight weeks, but these visits were rarely mentioned as a source of breastfeeding advice and support if there were any issues.

Mothers’ groups increased in importance as a source of peer advice and support as the babies grew older, but were often seen as the “blind leading the blind“.

Some of those who did have problems mentioned using a private Lactation Consultant or a Family Support Centre to gain advice and support. However, these avenues were not seen as being very accessible, if indeed mothers were aware of their existence, and many women encountering problems simply switched to formula, rather than persevering through problems.

Three months and over

At three months and over most mothers did not look for external advice and support, unless a serious problem had arisen with feeding, settling or sleeping. Mothers either tended to have breastfeeding well established by three months or they had moved to formula if problems had occurred earlier. There were not many who were encountering problems and still breastfeeding by this time.
Those who did have a serious problem may have gone to a Family Support Centre, but this needed a referral from another health professional. Most obtained information from their friends and extended family, as well as their mothers’ group if they were part of one, about when to move onto solids and stop breastfeeding.

**Health Professionals: Attitudes, Advice and Training**

There was a range of involvement by health professionals with regards to infant feeding, from General Practitioners (GPs) who had less involvement but were readily accessible, through to Lactation Consultants who could have a great deal of involvement, but were fewer in number.

Most health professionals felt confident giving advice and support for breastfeeding, however some health professionals reported some wrong information being given by GPs and some 'old-fashioned' or 'conflicting' information being given by Midwives. Some felt that GPs in particular should be referring on to other health professionals with more specific skills and experience in breastfeeding. There were also differences of opinion between breastfeeding influencers, for example between ABA counsellors and Child Health Nurses on babies’ expected weight gain and sleeping and settling advice.

Knowledge of the various guidelines for breastfeeding (for example WHO, Australia’s dietary guidelines, Baby Friendly Health Initiative (BFHI), Area Health Service guidelines) varied a great deal depending on type of health professional, with Lactation Consultants, Family Support Nurses and ABA Counsellors seemingly the most knowledgeable.

The introduction of the BFHI was seen as a huge influence over hospitals’ policies and procedures for breastfeeding. Most health professionals felt that this was a very positive development, although a small minority mentioned that they were concerned about not feeling able to talk about formula in hospital.
A number of health professionals were unsure of the recommended timeframe for exclusive or partial breastfeeding and most of those who did know, did not appear to adequately convey the timeframe to mothers. In addition, many could not express what the added benefits were of exclusive breastfeeding over non-exclusive breastfeeding. However, most were aware of the benefits breastfeeding presented and they felt that they were credible, with the benefit of 'breastfeeding protecting against diarrhoea, respiratory and ear infections in babies' expected to be the most persuasive to mothers.

Many health professionals reported a lack of timely access to support services - particularly in the first two weeks after leaving hospital. It was difficult for Child Health Nurses to visit frequently enough and waiting times for Family Support Nurses were seen as being too long at present, with many mothers giving up breastfeeding before they could get the help they needed.

The ABA was seen as being a valuable resource but face-to-face support was valued over telephone contact.

1.5 Recommendations

Outlined below are the main recommendations based on the findings of this study, which will better encourage and enable women to breastfeed for the suggested time period, along with supporting rationale.

It is worth noting however, that whilst the general direction and detail of the findings can be viewed with confidence, because of the nature of the qualitative technique they do not reflect a statistically accurate analysis, and some care therefore has to be taken in exact interpretation or extrapolation.

1. **Implement social marketing activities** to normalise breastfeeding, increase commitment to breastfeeding, dispel myths associated with breastfeeding and promote the benefits of breastfeeding.
2. Encourage and support commercial entities and employers to provide facilities and implement policies that support breastfeeding.

3. Promote breastfeeding and its benefits through antenatal classes. Classes should include information on common difficulties associated with breastfeeding, and identify how to access help and support.

4. Utilise ‘Bounty Bags’ provided to new mothers to distribute information and resources on breastfeeding, including information on common difficulties associated with breastfeeding and where to access help and support for overcoming difficulties. Also provide information for partners and family members about how they can give support.

5. Increase support services for new mothers at home during the first weeks following birth, including greater access to Child Health Nurses and Lactation Consultants.

6. Promote the importance of exclusive breastfeeding, and convey information on how long this should be maintained and when to introduce solids and other liquids.

7. Conduct an audit of breastfeeding-related education and training provided to Midwives, Maternity Nurses, Lactation Consultants and other health professionals to ensure information provided to mothers is consistent. Review and monitor training on a regular basis.

8. Provide GP’s and other health professionals with guidelines, information and other resources to assist them to promote and support breastfeeding. Encourage GP’s and other health professionals to refer mothers to other sources of help and support where required.

9. Explore options for utilising Lactation Consultants to provide education and training to other health professionals, particularly in maternity settings.
10. Conduct further research on specific CALD awareness and attitudes regarding breastfeeding.
Background and Methodology
2. Background and Objectives

The long and short-term health benefits obtained by breastfeeding, for both mother and baby, have been publicised widely. Research has shown that breast milk helps to protect the baby against a range of conditions including diarrhoea, respiratory and ear infections, as well as obesity and chronic diseases in later life. It also provides some protection to mothers in terms of reducing the risks of breast cancer, ovarian cancer, type 2 diabetes and osteoporosis.

Australia’s dietary guidelines recommend exclusive breastfeeding of infants until six months of age and the introduction of solid foods at around six months, with continued breastfeeding until the age of 12 months – and beyond if mother and infant wish. The World Health Organisation (WHO) actually recommends that children across the world be fed some breast milk for at least two years.

The Longitudinal Study of Australian Children found that 92% of children were breastfed at birth, but only 80% of infants were fully breastfed at one week of age. At three months of age, only 70% of infants were receiving some breastmilk and less than 60% were fully breastfed. At six months of age less than 55% of infants were receiving any breastmilk. This means that many Australian babies, and mothers, are missing out on the important short and long-term health benefits associated with breastfeeding.

There have been many initiatives to try to encourage breastfeeding and support mothers to do so. For example, the Baby Friendly Hospital (or Health) Initiative (BFHI) by UNICEF and WHO launched in 1991 has now been successfully

---


implemented in many hospitals across Australia, the Australian Breastfeeding Association (ABA) continues to provide support and publicise the benefits of breastfeeding and there is now a 24-hour toll-free national helpline to provide breastfeeding information and support.

However, the issues around breastfeeding have been shown to be complex, including factors at an individual, group and societal level. What health professionals say, what a woman’s partner thinks, and what the community around her thinks are just some of the factors that can influence a mother’s decision to breastfeed. Additionally, how her baby responds to it, the provision of breastfeeding support and going back to work can have an effect on the duration of breastfeeding. There is also a lot of guilt and emotion associated with this issue.

Therefore, there was a need to explore further infant feeding attitudes and experiences in order to understand how decisions about infant feeding are made and what barriers and enablers influence breastfeeding initiation, continuation and cessation.

2.1 Research Objectives

The objectives of the research were to:

- explore attitudes towards infant feeding amongst mothers, pregnant women, partners, grandmothers and health professionals,
- explore breastfeeding experiences of mothers and partners,
- explore the enabling factors and barriers that contribute to women’s decisions about the initiation, continuation and cessation of breastfeeding,
- explore the support strategies, networks and professional advice that women obtain while pregnant and/or breastfeeding; the points at which they engage with these, and the reasons why,
• explore the advice that different health professionals provide about breastfeeding, and their level of confidence in providing this advice, and
• investigate the levels of training available to/attained by health professionals advising on matters relating to breastfeeding.
3. Research Design

This study was exploratory in nature, and therefore conducted qualitatively, with a mix of techniques including group discussions and individual and paired in-depth interviews.

As a relatively robust qualitative study, the general direction and detail of the findings can be viewed with confidence, however because of the nature of the technique they do not reflect a statistically accurate analysis, and some care therefore has to be taken in exact interpretation or extrapolation.

Primarily, the study was conducted to uncover overall attitudes and behaviours of mothers and influencers of mothers, regarding infant feeding. The structure of the research therefore reflected this with the groups being split firstly according to their breastfeeding commitment, as well as by age, and whether they were first time or experienced mothers, to understand any variances in needs. A spread of socio-economic groups was achieved by using a range of geographic areas, and other groups such as working mothers and single mothers were specifically split out in a small amount of more targeted work. Pregnant women were not recruited on their intention to breastfeed or not as initiation rates of breastfeeding are high, so these participants were recruited according to age and first/subsequent children.

It was also important to talk to those who had not breastfed exclusively, or who had lapsed or never breastfed, separately from those who did breastfeed relatively exclusively, to allow these people to be more open in talking comfortably about their reasons.

It was important to create the most relaxed and comfortable environment possible for participants to be able to feel free to express some of the more complex and powerful emotions associated with parenthood and breastfeeding. For this reason a mix of mini-group discussions and paired and individual in-depth interviews were conducted at times and in places that were suitable for
participants, including some in home sessions. Mini group discussions allowed for greater coverage of subgroups and they also let people talk about their individual feelings to a greater degree than in a full group. Depths were included to enable exploration of some of the personal barriers and motivators to breastfeeding.

The facilities used for the groups were baby friendly, that is where necessary babies were able to be brought to the groups, and times and places were planned around the mothers’ needs.

The brief specified that the project should include research with pregnant women, mothers and partners. However, it was decided that a small number of grandmothers should also be included as they also have an influence on mothering practices.

3.1 Pregnant Women, Mothers, Partners and Grandmothers

30 mini-groups, 32 depth interviews and six paired-depths were conducted with pregnant women, mothers, partners and grandmothers. More detailed tables are supplied in the appendix.

Mothers were a mix of committed breastfeeding, non-exclusive or lapsed breastfeeding and people who had never breastfed. Participants were asked to self-report this information. Definitions are included below.

**Recruitment Definitions:**

*Committed* = breastfed exclusively or almost exclusively for at least the first six months

*Not exclusive* = started breastfeeding but did not do it exclusively for the first six months
Lapsed = started breastfeeding but switched to bottle feeding before the end of the first six months

Never = did not start breastfeeding (or tried in the first week but stopped)

Recruitment was carried out through a network of professional recruiters in the areas specified above. The recruitment screener is included in the appendix.
Six paired-depth interviews also took place with couples who were committed breastfeeders, non-exclusive/lapsed breastfeeders and pregnant couples.

The mothers and pregnant women ranged in age from under 25 to over 35. All mothers had one child or more who was less than two years old so that infant feeding experiences were recent.

All grandmothers had one grandchild or more who was less than two years old.

All pregnant women included in the research were at least five months pregnant so that they were past the common danger period and would feel more relaxed and confident about the pregnancy and discussing feeding issues.

Partners were either fathers or had a pregnant partner. Fathers had one child or more who was less than two years old, and there was a mix of partners who were committed breastfeeders and non-exclusive/lapsed breastfeeders.

Research with these groups was conducted across four states, including urban, regional and rural areas, to give a good range geographically - in New South
Wales (Sydney, Cowra), Victoria (Melbourne, Ballarat), Western Australia (Perth, Bunbury) and South Australia (Adelaide, Murray Bridge).

### 3.2 Health Professionals and Influencers

Amongst health professionals and influencers, in-depth interviews conducted by appointment were considered the best approach due to the difficulties involved with trying to set up groups with these audiences. In-depth interviews also allowed for a good spread of geographic areas and types of health centre or hospital.

Health professionals and influencers who had an influence on the mother in pregnancy, in hospital, and at home after the birth were included. For the hospital related work it was ensured that a mix of public and private hospitals were included.

The coverage of the health professionals was fine-tuned following a first wave of exploration with the pregnant women, mothers and partners.

One mini-group was conducted with ABA counsellors and 52 depth interviews were conducted with other health professionals. More detailed tables are supplied in the appendix.

**Table 2: Specification for Health Professionals and Influencers**

<table>
<thead>
<tr>
<th>Profession</th>
<th>Mini Groups</th>
<th>Depths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialists/GPs</td>
<td>-</td>
<td>6</td>
</tr>
<tr>
<td>Midwives/Maternity Nurses</td>
<td>-</td>
<td>10</td>
</tr>
<tr>
<td>Lactation Consultants</td>
<td>-</td>
<td>5</td>
</tr>
<tr>
<td>Antenatal Class Organisers</td>
<td>-</td>
<td>4</td>
</tr>
<tr>
<td>Child Health Nurses*</td>
<td>-</td>
<td>8</td>
</tr>
<tr>
<td>Practice Midwives and Nurses</td>
<td>-</td>
<td>5</td>
</tr>
<tr>
<td>Family Support Nurses**</td>
<td>-</td>
<td>4</td>
</tr>
<tr>
<td>ABA Counsellors</td>
<td>1</td>
<td></td>
</tr>
</tbody>
</table>
Research with these groups was conducted across four states, including urban, regional and rural areas, to give a good range geographically - in New South Wales (Sydney, Cowra), Victoria (Melbourne, Ballarat), Western Australia (Perth, Bunbury) and South Australia (Adelaide, Murray Bridge).

* Child Health Nurses are called different names in different states, for example Early Childhood Centre Nurses (NSW), Maternal and Child Health Nurses (VIC), Child and Youth Health Nurses (SA) or Child Health Nurses (WA). In this report they will be referred to as Child Health Nurses.

** Family Support Nurses are called different names in different states, for example Tresillian/Karitane Nurses (NSW), Ngala Nurses (WA), Torrens House Nurses (SA), Child and Family Health Service Nurses (VIC). In this report they will be referred to as Family Support Nurses.

The discussion guides are included in the appendix.
Detailed Research Findings from Mothers, Pregnant Women, Partners and Grandmothers
4. Top of Mind Associations with Infant Feeding

At the commencement of the mini-group discussions and depth interviews with mothers, pregnant women, partners and grandmothers, participants were asked to indicate words that “first come to mind” regarding breastfeeding and formula feeding.

The most common words associated with breastfeeding were positive associations such as ‘bonding’, ‘good/better’ (than formula), ‘healthy’ and ‘free’. Other common words mentioned were ‘nutrients’, ‘antibodies’ and ‘immunity’, showing that participants did have some knowledge about the benefits of breastfeeding, as well as ‘natural’, ‘normal’, ‘convenient’, ‘easy’ and ‘cheap’. There were also some negative words which highlighted the difficulties that some participants had experienced with breastfeeding, such as ‘hard’, ‘difficult’, ‘painful’, ‘hurt’, ‘frustrating’ and ‘stressful’.

The most common words associated with formula feeding were a mix of both positive and negative aspects including words such as ‘preparation’, ‘sterilising’, ‘easy’, ‘convenient’, ‘shared’, ‘help’, ‘cost’ and ‘expensive’. Later in the discussions participants often mentioned that with formula they know how much the baby is getting, that other people can share the feeding to give the mother a break, that it seems to fill baby up more so they are more likely to sleep through the night and that it is more accepted to feed baby in public using bottles. These ideas were reflected in the commonly mentioned words such as ‘relief’, ‘break’, ‘fills baby up’, ‘know amount’, ‘longer/good night’s sleep’, ‘comfortable in public’ and ‘accepted’.
5. The “Journey”- Pregnancy to Infancy

The main findings of the report have been set out under headings that reflect the journey that mothers experience from pregnancy to infancy.

**Figure 1: The Journey From Pregnancy to Infancy**

5.1 Pre-natal/Pregnancy Stage

The pre-natal/pregnancy stage was a time, when perhaps not surprisingly, most mothers were more concerned with the impending birth of the baby (particularly the highly anticipated pain of childbirth) and their baby being born healthy, rather than about how they would feed their baby when he or she arrived.

> “That will come soon enough.”

> “I just didn’t even think about breastfeeding much.”

Interestingly, amongst most first time mothers, there was a high expectation that they would at least “give breastfeeding a go” as they had heard that some mothers can have trouble or cannot do it. There were some who mentioned that they expected to be able to breastfeed, as their mother had breastfed her and/or a sister had breastfed, so they had not really acknowledged that they may have difficulties.

Overall however, at the early pre-natal stage there did not appear to be any
inherently strong barriers to breastfeeding amongst the majority of mothers.

There was a very small minority who had actively decided against breastfeeding for a variety of reasons, mainly younger women. The main reasons were largely related to their self-image and changes in their body’s appearance. Aspects such as feeling and looking sexy to others, their breasts changing shape or “sagging”, having even larger breasts (for those with large breasts), not being able to wear strapless/shoestring tops and needing to wear unappealing/unsexy maternity bras.

“Breastfeeding’s not sexy.”
“I was put off by the books, I didn’t want my boobs to look like that.”

There was also a small minority who had decided against it because they were embarrassed about breastfeeding in public due to the perceived social pressures against it (this was particularly strong in country areas).

“It’s banned in some public places.”
“My friend was asked to leave Maccas when she breastfed.”
“You get stares from some of the older people…they don’t like it.”

There was also a very small minority for whom the general notion of breastfeeding was seen to be simply too unappealing, for example just the idea of a baby “sucking hard on your nipples” was off putting.

The main cited benefit of breastfeeding amongst women pregnant with their first child was the relatively simplistic notion of “breast is best”. When prompted, there were a number of reasons as to why they thought this was the case. Firstly, they thought it would be good for the baby – it was seen as being natural and having all the nutrients the baby needed. Secondly, they thought that it would help them bond with the baby, that the cuddling and closeness of “skin on skin” would be a nice or pleasant experience.

There were also some references to breast milk helping the baby’s immune system, and also that it might help them get back into shape and lose some
weight after the birth.

Partners tended to be non-committal during pregnancy, although many admitted that they hoped their babies would be breastfed, but felt it would be up to the mother to make the final decision.

More experienced mothers had generally made up their mind already as to whether or not they were going to breastfeed this time around, largely based on their past experience. Many of those who had had trouble previously were expecting to have another go. The cited benefits of breastfeeding amongst the experienced mums were similar to those expressed by the inexperienced mothers, that is, it was seen as being natural, a bonding experience and had some health benefits (antibodies, nutrients). However they were somewhat more likely to suggest other more practical advantages such as the convenience and lack of hassle of breastfeeding (compared with the sterilizing, mixing and washing involved with formula feeding) and the cost benefit of breastfeeding.

Very few mothers suggested that they had sought any detailed information during pregnancy on breastfeeding, and there was a high expectation amongst first time mothers that it was “natural” and would “just happen” to some extent. In that regard, very few participants talked extensively about information sources. The main information source mentioned was antenatal classes, which some had attended, and which they saw as being clearly committed to helping mothers prepare for breastfeeding their babies. However, breastfeeding was seen as being only a very small component of the course. Many mothers stated that they could remember some information from the classes but partners who had attended did not recall much at all. Mothers frequently mentioned that the actual experience of breastfeeding was nothing like their expectations during pregnancy.

"We took a doll and practiced on that."
“I don’t remember anything about breastfeeding in antenatal classes.”
“What you hear in pregnancy is completely different to real life.”

Other information sources mentioned in the pregnancy stage included a “bag of
goodies” supplied by the GP, pregnancy and birthing books or websites and conversations with other mothers or family members. Specific books and websites mentioned within the course of this research included:

- Baby Love
- Parenting
- Websites: Mum and Baby, Huggies
- Bringing up Baby (TV Show)
- Up the Duff
- What to Expect when You’re Expecting
- Pregnancy magazine
- Royal Hospital for Women book

Expectations in pregnancy with regards to how long mothers planned to breastfeed varied considerably. First time mothers generally expected to breastfeed for about six months or more, whilst those who were in the workforce planned to breastfeed for approximately three to four months before going back to work. Some mothers were keen to breastfeed for 12 months but most had no real idea and suggested that they would just see how it went, and make that decision later.

Others had already decided that they would want to get their lives back to how they were before becoming pregnant as quickly as possible. This would include going out and socialising, so they wanted to be able to leave the baby with their husband, partner, or mother to feed. In these instances it had often been decided that they would use formula rather than expressing breast milk and using a bottle, as it was seen as easier and more appealing.

5.2 Birth/In Hospital Stage

For first time mothers this was a very emotional and anxious time – and often remembered as a fairly “surreal” period. For some, this period was also very stressful, painful and difficult. Often the actual experience of trying to breastfeed was very different to what they had expected.
As mentioned, most approached childbirth intending to breastfeed with only a minority not planning to. Experienced mothers generally knew what they wanted and were “left alone” by hospital Midwives if there were no problems.

The main sources of help and information in hospital were the hospital Midwives, and, where existing, Lactation Consultants for any problems or difficulties (mainly in city hospitals). In country areas it seemed that Midwives were generally carrying out the role of Lactation Consultant.

There was felt to be a great deal of support and guidance in hospital, in that there was somebody there in a “hands on” sense to help with feeding if it was needed. Midwives helped the mothers to physically attach the baby, observed positioning of the baby, evaluated milk supply and monitored feeding. They also explained what to expect and they talked the mothers through any problems. There was also sometimes the opportunity to attend breastfeeding classes with other mothers who were experiencing similar difficulties.

Having said that, both mothers and health professionals often indicated that Midwives and Lactation Consultants were very “stretched” in some of the larger hospitals, and whilst they offered wonderful support when they were there, they could be unavailable when mothers needed them (especially first time mothers).

Participants appeared to have highly variable experiences with Midwives – some reports were very good and some were very negative. For example, some of the mothers complained that Midwives could be very abrupt and mechanical, with a very patronising and unsympathetic tone of voice.

“They were breastfeeding nazis.”
“They just shoved my baby’s face on my boob.”
“I felt very manhandled in hospital.”

Additionally, Midwives were often viewed to be stating “their opinion” rather than a professional or trained methodology, and as a result of this they could be perceived as having a lack of professionalism, and were often considered to have a somewhat “old fashioned” point of view.
“Often they bring in their own experiences of breastfeeding rather than any training.”

“I wasn’t sure if she was a bit out of touch or not.”

Furthermore, many mothers felt they received conflicting advice from the various Midwives with no two Midwives apparently saying the same thing. Indeed mothers commented that sometimes the Midwives would outwardly disagree with the advice given by the Midwife on the previous shift, within the same hospital.

Due to the Midwives and hospitals being viewed as being pro-breastfeeding, some participants expressed the sentiment that they had felt “pressured to breastfeed”. It was reported that mothers had to bring their own bottles and formula if they wanted to bottle-feed so felt that the hospitals were clearly making it difficult to formula feed. And whilst many acknowledged that breast milk was probably “best for baby”, they also were quick to defend those who genuinely tried but could not breastfeed (for whatever reason) and were made to feel a bit like “second class citizens” by the Midwives.

Whilst the majority felt Midwives and hospital policy were very pro-breastfeeding, there were also isolated instances where individual Midwives suggested that the mother try formula, for example, when the baby was restless and crying a lot, seemingly because they were not getting enough breast milk, or when the baby was in intensive care, was jaundiced or in the nursery away from the mother and was very unsettled. Occasionally this was reported to happen without the mother’s consent.

“The Midwife fed my baby with formula in the hospital without asking me.”

Participants rarely recalled a specific stated period of time that was recommended for breastfeeding by Midwives. They recalled that Midwives seemed to express the sentiment “just as long as you can” or “any amount of breast milk is good for baby”.

"woolcott•research"
“They like you to try at least.”

This appeared to be supported by Midwives who said that they did not usually specify a preferred period of time to mothers.

“Usually just: As long as you can or the longer the better.”

The main benefits of breastfeeding that the mothers recalled being cited by the nurses and Midwives included the importance of the colostrum (which was felt to be vital/the most important milk), that it is good for the bonding between mother and baby, and that breast milk is simply best for babies because it’s natural and it helps to build up the baby’s immune system.

“As long as your baby gets the colostrum…that’s the main thing.”

“It’s liquid gold.”

“Everyone tells you it’s best for baby.”

Mothers could rarely recall any mention of long-term health benefits in breastfeeding for either mother or baby by Midwives or other health professionals in hospital.

In terms of sources of information, the various pamphlets and booklets found in the ‘Bounty Bags’, which are given out to new mothers by hospitals, were generally cited as the only materials mothers read when they were in hospital. Bounty bags contain a variety of information that changes over time. The hospital stay was seen as the only time when they (and their partner) actually had some spare time to read some of the pamphlets and ABA pamphlets were often cited in this context. They also had some time to merely “flick through” pregnancy magazines, such as “Mother and Baby”.

Visiting family, including grandparents, were generally less influential while the mother and baby were in hospital. It was seen as being too early for them to get involved and they just wanted to hold the baby and “fuss around”. Partners were often overwhelmed by the fact that they had a new son or daughter so did not get involved in being given advice or information on breastfeeding in
hospital. Mothers and in-laws were generally only sought for advice if the new mother was having problems, although some mentioned that the older generation often “just couldn’t help themselves”, and some family members were starting to make the “odd comment” or “planting the seed” for later, planning on introducing the bottle to ensure the baby receives enough milk.

Despite the willingness to try to breastfeed immediately after the birth of the baby, clearly there were many mothers who had difficulties. The main problems and reasons for cessation immediately after birth were that it hurt or was more painful than they had expected, the baby had difficulties latching on, they had inverted nipples or that the baby did not appear to be getting enough milk so was always crying and hungry.

“Nobody tells you it hurts.”

“They don’t understand that you just don’t have enough milk sometimes.”

Whilst a small minority of mothers in this study claimed they had ceased breastfeeding prior to leaving hospital, in most instances where mothers had ceased breastfeeding it was once they had got home, post-hospital stay.

In this respect those who had wanted to breastfeed and found that they could not breastfeed whilst still in hospital were extremely disappointed and upset.

“I was adamant to breastfeed and it’s very stressful when it doesn’t work!”

“I was devastated when I couldn’t do it… I felt I was not an adequate mother.”

Clearly there was a genuine sentiment of “I tried”/”I would if I could” amongst these women – which means that the communication “breast milk is the best” is a highly sensitive message amongst these mothers who believe they are physically unable to breastfeed, through no fault of their own.

Expressing breast milk and learning effective methods of expressing was generally covered at least briefly in the hospital stay. Most mothers agreed it was difficult (at least at first), time consuming and therefore really only
attempted once or twice, if that, in hospital. Many mothers were also more focused on breastfeeding and ensuring they were doing it properly, and generally said that they would think about expressing at a later stage – when they had established breastfeeding per se.

There were also some health related problems that meant that some mothers had never actually attempted breastfeeding. These included the following:

- Instances where the mother had been on some type of medication so was advised not to breastfeed (which in some cases was thought to be the wrong advice).

- Where the baby had a serious illness or needed an operation early in life, which meant breastfeeding was impractical.

- Premature babies or those who had needed an operation who had been given bottles initially and this was carried on (seemingly as a result of ‘nipple confusion’, when the baby won’t feed from the breast after being given a bottle).

- Although nobody in this research stated that they did not breastfeed because of sexual abuse, health professionals often mentioned it as a reason that some people did not breastfeed.

  “If someone’s been sexually abused as a child, breastfeeding can remind them of the abuse.”

- Health professionals also mentioned that breastfeeding is sometimes not encouraged by Midwives or Nurses in cases where there was illicit drug use and heavy substance abuse (smoking, alcohol).

5.3 At Home Stage – The First Two Weeks

The typical length of stay in hospital reported by participants after giving birth was between two and five days, with many stating they had been discharged
after two days. Indeed there were many instances where participants stated that they had been discharged from hospital prior to their milk arriving. This was usually as a result of the milk arriving later (three to four days) and the mother being dismissed at day two.

Health professionals also mentioned the decrease in the length of the average stay in hospital as being an element affecting likelihood to continue breastfeeding amongst mothers. They added that the increase in medical intervention (for example caesarians) could lead to delays in breastfeeding, due to factors such as the physical and mental stress of the surgery inhibiting lactation, a lack of hormonal preparation for the birth if the mother had a caesarian before she went into labour, or simple exhaustion so that the mother was not putting the baby to the breast enough. It was also mentioned that drug assistance and birth trauma could affect the baby’s alertness and coordination, which could lead to breastfeeding problems initially.

“Epidurals can have a huge effect on some babies’ coordination, even for days and weeks after the birth.”

Overall it appeared that many mothers had left hospital before breastfeeding had been properly established and were therefore attempting to breastfeed themselves at home, often alone, with little “hands on” or one-on-one assistance from somebody who was experienced or trained in lactation.

“The simple fact is that often mothers are going home without having resolved any breastfeeding issues, often before the milk’s come in and often before they are confident on any level.”

As mentioned, although most mothers claimed to want to carry on breastfeeding at home, there were a number of difficulties experienced and many struggled to continue breastfeeding. Key problems and reasons for ceasing to breastfeed during the first two weeks included sheer exhaustion from having just given birth and lack of sleep to feeling low or getting the baby blues at the same time as trying to establish breastfeeding, resulting in mothers “giving up” because it was too difficult. Further reasons for ceasing were sore, cracked
nipples and mastitis (with many believing that you had to stop breastfeeding if you got mastitis) and the baby crying continuously - leading to a fear that the baby was not getting enough milk.

“I felt like I was never going to catch up on sleep ever again and I just needed a good night’s sleep.”

“It was so painful.”

“I was scared my baby wasn’t getting enough…she kept crying even after I’d breastfed.”

First time mothers in particular did not feel at all confident about the practical aspects of breastfeeding and were not sure what they were doing “wrong”. In addition, there were many myths that added to their confusion and doubt about their ability to breastfeed. Some of these myths included:

- if you had small breasts then you would not have as much milk,
- if you had large areolas then you would not be able to breastfeed,
- if your mother could not breastfeed or had a low supply then you would have the same problems, and
- if you were fair-haired then you were more likely to get cracked nipples and a way around this was to scrub your nipples when you were pregnant!

In terms of information and support, many were not sure where to turn to in the first two weeks – they had left the safety of the hospital and often felt very alone. Practically, the partners felt that they were not much help during the first couple of weeks as they could not breastfeed themselves and did not feel qualified to give advice. Partners had either already gone back to work or were going back to work shortly and there were also some reports by mothers of the partners feeling jealous or left out. Some health professionals mentioned that partners did not seem to be aware that they had an important role at this time – helping around the house, cooking for the family and bathing the baby so that the mother could stay relaxed and concentrate on breastfeeding. Instead they often wanted to get involved in the feeding itself (by giving a bottle) or simply stayed out of the way because they felt they could not do anything.
“I (partner) can help and the other kids can. When you’ve got a big family, being able to help with feeding is a big factor. The kids wash the bottles out.”

The attitudes and beliefs of the grandmothers/in-laws and partners about breastfeeding and formula were a major influence in the first few weeks. It could be very hard for the new mother to carry on breastfeeding if she did not get support from her family. The partners and grandmothers saw that the mother was struggling with breastfeeding and often tried to help “solve” the problem by encouraging them to switch to formula feeding. Formula feeding was widespread and seen as the “modern way” to feed in the grandmother’s era so they were often quick to recommend switching.

“Don’t you think bottles would be easier?” (grandmother)
“I bottle fed you and you’re ok!” (grandmother)
“I was bottle fed and I’m ok.” (partner)
“I can help by getting the bottles ready.” (partner)
“I can do a feed in the night and then you can get some sleep.” (partner)

Child Health Nurse visits were highly valued in the first couple of weeks but resources were seemingly sparse. Participants often reported that they only got one visit in the first 10-14 days after birth. In addition, they often had to visit the Child Health Centre for this type of advice, which seemed like a big obstacle in the first few days. Many said that they had to remember to prepare specific questions to ask, as they did not receive hands-on help with feeding at the time when they were breastfeeding. Additionally, the support was not accessible 24 hours a day seven days a week. The Child Health Nurses were generally the main instigator of mothers’ groups which some of the mothers joined early on, although most sought some form of mothers’ group at least a few weeks following the birth.

A few hospitals or health centres seemingly ran drop in clinics for breastfeeding problems and these were viewed positively and praised by health professionals and mothers alike. They were either run by Lactation Consultants or Midwives
with extensive experience of breastfeeding issues. However they were not widely available and they were not accessible 24 hours a day, seven days a week.

5.4 One to Three Months Stage

If breastfeeding was established and going well by the one month stage, it appeared likely for the mother to carry on at least until the three month stage. However if there were problems still present at one or two months then, as previously stated, the mother had to have very strong beliefs about the benefits of breastfeeding to continue, especially if the family was advising her to switch to formula to ensure the baby was getting enough to eat/drink.

“I felt like I was starving my child.”

One of the main problems reported during this time was the perception that the baby was not getting enough milk or a concern that they did not know how much milk the baby was getting. In contrast, formula was seen as an easy way to measure the quantity of milk the baby was drinking and so it was easy for mothers to switch to formula in this situation. Formula was also seen to make babies sleep better because it “fills up their tummies for longer”, which had the added benefit of enabling the mother to have more (much needed) sleep. Mothers were particularly concerned about larger babies getting enough milk as some thought that these babies needed more milk.

Health professionals said that the child health medical record, commonly referred to as the ‘blue book’ in NSW, added to a mother’s concern because the weight charts were based on formula fed babies rather than breastfed babies and this meant that the target weights were higher. They also mentioned that anxiety about providing their baby with enough milk could lead to less milk supply, so it was a vicious cycle for mothers.

It was also commented that sometimes the mother and baby learnt “bad habits” or got into extreme patterns that were not sustainable longer term, in terms of feeding, settling and sleeping. A common habit mentioned was that the baby
used the breast as a comforter and so fed very frequently, for example every hour and a half, or that the baby would only sleep on the mother or the breast.

Post Natal Depression (PND) was an issue mentioned by some between one and three months. Health professionals said that the age at which people have their first baby was increasing and depression is becoming more common amongst older mothers. It was seen as a vicious cycle for breastfeeding – PND can be the result of breastfeeding difficulties but then once afflicted it can lead to not feeling able to carry on breastfeeding.

“Breastfeeding problems are linked to PND. If you don’t breastfeed you feel guilty. Then if you are feeling depressed you can’t bear your baby crying so it impacts on feeding and settling.”

“Not being able to breastfeed meant that my wife had depression with the second one.”

At one to three months most mothers were starting to go out with their baby and socialise a little bit more often, which meant that if they were breastfeeding they had to start breastfeeding in public, for example, in a café during breakfast, a local restaurant or at parties. This was seen as embarrassing and difficult for some, and they claimed it put them off both breastfeeding and going out, which in turn created feelings of resentment. This did not help if they were feeling alone and restricted to the house. Breastfeeding in public was not felt to be the social norm at the moment, especially in country areas. There were some stories amongst country participants, of older people approaching them and telling them it is “disgusting”, that they were “putting them off their food” in cafes. Some also mentioned that they felt that it was a bit “hippy-like”. Further, baby-feeding rooms were often perceived to be unpleasant, dirty and uninviting, which did not encourage breastfeeding whilst out shopping or meeting friends for a coffee.

After a couple of months some mothers wanted to “get their lives back” so made the decision to switch to formula. Some younger mothers in particular wanted to go out socialising during the evening, so wanted the option of leaving
the baby with others to feed using formula, often for a whole night which could mean two feeds in a row. For mothers with more than one child, looking after their other children, doing the housework and cooking for the family all contributed to continuing breastfeeding more difficult.

There was also a widespread feeling that two to three months “worth” of breast milk was sufficient, and the introduction of the odd formula feed would help the baby sleep longer at night and allow the mother to leave the baby with the father/babysitter/grandmother for a while to go shopping or have a night out. Amongst these mothers there was little awareness of the benefits of continuing to breastfeed exclusively, compared with continuing predominantly with breastfeeding but introducing the occasional formula feed to supplement breast milk.

Breastfeeding support continued to be crucial between one and three months. It helped if the partner and other family members were supportive in terms of cooking, doing the housework and looking after any other children so that the mother could concentrate on breastfeeding.

Many mothers joined a mothers’ group, and found these to be very valuable in terms of sharing problems and getting advice and feedback from other mothers regarding breastfeeding problems. Although within these mothers’ groups it was often felt to be the “blind leading the blind”, the mothers who were part of such groups agreed that the fellowship found here was indeed a contributing factor to successful breastfeeding methods. Many of the mothers who were not in mothers’ groups were somewhat more likely to mention feeling isolated, lacking confidence or frustrated at times, and overwhelmed by the lack of time to do basic household tasks such as cleaning, shopping and washing.

Child Health Nurses were still available but visits were infrequent. Mothers tended to have a health check up for their babies at six to eight weeks, but these visits were rarely mentioned as a source of breastfeeding advice and support if there were any issues. Sometimes the difference between breastfeeding being successful or not was a Lactation Consultant being there to support all the way through this period, but they were seen as being quite
expensive. One partner who had five children reported that only one of his children had been successfully breastfed and this was due to a Lactation Consultant helping throughout the first few months.

Family Support Nurses were seen as the last resort and a referral was needed by a health professional to visit them. However, they were only available in the city and there were often long waiting lists. Mothers often did not know of this resource and if they did they did not regard these professionals as being easily accessible if there were problems with feeding. Amongst the participants who had used these facilities, for example Tresillian and Karitane Centres, there were generally positive experiences, with most agreeing that the somewhat intensive one-on-one methods were successful in establishing or re-establishing manageable breastfeeding and/or sleeping patterns.

5.5 Three to Six Month Stage

Mothers still breastfeeding at three months had established breastfeeding routines and were generally breastfeeding with no problems. However, breastfeeding exclusively was often stopped prior to six months for a number of reasons.

Firstly, often mothers were not aware that there were guidelines on how long to breastfeed exclusively for, or what the health benefits were of breastfeeding exclusively for six months as opposed to four months.

Secondly, at around three months there was often a growth spurt where the baby fed more and the milk changed. Mothers reported that their breasts did not feel as engorged as they had done earlier, so around this time they often thought that the baby was still hungry and that they were not providing enough milk, so they switched to or supplemented with formula. Sometimes a family member or a health professional encouraged this.

“Breastfed babies put on a lot of weight at the beginning then plateau at three months. That’s when someone will say ‘give formula’.”
Thirdly, the introduction of solids tended to happen before six months (often at about four months). Grandmothers often recommended this because in “their day” the advice was to start on solids earlier. Once the baby started solids, there was a feeling from some mothers that their ‘job was done’ in terms of breastfeeding, and that they had given their baby a good start with sufficient breast milk. There was little knowledge of any health benefits of partial breastfeeding after they had started solids. They thought that continuing would really only be for comfort or enjoyment reasons and not substantial health benefits.

Additionally, some mothers had simply had enough of breastfeeding after three to six months. There was a common perception that when breastfeeding they had to avoid certain foods and drinks, such as strong tasting foods like chilli or curry, alcohol and coffee, in order to ensure that baby settled well and did not get “wind” or indigestion. In this respect many mothers were tired of watching what they ate and drank, and felt that they had breastfed long enough for the baby to get the nutritional benefits to give them a good start in life. By this time they had often “given up” alcohol for over a year, or even longer if they had been trying to conceive for a long time before getting pregnant.

“I wanted my body back.”

There was also a perception that breastfeeding could not be continued when the baby developed teeth as it might be painful.

Many returned to work between three to six months after the birth and felt that continuing to breastfeed would be too difficult. Trying to express breast milk at work was not seen as a viable option for many working mothers, as there was nowhere to go to express at work, and the notion of trying to visit the baby or getting someone to bring the baby to work for feeds was not seen as being practical for most.

“There would be zero tolerance in the finance industry.”
Indeed some mothers spoke very unfavourably about their attempts to express breast milk. Most did not like the overall experience and had extremely variable results with obtaining sufficient milk – sometimes it worked and sometimes it did not. They also did not like the thought of pumping breast milk, believing it to be demeaning and “weird” - they spoke of cheap, poor quality breast pumps, and they lacked knowledge regarding when would be the best time to express breast milk within the feeding routine.

“I felt like a cow.”

5.6 Over Six Months

Within this research it was rare for a mother to be still breastfeeding exclusively at six months as most had introduced solids by this time, generally at about four months. Some committed breastfeeding mothers were still partially breastfeeding (in addition to solids) for up to a year, but this was very rare when their infant was over a year old. It was generally thought that if the infant was old enough to ask to be breastfed then they did not need breastfeeding! There were a few very committed breastfeeding mothers who claimed to breastfeed their children until 24-26 months, however these participants were very reluctant to admit this fact and mentioned that they always received strange looks and comments from people when they did so. Indeed these women were generally not breastfeeding their two year old children in public.

Partial breast and formula, together with solids, was very common after six months, with many mothers claiming to still enjoy breastfeeding and wanting the bonding time with their baby. Formula feeds were often being introduced as the last feed for the night, with the belief that it was filling up their baby’s tummy to sleep through the night. Further formula feeds were then introduced during the day to allow mothers to go back to work and for the various reasons mentioned in the previous section. For example, they thought they had breastfed for long enough and wanted their body back, they wanted to be able to leave the baby with their partner or a family member to go out, and not knowing or not being aware of the benefits of breastfeeding beyond six months. During this stage
(over six months), it was also common for mothers to retain a breastfeed for the first feed of the day, with the remaining feeds being formula.
6. Cultural Differences

Although this research did not specifically aim to explore cultural differences there were some differences uncovered.

In areas where there were high proportions of Asians, health professionals reported that ethnic groups such as the Vietnamese tended to be more likely to breastfeed, and that they seemed to have fewer difficulties, such as latching on and cracked nipples, than the Caucasian population. It was hypothesized that this could be due to a number of reasons. Firstly, populations such as the Vietnamese and Filipinos tended to breastfeed because it was the cultural norm to breastfeed for these cultures; they grew up seeing their relatives doing it and it was an accepted part of their society. Secondly, they had fewer problems because in these cultures the extended family often lived in close proximity so they would give help and support in terms of housework, cooking and looking after any other children as well as advice on any breastfeeding difficulties. Sometimes the mother’s mother would come and stay for a month after the birth. Indeed, in some Asian cultures, it was thought that the mother should stay in bed and do nothing for a month (including washing her hair). This resulted in mothers being more relaxed and having more patience with breastfeeding.

“In the Asian culture you are not allowed to do anything for a month after the birth. It is the responsibility of the nearest female relative to come and look after you.”

“In Western culture we’re expected to have the baby, clip your earrings on, grab your briefcase and carry on as if nothing has happened.”

Health professionals reported that some Asian cultures, in particular the Chinese, Korean and Filipino cultures, did not give colostrum to babies because it was seen as being bad for them. Instead, boiled rice milk or formula was given until the milk arrived between days two to four.
It was said that there was also a focus amongst the Chinese and Indian cultures on making their babies heavier as big babies were regarded positively. Therefore, they were more likely to use formula as it increases a baby’s weight. Asian cultures such as the Vietnamese also tended to supplement breastfeeding with substances such as rice water or ‘gruel’ after one month.

“There is still this thing in Chinese culture about big babies. From my experience, trying to get a Chinese baby from naught to one years old without any formula is an uphill struggle.”

The refugee worker interviewed reported that Eastern European groups tended to wean their infants early and often chose foods with high sugar content when they gave solids, using foods such as biscuits.

“Now they are living in Australia there is lots of access to high sugar and high fat foods. There’s lots of reliance on [cow’s] milk. One child who was two years old only ate biscuits and drank milk all day.”

Anecdotal evidence also suggested that the Sudanese community in Ballarat had been told that breastfeeding in public was illegal, and in other country areas clearly participants were unclear about the rules or rights regarding breastfeeding in cafes and restaurants, generally believing that retailers and restaurateurs were allowed to ask people to leave if they were breastfeeding in their establishment.
7. Summary of Key Differences Between Committed and Non-Exclusive / Lapsed Breastfeeders

The research supports the notion that there is a particular demographic that are more likely to be committed to breastfeeding exclusively for six months, and partially for longer. These mothers tended to be more educated, of higher socio-economic status and slightly older. They tended to have read more information about feeding – both on and offline. Often they were also able to be absent from work for a relatively long period of time (12 months or more).

Mothers committed to breastfeeding seemed prepared to try much harder than others when there were physical difficulties. They had also built up better support systems amongst friends and family or had educated themselves about where to go for help and advice. Supportive partners and family also helped them keep breastfeeding their baby for longer.

Their commitment seemed to be more often based on the strong general belief that a "natural" approach was best and they were often more concerned about feeding themselves and their baby natural foods that were organic and unrefined or unprocessed. They were more aware of and receptive to the health benefits of breastfeeding for the baby and mother, and whilst they were not all aware of the detailed health benefits, they did tend to believe that it helped “boost the immune system” of the baby. The benefits to the mother were seen to be more about the better nurturing/bonding aspect, rather than the specific health aspects.

The less committed were more likely to be in the lower socio-economic group, and younger. Some were openly concerned about body appearance issues, but the majority reported physical difficulties in the first few weeks that had been too hard to overcome. To these people formula feeding offered a very
appealing option, sometimes being suggested to them by their mothers or partners.

However, many ‘lapsed’ breastfeeders interviewed for this research actually thought that they were committed breast feeders. Clearly there was a lack of awareness of any breastfeeding guidelines that communicated the benefits of breastfeeding beyond three to four months, with many participants under the impression that they had breastfed for a sufficient period of time to give their baby a good start in life.

Many ‘non-exclusive’ breastfeeders were not sure how much breast milk needed to be given to obtain the benefits of breastfeeding, so they believed that they were giving their babies some benefits of breast milk if they were mixing formula and breast milk.

“Some is better than none.”
“They’re getting the best of both worlds.”

As mentioned, many others were non-exclusive/lapsed breastfeeders because of reported physical problems with breastfeeding, which meant they felt they couldn’t carry on. For example many experienced pain, mastitis or perceived that they did not have enough milk to feed the baby sufficiently.

There was also some evidence of the belief by some of the non-exclusive/lapsed participants that formula provided something “extra” to breast milk such as Omega 3s, and was a viable alternative for lactose intolerant babies. Some partners particularly mentioned the “added benefits” of formula as a justification for switching to formula if breastfeeding was problematic. Formula offered added advantages to them in that it allowed the father and others to also have that feeding/bonding experience.
8. Summary of Perceived Benefits of Breastfeeding & Formula Feeding

The tables below show the most commonly mentioned advantages and disadvantages of breastfeeding and formula feeding as perceived by mothers, pregnant women, partners and grandmothers. Whilst the information is captured throughout the discourse of the report it is also provided here to summarise the findings succinctly and draw the issues together. Where specific groups are more likely to mention an advantage or disadvantage, these are indicated.

Table 3: Advantages of Breastfeeding and Formula Feeding

<table>
<thead>
<tr>
<th>Breastfeeding</th>
<th>Formula Feeding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Convenient / 'there' / no prep / practical</td>
<td>Bond with others / others can feed / help</td>
</tr>
<tr>
<td>Free / inexpensive / cheaper</td>
<td>- inexperienced, not exclusive</td>
</tr>
<tr>
<td>- inexperienced, lapsed</td>
<td>Better / more sleep (mother &amp; baby)</td>
</tr>
<tr>
<td>Bonding</td>
<td>Convenient / can do anywhere</td>
</tr>
<tr>
<td>Health benefits</td>
<td>Easy</td>
</tr>
<tr>
<td>Immunity / antibodies</td>
<td>Know how much baby is getting</td>
</tr>
<tr>
<td>- inexperienced, committed</td>
<td>Baby puts on weight quicker</td>
</tr>
<tr>
<td>Breast milk 'tailor made' to baby</td>
<td>- inexperienced</td>
</tr>
<tr>
<td>Helps mother lose weight</td>
<td>Socially better / easier / no embarrassment</td>
</tr>
<tr>
<td>Good nutrients / nutritional</td>
<td>- inexperienced</td>
</tr>
<tr>
<td>Easy</td>
<td>Can wear anything</td>
</tr>
<tr>
<td></td>
<td>Mother can eat / drink anything</td>
</tr>
</tbody>
</table>
Table 4: Disadvantages of Breastfeeding and Formula Feeding

<table>
<thead>
<tr>
<th>Breastfeeding</th>
<th>Formula Feeding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public feeding - not comfortable</td>
<td>Prep / sterilising</td>
</tr>
<tr>
<td>- inexperienced, not exclusive</td>
<td>- inexperienced, not exclusive</td>
</tr>
<tr>
<td>Leakage</td>
<td>Not as good for baby / not as healthy</td>
</tr>
<tr>
<td>Mother is restricted</td>
<td>Not getting immunity</td>
</tr>
<tr>
<td>Partner can’t help / not involved</td>
<td>- inexperienced, committed</td>
</tr>
<tr>
<td>Less sleep (baby &amp; mother)</td>
<td>Costs / expensive</td>
</tr>
<tr>
<td>Draining</td>
<td>- inexperienced, not exclusive</td>
</tr>
<tr>
<td>Pain / mastitis / cracked nipples</td>
<td>Confusion (trial &amp; error) of formula</td>
</tr>
<tr>
<td>- inexperienced, not exclusive</td>
<td>- inexperienced, not exclusive</td>
</tr>
<tr>
<td>Certain food/drink can’t eat / no alcohol</td>
<td>Baby constipated / vomiting</td>
</tr>
<tr>
<td>Lots of pressure</td>
<td>Lose bond</td>
</tr>
<tr>
<td>No time to yourself / no social life</td>
<td>Poos smell</td>
</tr>
<tr>
<td>Can’t take medications</td>
<td>Not as convenient</td>
</tr>
<tr>
<td>Cost of breast pads / wearing pads</td>
<td>- experienced, committed</td>
</tr>
<tr>
<td>- inexperienced</td>
<td>Baby getting too much / over eating</td>
</tr>
</tbody>
</table>
9. Awareness and Perceptions of the ABA

The ABA Helpline number was often included in literature given out to mothers and many had heard of them. However, most partners had not heard of the ABA.

A few participants had used the Helpline and believed it to be a very good resource if they had problems breastfeeding, as it was seen to provide valuable information, reassurance and encouragement. Often there was a perception that there was nowhere else to turn, especially in remote areas.

However, most mothers did not contact them if they had issues, because they perceived that talking to someone on the telephone was not going to solve their problems. They felt the need to see someone face-to-face to show them how they were breastfeeding and not just talk over the phone, to obtain practical feedback on their technique.

There was also some perception (backed up by some health professionals) that the ABA would be “too pushy” and would put pressure on to carry on breastfeeding. One health professional said that she would not recommend that a mother with PND contact the ABA because they might pressurise them to continue breastfeeding when actually the mother might not be able to cope with this.

“They are very focused on breastfeeding, so if a mother is depressed then they wouldn’t be applicable.”
10. Awareness and Reactions to the Guidelines

10.1 Reactions to Exclusive Versus Non Exclusive Breastfeeding

Most participants had a good understanding that ‘exclusive’ meant only breast milk. However, it was not a term they generally thought of or used in association with infant feeding. There was also confusion amongst a small number as to whether or not water could be included in this definition, or even solids.

When prompted for the benefits of exclusivity, participants tended to talk about the benefits of breast milk per se that had already been discussed, such as breast milk being natural, having antibodies and helping with the baby’s immune system. Generally, they did not perceive any specific advantages to exclusive breastfeeding. Importantly, there was not thought to be much extra benefit from a long period of exclusive breast milk or a real reduction in benefits if formula feeds supplemented breast milk.

Whilst there was little confusion regarding the term ‘exclusive’, there was a range of responses in terms of how long the exclusive diet should last, with most thinking sometime between three to six months and a minority thinking up to a year (generally younger pregnant women).

Rather than the benefits of an exclusive breast milk diet being top of mind, difficulties and practical constraints were more often raised, for example returning to work, issues with expressing and the baby needing more than just breast milk to fill them up.

10.2 Knowledge of Guidelines

Following the unprompted discussion covering awareness and knowledge surrounding the benefits of breast feeding versus formula feeding, participants
were asked about their awareness of any specific guidelines, as well as their awareness of a number of health benefits for the baby and the mother.

Most were not aware of any set guidelines relating to the length of time for breastfeeding, and perceptions varied with regard to the ideal length of time to continue breastfeeding.

Most thought that the recommendations would be three to six months for exclusive breastfeeding before introducing solids. Some thought that the recommendation would be to introduce some formula if the baby was not putting weight on or not sleeping well.

Reactions to the notion of six months exclusive breastfeeding were positive – most thought it sounded “fair enough” and achievable as long as the mother was not having problems or returning to work. However, the introduction of solids was a concern, as many thought this should happen at around four months.

Most were not sure how long partial breastfeeding was recommended for, and indeed whether or not it was important to carry on with some breast milk. There were some mentions of 12 months “I think”. They thought that cow’s milk should generally be introduced at 12 months, as breast milk only was not thought to be necessary any more. Adding formula was thought to be acceptable between six and 12 months, but some thought that it was good to include some breast milk feeds, for example first thing in the morning.

The notion of 12 months of partial breastfeeding was generally considered a long period of time, but not atypical or unusual. Many claimed that whilst they had not breastfed for this long, they certainly had friends who had fed for 12 months or more. Those who did not breastfeed for 12 months generally agreed that it would be impractical because of work commitments and simply wanting to “get on with their lives”.

A minority was aware of the World Health Organisation’s recommendation of some breast milk for up to two years, but most thought that this did not apply here, as they thought that the guidelines in Australia were only one year.
Those still breastfeeding at two years were often embarrassed to admit it to others – they claimed to get strange looks from people. Two years was generally thought to be unrealistic and a bit of a “turn off” for many.

“They’re walking by then!”
“|I’ve met a lot of closet breast feeders over the years….when they (friends/associates) hear you’re still breastfeeding at two years they treat you like an outcast….it’s worse than being gay I reckon.” |

Generally partners did not know that guidelines existed nor did they know what they might be. Many simply thought that “breast is best” and thought you should breastfeed for “as long as possible”. They thought if things were going well for the mother and baby that six months of breastfeeding should be possible.

10.3 Reactions to Presented Benefits of Exclusive Breastfeeding

During the course of the interviews and discussion groups, the moderator presented some proven benefits of breastfeeding exclusively for the first six months. Participants’ reactions are summarised under each benefit presented.

**Breastfeeding helps protect against diarrhoea, respiratory and ear infections in babies.**

Overall most participants were familiar with the breastfeeding benefit of immunity/antibodies – and protection against respiratory and ear infections was seen as relating to this. However, pregnant women and couples with their first child were less likely to know about these benefits. Also, partners were generally less aware of these benefits, although some had heard that breastfeeding gave general immunity support.

Breastfeeding protecting against diarrhoea was less well known with some suggesting that breastfed babies often have “runny poo”. 
The majority of participants accepted this benefit, and agreed that it was "probably true", with most understanding the link between antibodies/immunity and infections. Clearly there were some differences between committed and non-exclusive/lapsed breast feeders in the strength of their belief. The initial reaction from some non-exclusive/lapsed participants tended to be "yes.....but....." with frequent reference to breastfed babies who had been very sick, whereas more committed breastfeeders accepted this benefit more wholeheartedly.

"Other babies got the flu, ours didn’t."

Partners were generally curious and somewhat more skeptical about the research related to this. They wanted to see the evidence for this benefit and to what degree it was true, for example the extent to which breastfeeding protects against these illnesses, and comparisons between exclusive breastfeeding for six months and, say, three or four months. They thought the individual make-up of the baby would be more important.

"Every kid is different."

Most participants agreed in theory with this benefit (because many were aware of the immunity benefits already), and thought that it was important. It was seen as the most persuasive benefit of the three presented. However for some it was easy to rationalise against and to dismiss, based on personal experience.

Breastfeeding helps protect babies against obesity and chronic diseases in later life.

There was some familiarity with this benefit, particularly for breastfeeding protecting against "chronic diseases". A fairly large number of participants thought they had heard about this on television and also mentioned links
between obesity and formula. Some mentioned that formula fed babies are fatter and that maybe this likelihood to gain weight carries on in later life.

However, initial reactions tended to be skeptical and questioning – particularly in relation to the obesity component. Many could not understand how this could be the case over such a long period of time, so wanted more information about this and proof that this was true. They reasoned that other factors must play a large role in determining susceptibility to chronic disease and obesity in later life.

“How could it?”
“How obesity is just the latest catchphrase.”
“I think your diet and lifestyle later in life are a bigger factor!”

Again, personal experience was mentioned. Some participants compared their own offspring, some of which were breastfed and some who were not, to say that there was no difference in health between the breastfed and non-breastfed ones, thus ‘proving’ that breastfeeding does not make children healthier.

“There are no health differences between the one who was breastfed and the ones who weren’t. In fact, the oldest is the smartest and healthiest and he wasn’t breastfed.”

“I just don’t agree, personal experience says that breastfeeding makes no difference.”

There was also some feeling that people of higher socio-economic status were more likely to breastfeed and at the same time less likely to be obese, and it was felt that it was this lifestyle that is key, not breast milk.

Most agreed that although breast milk certainly gave babies the best start in life, lifestyle factors were the main contributors to obesity and chronic disease, so they did not think that this benefit was very persuasive.
Breastfeeding benefits a mother’s health by reducing the risk of breast cancer, ovarian cancer, type 2 diabetes and osteoporosis.

Of the three presented, there were lower levels of awareness for this benefit amongst all participants, although there was some low level recollection of the “breast cancer” link.

Type 2 diabetes was thought to be largely lifestyle influenced, so this benefit was not accepted easily. However, participants thought that the breast cancer association seemed to make sense as “breasts were made to feed”, but did find it hard to understand exactly how breastfeeding and cancer were linked.

Breastfeeding protecting against ovarian cancer and osteoporosis seemed plausible to most participants, but they questioned how breastfeeding would lower the risk of these conditions and also to what degree.

Again there were connections made to personal experience and exceptions to this benefit. Some participants cited examples of women they knew who had breast cancer in later life and had breastfed their children.

Similarly to obesity, there were also the arguments that cancer is caused by many things in the environment, such as radiation, artificial foods and preservatives, so participants wanted to know how the research was conducted to single out breastfeeding. And there was some degree of cancer scepticism, in that “everything causes cancer” and “now not being breast fed causes cancer!”

It was felt that there was a need for more information in this area, and some explanation that linked breastfeeding with these conditions, particularly by partners. Overall this was seen as a less persuasive cited ‘benefit’ and easy to dismiss. However, some thought that if there was breast or ovarian cancer in the family then it might influence a mother to breastfeed.
Detailed Findings from Health Professionals
11. Interaction with Health Professionals Regarding Feeding

The following chart highlights the points at which mothers interact with health professionals regarding infant feeding.

**Figure 2: Interaction with Health Professionals Throughout the Journey from Pregnancy to Infancy**

The following sections outline the ways that each health professional interacts with mothers and babies, what issues they are likely to deal with, who they refer to, where they get their information from and what training they have received. It is ordered according to the journey from pregnancy to infancy above.
11.1 GP Involvement

Although still influential, GPs seemed not to be as involved in giving support and advice about infant feeding as some of the other health professionals interviewed. They saw patients in pregnancy where breastfeeding was not really discussed in detail and then later on after the birth if there were perceived health issues associated with breastfeeding (such as mastitis). Most mothers did not see general breastfeeding problems (such as difficulties latching on) as a health issue, so they tended to access other sources of support and information first rather than their GP, for example Child Health Nurses or Midwives mainly, or Lactation Consultants or the ABA.

The kinds of infant feeding issues the GPs interviewed dealt with were constipation, reflux, intolerance to formula, supply issues, cracked nipples, mastitis and weaning. The GPs said that they felt confident giving basic advice about breastfeeding. However, although they said they encouraged it, GPs did not seem to encourage continuation of breastfeeding as much as did other health professionals. Other health professionals also viewed GPs as being less informed about breastfeeding and its associated problems. Some reported that GPs had given patients the wrong antibiotics for mastitis or had given the wrong advice, for example to give up breastfeeding if they had mastitis or that they should not breastfeed if they were on particular medications. Those GPs interviewed also seemed to be slightly less aware of the benefits of breastfeeding than other health professionals.

Some of the GPs said that they referred to pediatricians for formula problems such as if they suspected allergies, Lactation Consultants for technique issues and Family Support Nurses if they thought the mother was not coping. However, this was not always the case and other health professionals criticised GPs for not referring on enough.

“I know we have a Lactation Consultant but I haven’t made use of them.”
GPs did not actively seek out information on breastfeeding as much as did the other health professionals interviewed. Their cited sources of information included professional associations and journals. Some were aware of the ABA but they did not always use their support or refer on to them. They assumed that other health professionals would be giving mothers the relevant information, for example Midwives or Child Health Nurses.

“The ABA - I know of them but I have to admit that I haven’t made use of them.”

The training received on infant feeding issues was in their initial medical degree. They were not aware of and had not received further breastfeeding training.

11.2 Midwives/Antenatal/Maternity Nurses’ Involvement

Midwives were involved in infant feeding issues through antenatal classes and immediately after the birth in the hospital environment. The antenatal classes tended to take place at hospitals and the breastfeeding component was around two hours in length. There were also breastfeeding classes available in some hospitals immediately after the birth, open to new mothers who were having problems or simply wanted to learn more about breastfeeding.

The main aim of Maternity Nurses and Midwives was to establish breastfeeding in the first few days of a baby’s life. They gave very practical hands-on support to mothers. They were very confident about giving advice, but as mentioned, could appear to mothers to be giving it based on their own opinions rather than any professional training. Consequently it could seem old fashioned and there were reports from mothers, other health professionals and even some Midwives themselves that advice could vary substantially between different Midwives. For example, some Midwives gave nipple shields for sore nipples whereas others thought that these were detrimental in the longer run, and there were reports that they gave different advice about frequency and length of individual feeds.

“Some Midwives are saying that mothers should only feed for 20 minutes each side. Some are saying only feed on one side.”
They rarely gave any guidance on the length of time it is recommended that mothers breastfeed for, in terms of months or years, unless specifically asked. They generally advised mothers to try breastfeeding for “as long as they can”, claiming to be sensitive to appearing too pro-breastfeeding and forceful.

Most Midwives gave out information on breastfeeding for mothers to take home with them, for example telephone numbers for helplines and Family Support Nurses. There was a breastfeeding DVD used in many hospitals, but many health professionals and mothers said that they thought it was old fashioned and was in need of modernising.

Midwives said that they referred on to paediatricians or dieticians if babies were failing to thrive on the post-natal ward, or Lactation Consultants and Allied Health Professionals if there were specific physiological problems with feeding in hospital. If there were still problems when the mother left hospital they made these known to the Child Health Nurses through the discharge information.

“I’d refer to the Paediatrician if I thought there was something wrong for medical reasons – protein intolerance or something.”

They obtained information on breastfeeding from talking to Lactation Consultants who worked in the hospital, the BFHI guidelines and the relevant area health services. Many hospitals also got information from the ABA to give to patients.

Most hospitals were aware of and were working towards BFHI accreditation so were not allowed to advertise or promote formulas in hospital. Therefore, formula production companies had limited influence on infant feeding advice and decisions in hospitals. Some Midwives expressed concern that they were “not allowed” to discuss formula with mothers due to BFHI guidelines.

Also Midwives obtained their information about breastfeeding from their midwifery training. However, the content of the courses was not thought to be
consistent across Australia. In addition, Lactation Consultants ran more informal training in hospitals periodically.

“There are no standards for breastfeeding education within midwifery programs in Australia.”

11.3 Child Health Nurse Involvement

Child Health Nurses have different names in different states, for example Early Childhood Centre Nurses (NSW), Maternal and Child Health Nurses (VIC), Child and Youth Health Nurses (SA) or Community Child Health Nurses (WA).

They stepped in where hospitals left off. Generally they were tasked with seeing new mothers within 10 days of leaving hospital but due to sparse resources sometimes it could be longer than this. If a mother was having a serious problem with feeding, the Child Health Nurse would sometimes see her more than once in the first ten days, so more than they were funded for. Frequently the Child Health Nurses interviewed, and other health professionals, mentioned how overstretched they were and that they sometimes have to defer to other resources.

“We can’t always get to them within two weeks.”

“If our diaries are full we refer to Tresillian.”

“There should be assistance with breastfeeding immediately after discharge. We need to get to them sooner, we need more staff.”

They were alerted to specific problems with feeding in the discharge information from the hospital Midwives. However, there were some reports that this information was not always accurate. Some nurses mentioned cases where discharge information had not highlighted any issues but when they had seen a mother, she mentioned that she had been having problems in hospital with breastfeeding. There were many cases where discharge information had
mentioned a problem, only for the nurse to find that the mother had switched to formula by the time they had seen them.

Child Health Nurses said they encouraged breastfeeding and were confident about giving advice. They gave help and advice on lots of physical problems, for example cracked nipples, mastitis, baby not latching on properly, concern that the baby is not getting enough milk, and emotional problems, for example Post-Natal Depression, bonding, low self esteem, stress and feelings of not coping. They mentioned the link between breastfeeding issues and emotional problems.

"Feeding problems definitely multiply the risk of PND."

Many health professionals mentioned that sometimes the mothers just needed reassurance that the baby was putting on enough weight. From the research it was apparent that this was not always straightforward, as different sources of support had different ideas about how much weight the baby should be putting on. Child Health Nurses said that babies should be putting on about 800 grams a month whereas the ABA believed it should be 500 grams. There were further differences of opinion between the ABA and others about sleeping and settling. The ABA counsellors interviewed mentioned that the sleeping and settling advice given by Child Health Nurses and other health professionals was not particularly breastfeeding friendly, for example advising mothers not to sleep with their babies, although it was acknowledged that sleeping with the baby has been cited as a risk factor for Sudden Infant Death Syndrome (cot death).

Child Health Nurses referred mothers to the ABA for more information and to Family Support Nurses if there were serious problems, but this was available in the cities only. They would sometimes refer to a GP to rule out physical illness or to an allergy specialist if they thought there might be allergies present. They would also recommend Lactation Consultants if there were unusual problems.

Many actively sought information on breastfeeding from conferences, ABA (Lactation Resource Centre), seminars, Internet, books and journals. Information from formula production companies was not used.
Often they had received training in a number of different areas, for example training in Nursing, Midwifery, Women’s Health, Family Planning and Child Health. They had to obtain formal qualifications to become a Child Health Nurse, such as a Post Graduate Diploma, or a Masters Degree in Child and Family Health in Victoria.

11.4 Lactation Consultants' Involvement

Lactation Consultants were involved in feeding issues in hospital just after the birth or in the community after the mother and baby had left hospital. Midwives referred to them in hospitals if there was a difficulty with breastfeeding. Lactation Consultants sometimes ran lactation clinics and breastfeeding classes for patients, or drop in centres in some hospitals for non-patients (these were not prevalent).

“The drop in clinic for the public is amazing - people can just drop in if they have problems.”

Lactation Consultants outside hospitals were in private practice and mothers did not need a referral, so Child Health Nurses and Family Support Nurses sometimes suggested that mothers saw a Lactation Consultant.

Lactation Consultants saw mothers face-to-face, gave them practical advice and helped them to ‘learn’ how to breastfeed. They tended to deal with difficult or chronic problems associated with breastfeeding as well as the more common problems such as poor attachment or sore/cracked nipples.

Lactation Consultants were very pro-breastfeeding but believed that ultimately it is the mother’s choice whether or not she breastfeeds, and that the relationship between the mother and baby is most important. In the rare circumstances where feeding was impacting on the relationship between mother and baby in a negative way, they would recommend switching to formula feeding. They were very confident about giving advice and information on breastfeeding.
Lactation Consultants were highly knowledgeable and skilled – there was a lot of praise from mothers who had had problems and from other health professionals who had referred to them.

They referred to Family Support Nurses if they thought that the mother and baby needed a whole day or longer to work on their problems. They also referred to the ABA for information.

The Lactation Consultants who participated in the research said that they actively sought out information on breastfeeding to keep up-to-date, as they had to do this for their re-certification. Resources mentioned were the Australian Lactation Consultants Association, lactation interest groups, conferences, seminars, the Australian Breastfeeding Association and lactation colleges.

Most Lactation Consultants interviewed were also Midwives so had received their midwifery training as well as Lactation Consultant training. To become a Lactation Consultant, the health professional must pass an exam developed by the International Board of Certified Lactation Consultants. Before being eligible for the exam, they have to demonstrate that they have had extensive clinical experience working with breastfeeding mothers as well as some level of formal education in breastfeeding. Most professionals paid for the exam and studied in their own time over a one to two year period, so many mentioned that they had to be very dedicated to complete it.

Lactation Consultants have to recertify every five years – either through an exam or continuing education. Many of the participants mentioned that some Lactation Consultants were leaving or thinking of leaving the profession because they felt that there was no great incentive to stay.

Almost all the Lactation Consultants and many other health professionals interviewed mentioned that they thought people should be able to get Medicare rebates for using their services, which is currently not the case.

“It would be good if Lactation Consultants had Medicare provider numbers - they cost $200 each visit. It would save billions of dollars later on.”
11.5 Family Support Nurses’ Involvement

Family Support Nurses such as Tresillian or Karitane (NSW), Ngala (WA), Torrens House (SA) or Child and Family Health Service (VIC) nurses provided support for parents of children up to five years of age. They helped with parenting difficulties such as sleeping and settling, breastfeeding, post-natal depression and relationship issues caused by having children.

There were a number of options for face-to-face support for mothers, fathers and babies ranging from day stays to stays of up to a week to obtain practical and emotional support. However, the waiting lists were often quite long which was seen as being an issue.

“Currently our waiting times are two weeks. If you are having breastfeeding problems this is too late.”

They promoted breastfeeding but believed that ultimately it is the mother’s choice, and sleeping and settling are also priorities. They said that they felt very confident about giving advice.

“We ask the mother what their goal is and work in partnership with them to achieve it. It doesn’t work if you have your own agenda.”

Family Support Nurses are a secondary service, so a referral is needed from another health professional to access their services. Many other health professionals were aware of them and did refer to them.

They said that they tried to work closely with other health professionals to develop a ‘cohesive’ plan for a mother, for example with GPs, Child Health Nurses, Psychologists (if PND is present), Social Workers and Paediatricians. If they felt that the mother or baby was at risk then they would share confidential information with other professionals.

“It’s good to talk to other health professionals because sometimes you are only getting part of the picture.”
They also actively sought information on breastfeeding from conferences, seminars, journals, the ABA and breastfeeding magazines. Some Family Support Nurses also held their own conferences, for example Tresillian holds a conference every two years on various aspects of parenting for health professionals from a range of disciplines.

They felt that many other health professionals were not always well educated about breastfeeding, and they would often provide training for other health professionals. For example, Tresillian in Sydney provided workshops for Child & Family Health Professionals working with families to give them the opportunity to update their knowledge.

“One Paediatrician tells mothers that after six weeks, breastfeeding is of no value whatsoever, and she has been telling patients that for over 10 years.”

All Family Support Nurses were Registered Nurses so they had completed this training. On top of this many were also Midwives. To become a Family Support Nurse they had to have a university qualification. For example, Tresillian worked with the University of Technology in Sydney to provide a 12-month course resulting in a ‘Graduate Certificate Child & Family Health Nursing’ for Registered Nurses. For Karitane the qualification provided was a Master of Nursing (Child and Family Health – Karitane) from University of Western Sydney. Many also had Lactation Consultant training.

11.6 Indigenous Health Workers’/CALD Workers’ Involvement

Many Indigenous Health Workers/CALD Workers were also involved in feeding issues throughout the first few years of life. In particular, they provided support to refugees such as Iraqis, Afghans, Africans, Burmese and also indigenous communities.

Their advice and support covered a wide range of issues and could sometimes include breastfeeding, so it was not one of their main areas of focus. These participants mentioned that PND was a common issue for refugees – they often
lacked the support around them that they would have received in their own country from their extended family. In turn this could affect breastfeeding. Although breastfeeding was the norm in these cultures there was often a high level of stress from being in another country, which could lead to difficulties with breastfeeding.

“Breastfeeding is a given. Generally it is just accepted that that’s what the feeding practices will be. But the support systems aren’t in place. The mothers in their community traditionally support them but here it is fragmented.”

They said that they advised and encouraged breastfeeding, however if it were seen as being to the detriment of mother and baby, then they would advise the mother to stop and switch to formula feeding.

“If they are becoming upset or the baby’s not being nourished enough then we supplement with formula. There is no drama in bottle-feeding. When breastfeeding becomes more of a stress than a convenience then give up.”

They often encouraged the immediate family to provide more support, as in their home country the mother would have relied more on their extended family, who were not always present here.

They were confident about giving basic advice but would refer to a GP or Child Health Centre if there were larger problems with feeding.

Those interviewed said that they obtained information about breastfeeding from lots of different sources, such as the Area Health Service, Child Health Nurses, ABA and Better Health Channel (VIC).

Because they dealt with many different issues, their training was very varied - some had Midwife training and some were Lactation Consultants - and they had many areas of specialty. They rarely had any formal training on breastfeeding outside any other medical training they possessed. Some said they used their ‘own experience’ to advise on breastfeeding matters.
11.7 ABA Involvement

The ABA Counsellors interviewed felt that they were often approached as the last resort in the chain of breastfeeding support. They tended to see the same problems as health professionals, for example difficulties in latching on, mastitis and supply issues. They reported that they were hearing from mothers a lot earlier than they did five to ten years ago, because mothers are leaving hospital earlier without breastfeeding being properly established, so they are encountering more problems.

Their 24-hour Helpline is seen as being particularly beneficial to “tired mums in early mornings and evenings” and people in remote areas with no easy access to health professionals.

They were very confident about giving support but were adamant that they “do not give advice”. Rather, they gave lots of information to inform the mother so that she could make up her own mind in feeding decisions. They focused on counselling - listening and reassurance - as this was often seen as being lacking previously.

“We don’t give advice, we give people a range of options and help them decide what they want to do with their baby.”

“We give them support. We often see them at the end of a long road. They just don’t get the time with other services to be heard. We listen to them.”

They referred to a local ABA group if possible, so that the mother could speak to someone face-to-face. They would also refer to a Lactation Consultant if there was a major problem and practical advice was needed.

They reported that other health professionals did not refer on to the ABA as much as they could and they also thought that many health professionals needed more education about breastfeeding. They felt that some gave advice that was not always breastfeeding friendly.
“Quite often they’ve been trained 30 years ago and they are not keeping up to date with recent information.”

They obtained their information from the ABA’s Lactation Resource Centre. This centre gathered all research and information on breastfeeding and evaluated it. If the research was seen as being credible it is added to their collection and used in their information and support. The ABA also organises their own annual conferences that were often mentioned by other health professionals.

All ABA Counsellors received their own ABA training on breastfeeding, consisting of 130 hours of basic training. This leads to a Certificate in Breastfeeding Education (Counselling). All were volunteers and they normally counselled face-to-face at local groups, by email and/or on the National Breastfeeding Helpline.
12. Health Professionals’ Awareness of and Reactions to Guidelines

12.1 Knowledge of Guidelines

Knowledge of the various guidelines for breastfeeding varied a great deal, depending on the type of health professional, with the Lactation Consultants, Family Support Nurses and ABA Counsellors interviewed having the most knowledge. They mentioned guidelines from their own organisations as well as WHO, Government, Area Health Service and BFHI guidelines.

Figure 3: Level of Knowledge of the Guidelines by Health Professionals

<table>
<thead>
<tr>
<th>GPs Obstetricians Community workers</th>
<th>Maternity Nurses</th>
<th>Midwives Child Health Nurses</th>
<th>Lactation Consultants Family Support Nurses ABA Counsellors</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Limited knowledge</td>
<td>- Some awareness of hospital guidelines</td>
<td>- Aware of hospital or centre procedures</td>
<td>- Extensive knowledge of a number of guidelines e.g. WHO, Area Health Service, DoHA, BFHI, ASCIA – guidelines on allergies and breastfeeding, professional associations</td>
</tr>
<tr>
<td>- Vague about recommended length of time to breastfeed</td>
<td>- Recommend excl breastfeeding for a period (unspecified)</td>
<td>- References to ‘Baby Friendly’ status/standards</td>
<td>- Rec’l feeding for 12 mths (2years for developing countries)</td>
</tr>
</tbody>
</table>

12.2 Understanding of ‘Exclusive’ Breastfeeding

Health professionals regarded the term “exclusive” as fairly self-explanatory, and all understood that it meant breast milk only (expressing included), no formula feeding, no bottled water and no solids.
However, a number were unsure of the recommended timeframe for exclusive breastfeeding, and most of those who did know did not convey the timeframe to mothers. This was mainly due to being wary of putting extra pressure on the mother and being most concerned with immediate issues and problems with breastfeeding rather than thinking long term.

Also, while all thought that there were added benefits for exclusive breastfeeding not all could articulate what they were (except Lactation Consultants, Family Support Nurses, Child Health Nurses and ABA counsellors).

Those who did mention specific benefits referred to:

- physical benefits for the baby (immune system, jaw development, gut flora, vision, asthma),
- psychological benefits (mother and baby),
- physical benefits for the mother (faster weight loss, reduced risk of cancer), and
- long-term benefits for the baby (obesity, diabetes, cardiovascular disease & IQ).

12.3 Goals/Target Rates for Breastfeeding

Those operating in a hospital environment were generally aware that there were targets for initiating breastfeeding. Some mentioned 75%-80% as the target rate for the Baby Friendly accredited hospitals, with some mentioning higher rates/goals (for example 90%). Many were aware that the BFHI guidelines recommended initiating breastfeeding in the first hour after birth.

Health professionals across the sample were less likely to be aware of any set goals or targets for breastfeeding in the months after birth, for example six months or a year.

“I didn’t actually realize they had set goals for that.”
“I know there are target rates but I don’t know what they are.”
“I think it’s 50% at six months at the moment but it should be 80%. I don’t know the exact figure.”

It was assumed that data was kept to measure breastfeeding initiation rates in hospital and that Child Health Nurses continued to collect data outside hospitals.

However, nobody knew of any statewide or national data collection on breastfeeding.
13. Health Professionals’ Reactions to the Presented Benefits

Similarly to mothers, pregnant women, partners and grandmothers, health professionals seemed to be aware of these benefits.

They indicated that this benefit was commonly conveyed to mothers in terms of giving antibodies to help prevent infection and provide immunity benefit.

There were no issues with the credibility of this information.

It was considered to be a very persuasive fact because of its immediacy (being about the baby at a time when the mother’s concern about the baby is heightened).

Many health professionals were aware of this, although there was lower awareness than for other benefits.

The general perception was that mothers weren’t educated about this aspect. Some wondered about how acceptable this would be to the general public and whether they would believe this benefit.

“They would see a lot of other influencing factors.”

While this benefit also dealt with the health of the baby, it was considered to be too long-term to be truly persuasive.
Breastfeeding benefits a mother’s health by reducing the risk of breast cancer, ovarian cancer, type 2 diabetes and osteoporosis.

Most health professionals interviewed were aware of this, though not necessarily all aspects, for example they may have been aware of breast cancer but not the other conditions.

The general perception was that mothers weren’t properly informed of this.

The information was generally viewed as credible but some said it might be hard to explain the reduction of the risk of osteoporosis, as the general perception is that breastfeeding removes calcium from the mother’s body.

While they felt that it was important for mothers to know this, many felt that the concern over the baby would take priority and that this benefit would not be persuasive.
Conclusions and Recommendations
14. Conclusions and Recommendations

In line with the objectives of this research project, the findings provide a greater understanding of the:

- attitudes and experiences of breastfeeding amongst pregnant women, mothers, partners, grandmothers and health professionals;
- enabling factors and barriers that contribute to decisions about initiation, continuation and cessation of breastfeeding;
- support strategies that women obtain;
- attitudes of health professionals, the advice they provide and their level of confidence in providing this advice; and
- levels of training available to/attained by health professionals advising on breastfeeding.

Outlined below are the main recommendations based on the findings of this study, which will better encourage and enable women to breastfeed for the suggested time period, along with supporting rationale.

It is worth noting however, that whilst the general direction and detail of the findings can be viewed with confidence, because of the nature of the qualitative technique they do not reflect a statistically accurate analysis, and some care therefore has to be taken in exact interpretation or extrapolation.
14.1 Implement social marketing activities to normalise breastfeeding, increase commitment to breastfeeding, dispel myths associated with breastfeeding and promote the benefits of breastfeeding.

The research has shown that many mothers find breastfeeding in public uncomfortable and embarrassing and it is not always accepted, particularly in country areas and amongst lower socio-economic groups.

These findings suggest it will be beneficial to instigate national social marketing activities to help normalise breastfeeding and encourage acceptance of it and recognition of it as beneficial for the mother and child.

Along with the more emotionally based “bonding” and “natural” benefits, the research found that the most motivating specific health benefit is the suggestion that breastfeeding helps strengthen the immune system of the baby, and helps protect against diarrhoea, respiratory problems and ear infections, and we suggest this be built in to the social marketing activity.

The misperceptions found in the research that will need correcting include:

- breastfeeding in public is illegal,
- formula provides extra benefits over breast milk,
- solids should be introduced at four months,
- babies do not put on “enough” weight or get “enough” milk whilst breastfeeding,
- mothers are not able to breastfeed when the baby has teeth,
- breastfeeding is not possible if you get mastitis or are on medication, and
- if the grandmother had problems breastfeeding then the mother is also likely to have problems.

However, we must stress that our research has highlighted that breastfeeding is a very sensitive subject, and any activity must be very carefully crafted so as not to
exacerbate guilt and feelings of failure, as well as prejudice, through creation of blame and stress amongst those who cannot breastfeed.

14.2 Encourage and support commercial entities and employers to provide breastfeeding facilities and implement policies that support breastfeeding.

The research showed that after about three months, external factors such as community and employer attitudes and the availability of facilities for feeding start to have a relatively strong impact on continuation of breastfeeding, as the mother starts to go out more and possibly returns to work.

Employers should be encouraged to provide breastfeeding and “expressing friendly” facilities in the workplace so that mothers continue to breastfeed after returning to work.

It is also recommended that policies be implemented to promote and support breastfeeding, for example policies to promote breastfeeding friendly cafes and businesses, to encourage more local facilities, and policies that help provide flexibility in the workplace so women can more easily combine work and breastfeeding.

14.3 Promote breastfeeding and its benefits through antenatal classes. Classes should include information on common difficulties associated with breastfeeding, and identify how to access help and support.

During pregnancy women are often more focussed on the birth itself than how they are going to feed their baby, so they do not go out and search for information on feeding themselves.

However, expectant mothers could be better educated in order to manage their expectations and explain the various physical feelings and sensations which will
be experienced, obviously with a positive slant that it is definitely something worth persevering with.

Antenatal classes are an ideal medium to communicate the benefits of breastfeeding and potential problems associated with it, as well as the sources of help and support available for use during the first few weeks after the birth if they need it.

It was suggested that demonstrations of “real” mothers feeding would be helpful, and up-to-date DVDs available through classes or accessible online could also help in this regard.

Antenatal classes could also be used to try and get across to the prospective mothers and partners the importance of building up a support network of people such as friends and family who can be called on if possible to give help at the most critical time of the first few weeks.

14.4 Utilise ‘Bounty Bags’ provided to new mothers to distribute information and resources on breastfeeding, including information on common difficulties associated with breastfeeding and where to access help and support for overcoming difficulties. Also provide information for partners and family members about how they can give support.

 Mothers are very receptive to information immediately after birth whilst in hospital, and eager to learn, and they could also benefit from some advice and strategies about what to do when they get home, how to cope on their own and how to try and overcome some of the common problems.

 Mothers should be encouraged to seek help once they get home if required, and better advised that many people have problems, that there is no one way to breastfeed, with advice presented in an encouraging and sensitive manner, so that they do not feel pushed or bullied, as this adds further to stress levels.
Pamphlets in the “Bounty Bags” are generally read and taken notice of, and this would offer a good means of disseminating information about help available.

Communication materials, with hints and tips for partners and grandmothers about how best to support the mother during this time could also be provided through the Bounty Bags.

14.5 Increase support services for new mothers at home during the first weeks following birth, including greater access to Child Health Nurses and Lactation Consultants.

The first weeks following birth was clearly a very stressful and difficult time for many mothers, particularly for those who did not have much support around them.

Given that the mothers were often out of hospital after two or three days, some without even having had the “milk come down”, they were left very much to their own devices at home, to try and establish breastfeeding with their baby without hands on or professional support.

The research showed that it was a time when the tendency to give up was very high, due to feelings of exhaustion, pain, cracked nipples and possibly mastitis, not knowing if the baby was getting enough milk, and possible PND and feelings of desperation.

Mothers and health professionals felt that there was only a limited amount of outside help and advice available and which was accessible in the first two weeks. There were occasional visits with Child Health Nurses but these were not always able to be at the time when help was needed, or when they could breastfeed in front of a nurse and gain practical advice on technique. There were few “drop in” facilities, and these were particularly seen as an effective means of providing help and encouragement.
In the first few weeks mothers could in fact be encouraged to give up by partners or grandmothers, who were concerned about the difficulties and pressures it was causing for the mother, baby and the household generally.

Therefore, access to support once at home with the child in the first few weeks of its life is vital, and this includes:

- Increasing the level of in-home support available through greater access to Child Health Nurses or visiting Midwives,
- Provision of more 24 hour “drop-in” centres where mothers can take the child and breastfeed with a professional, at the time when “hands on” help and advice is needed most, and
- Greater access to Lactation Consultants.

Ideally women would be able to stay in hospital longer or in some sort of ‘halfway’ facility, at least until the milk has arrived and breastfeeding had been established. However in the absence of this, then greater access to help in the early stages would be crucial to the successful continuation of breastfeeding for many of those with difficulties.

The availability of the 24-hour national Breastfeeding Helpline from the ABA will help in this regard, but many mothers said they needed face to face help so that the baby could be fed in front of a consultant.

In home support from family members and friends is also important to encourage.

14.6 Promote the importance of exclusive breastfeeding, and convey information on how long this should be maintained and when to introduce solids and other liquids.

The research found that many mothers were not clear about the benefits of exclusive breastfeeding, so felt that they were able to feed formula some of the
time such as at night, or if they went out, and still obtain the benefits from some breast milk.

Other aspects such as teething, the introduction of solids, the baby seeming to want more as a result of a growth spurt, or the milk changing and the breasts not feeling as engorged, all led to changes in feeding, particularly if the mother was not aware of the guidelines or benefits associated with longer term breastfeeding. They often felt their “job was done” after a few months of feeding and were not too worried about switching to formula.

Therefore, after the first three months of the baby’s life, emphasis is better placed on trying to communicate with mothers using any possible channels or “touch points” to get across the need for exclusive feeding, how long this should be maintained, and when to introduce solids and other liquids.

Health professionals, particularly the less specialised, such as GPs, can be used to help advise about this when the mother presents to them with other baby related questions. However, a number of health professionals were unsure of the recommended timeframe for exclusive or partial breastfeeding, and most of those who did know did not adequately convey the timeframe to mothers. This was mainly due to being wary of putting extra pressure on the mother, and being most concerned with immediate issues and problems rather than thinking long term. In addition, many could not say what the added benefits were of exclusive breastfeeding over non-exclusive breastfeeding. So there is a need to provide these professionals with clearer guidelines and education to ensure their advice is consistent (see recommendation below).
14.7 Conduct an audit of breastfeeding-related education and training provided to Midwives, Maternity Nurses, Lactation Consultants and other health professionals to ensure information provided to mothers is consistent. Review and monitor training on a regular basis.

It would appear that most hospitals are aware of and support BFHI, and are either accredited or going through accreditation, so are already “pro” breastfeeding. They also have hospital policies for breastfeeding that health professionals working in the hospital should adhere to. However, the research found that information and advice given to mothers about breastfeeding was not always consistent within and between health professions.

The research found that the hospital Midwife was critical as the main source of information and help in a functional sense. However, they could often provide conflicting advice, and they were sometimes seen to have very strong opinions and not be very understanding. It was reported that they could also be insensitive in their treatment of mothers who might be experiencing difficulties with breastfeeding, and this could impact significantly on the mother’s choice to continue with it or not, particularly if she was not initially totally committed to the concept.

There were also reports of inconsistencies in advice and information given by different breastfeeding influencers e.g. the ABA and Child Health Nurses on babies’ expected weight gain and sleeping and settling advice.

Therefore, there is a need for an audit of the training and updates received by key health professionals to help ensure consistency in approach and advice.
14.8 Provide GP’s and other health professionals with guidelines, information and other resources to assist them to promote and support breastfeeding. Encourage GP’s and other health professionals to refer mothers to other sources of help and support where required.

There were reports of GPs and hospital consultants giving wrong advice or guidance, such as advising not to breastfeed if a mother had mastitis or was on specific medication. Although GPs do not deal with breastfeeding problems as much as Lactation Consultants or Child Health Nurses, they do see mothers who are presenting with ‘health related’ breastfeeding problems, and they therefore can have an influence on breastfeeding continuation. It is important to ensure that GPs do have accurate and up to date information, and are encouraged to refer on to other health professionals who are specialists in the area of breastfeeding where necessary.

GPs could also be provided with pamphlets that they could easily give to patients in pregnancy or after the birth, to help educate about the benefits of breastfeeding and the length of time recommended, to encourage continuation and to help dispel the myths.

14.9 Explore options for utilising Lactation Consultants to provide education and training to other health professionals, particularly in maternity settings.

Lactation Consultants were seen as extremely knowledgeable and were a highly valued resource by the mothers who had used their services and by many health professionals included in the research.

Therefore, it is recommended that Lactation Consultant numbers be increased, to help ensure greater access to these professionals at the most crucial times for the prevention of lapsing. We suggest greater encouragement and
incentivisation for more nurses to become Lactation Consultants, to increase this resource within the community.

Encouraging Lactation Consultants to provide internal training in hospitals to Midwives and other staff would also be useful in encouraging consistency, and the provision of up to date information.

**14.10 Conduct further research on specific CALD awareness and attitudes regarding breastfeeding.**

This study did not include a specific CALD component, with CALD participants falling out naturally in the recruitment. Feedback was also obtained from health professionals regarding this segment.

The feedback received does however suggest there are a wide range of differing attitudes and levels of awareness regarding breastfeeding amongst certain CALD groups, and therefore it would appear a separate investigation of this in more depth is advisable.
Appendices
15. Appendices

15.1 Detailed Research Design

a) Mothers/Pregnant Women/Partners

i) Mothers of Children Under 2 years - 18 Groups & 20 In-Depth Interviews

<table>
<thead>
<tr>
<th>Group Specification Codes:</th>
<th>Mini Groups N=18</th>
<th>Depths N=20</th>
</tr>
</thead>
<tbody>
<tr>
<td>C= Committed Breastfeeder</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>NL = Not Exclusive/Lapsed Breastfeeder</td>
<td>11</td>
<td>9</td>
</tr>
<tr>
<td>Never (i.e. Not after 1st week)</td>
<td>1</td>
<td>5</td>
</tr>
</tbody>
</table>

Mini Groups N=18

<table>
<thead>
<tr>
<th>SEGMENT</th>
<th>TOT-AL</th>
<th>NSW</th>
<th>VIC</th>
<th>WA</th>
<th>SA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Syd.</td>
<td>Cowra</td>
<td>Melb</td>
<td>Ballarat</td>
</tr>
</tbody>
</table>

Age had child

<table>
<thead>
<tr>
<th>Total</th>
<th>6</th>
<th>I_NL</th>
<th>I_C</th>
<th>-</th>
<th>-</th>
<th>I_NL</th>
<th>I_C</th>
<th>I_NL</th>
<th>I_NL</th>
</tr>
</thead>
<tbody>
<tr>
<td>25-35yrs</td>
<td>8</td>
<td>2</td>
<td>-</td>
<td>2</td>
<td>I</td>
<td>I</td>
<td>-</td>
<td>I</td>
<td>I</td>
</tr>
<tr>
<td>1st Child</td>
<td>4</td>
<td>I_NL</td>
<td>-</td>
<td>I_C</td>
<td>-</td>
<td>I_C</td>
<td>-</td>
<td>-</td>
<td>I_NL</td>
</tr>
<tr>
<td>2+ Child</td>
<td>4</td>
<td>I_C</td>
<td>-</td>
<td>I_NL</td>
<td>I_NL</td>
<td>I_NL</td>
<td>-</td>
<td>-</td>
<td>I_C</td>
</tr>
<tr>
<td>Total</td>
<td>4</td>
<td>I</td>
<td>-</td>
<td>I</td>
<td>I</td>
<td>I</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>35+ yrs</td>
<td>4</td>
<td>I</td>
<td>-</td>
<td>I</td>
<td>I</td>
<td>I</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>1st Child</td>
<td>2</td>
<td>-</td>
<td>-</td>
<td>I_NL</td>
<td>-</td>
<td>I_NL</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>2+ Child</td>
<td>2</td>
<td>I_C</td>
<td>-</td>
<td>-</td>
<td>I_NL</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>18</td>
<td>4</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>
**In-Depth Interviews N=20**

<table>
<thead>
<tr>
<th>SEGMENT</th>
<th>TOTAL</th>
<th>NSW</th>
<th>VIC</th>
<th>WA</th>
<th>SA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age had child</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total &lt; 25 yrs</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total 25-35 yrs</td>
<td>7</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1st Child</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2+ Child</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total 35+ yrs</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1st Child</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2+ Child</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Never</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
<td>4</td>
<td>1</td>
<td>4</td>
<td>2</td>
</tr>
</tbody>
</table>

* A total of 4 depths specifically with single mothers and 2 with mothers who have returned to work prior to 6 months

**ii) Pregnant Women - 6 Mini Groups & 6 In-Depth Interviews**

**Mini Groups N=6**

<table>
<thead>
<tr>
<th>SEGMENT</th>
<th>TOTAL</th>
<th>NSW</th>
<th>VIC</th>
<th>WA</th>
<th>SA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age had child</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total &lt; 25 yrs</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total 25-35 yrs</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1st Child</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2+ Child</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total 35+ yrs</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Pregnant Women - In Depth Interviews N=6

<table>
<thead>
<tr>
<th>SEGMENT</th>
<th>TOTAL</th>
<th>NSW</th>
<th>VIC</th>
<th>WA</th>
<th>SA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age had child</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total &lt; 25 yrs</td>
<td>2</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total 25-35 yrs</td>
<td>2</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>1st Child</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>2+ Child</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Total 35+ yrs</td>
<td>2</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>1st Child</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>2+ Child</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>6</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

iii) **Partners** - N= 4 Mini Groups, N=6 In-depth Interviews & N= 6 Paired depths (with Mothers/Pregnant Partner)

<table>
<thead>
<tr>
<th>SEGMENT</th>
<th>TOTAL</th>
<th>NSW</th>
<th>VIC</th>
<th>WA</th>
<th>SA</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 Mini Groups</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Partner Committed</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Partner Non Exclusive/ Lapsed</td>
<td>2</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Pregnant Partner</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>4</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

| 6 In Depths – Partners |       |       |       |       |       |       |       |       |       |
| Partner | 2 | 1 | - | 1 | - | - | - | - | - |
### Committed

<table>
<thead>
<tr>
<th></th>
<th>NSW</th>
<th>VIC</th>
<th>WA</th>
<th>SA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partner Non Exclusive/ Lapsed</td>
<td>2</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Pregnant Partner</td>
<td>2</td>
<td>-</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>6</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

### 6 Paired Depths – Both Partners

<table>
<thead>
<tr>
<th></th>
<th>NSW</th>
<th>VIC</th>
<th>WA</th>
<th>SA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partner Committed</td>
<td>2</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Partner Non Exclusive/ Lapsed</td>
<td>2</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Pregnant Partner</td>
<td>2</td>
<td>1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>6</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

### b) Health Professionals

<table>
<thead>
<tr>
<th>Category</th>
<th>NSW</th>
<th>VIC</th>
<th>WA</th>
<th>SA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Doctors/ Specialists</td>
<td>6</td>
<td>2</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>GP’s</td>
<td>3</td>
<td>1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Obstetricians/Gynaecologists/ Paediatricians</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total Hospital Influencers</strong></td>
<td>19</td>
<td>4</td>
<td>2</td>
<td>4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Category</th>
<th>NSW</th>
<th>VIC</th>
<th>WA</th>
<th>SA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Midwives</td>
<td>5</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Maternity Nurses</td>
<td>5</td>
<td>1</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Lactation Consultants</td>
<td>5</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Antenatal class organisers</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>----------------------------</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Total Non Hospital Influencers</td>
<td>31</td>
<td>10</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Child Health Nurses*</td>
<td>8</td>
<td>2</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Practice Nurses</td>
<td>2</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Community/Practice Midwives</td>
<td>3</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Family Support Nurses**</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>ABA Counsellors #</td>
<td>4</td>
<td>4*</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Indigenous Health Workers/CALD Health/Community Workers</td>
<td>6</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Remote GP’s/Health Workers (phone)</td>
<td>4</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>56</td>
<td>16</td>
<td>6</td>
<td>9</td>
</tr>
</tbody>
</table>

# A mini-group was carried out with the ABA counsellors

* Child Health nurses are called different names in different states, for example Early Childhood Centre Nurses (NSW), Maternal and Child Health Nurses (VIC), Child and Youth Health Nurses (SA) or Child Health Nurses (WA). In this report they are referred to as Child Health Nurses.

** Family Support nurses are called different names in different states, for example Tresillian/Karitane (NSW), Ngala (WA), Torrens House (SA), Child and Family Health Service (VIC). In this report they are referred to as Family Support Nurses.
15.2 Infant Feeding Topic Guide - Mothers

Introduction: Put everyone at ease, go through the introduction sheet in a very informal way, that it is a study being done by the Department of Health and Ageing, to ensure they understand women’s needs and the issues involved with motherhood and babies, and to ensure they can offer the right sort of support. Reassure everyone that it is an open discussion, all comments welcome, definitely no right or wrong answers, that we believe everyone has the right to decide what is best for their own baby, and we don’t have a view on that one way or another. Also let them know that they have been grouped together with people who have relatively similar attitudes, so they can feel very open about saying how they feel at any time.

Tell them group members can feel free to let us know if they are uncomfortable in any way, and to get up and go to the loo etc. If they have their baby with them and would prefer to briefly leave the room to feed or settle him/her, to please do so.

Also inform that people might be viewing, and that we will be recording for our purposes only.

Putting at ease/Collection of family composition
Just to start off as background, let’s just go round the room to introduce ourselves, and tell the group how many children you have, what age etc…

Top of Mind Associations
As you know we are going to be mainly talking about infant feeding and other baby related issues, so let’s firstly just have a quick five minute sharing of the first five words that come into your head when you think of breastfeeding in particular, (ROTATE breast and bottle) regardless of whether you know much about it, or whether you have had experience with it…. who’s first…shout it out and we will scribble them on here (write on butchers paper, don’t allow time to think or discuss at this stage).
And what about **bottle or formula feeding**, the first five words that come into your head.

That's great...we might come back to some of those later!

**Infant Feeding Experiences**

Can we now talk about your own experiences with feeding your last baby....and how you decided what to do and when,

**Prior to birth:**

- Can you remember when you first started thinking about how you would feed your child? And when did you start to think more seriously?
- Before you had the baby how did you find out what was involved in feeding? Did you look at any information (eg books, magazines, Internet, what sites, other, what were you looking for)?
- And who did you talk to about it?...Probe for health professionals, family etc in detail (probe for detail about what they have heard, the type of information and advice from whom, and how frequent/how much notice is taken etc, eg family vs in-laws vs outside advice)
- Did you ask for the information or was it something that you were approached with?
- What information or who were you most likely to listen to or take notice of at that stage?
- How were you feeling about breastfeeding vs formula or bottle feeding before the birth, was breast feeding something you felt you would just try for a while, or were you pretty determined about it, did you think it would be easy/hard, why?
- *If previous children,* were you going to feed your last child in the same way as previously? Why or why not, what made you change your intentions?
After the Birth:

- Tell me about your very first experiences with feeding your last child, the good things, the bad things, how you felt, what was helpful, what was difficult (go through the first hours, days)?

- What was the hospital like that you were in, what was their attitude toward feeding, did that influence you, how?

- Who were you getting advice and help from at that stage, what were you being told, what was most useful, what sources did you most trust, or take most notice of? (Probe for family member, mother in law vs mother, others involved, as well as medical and hospital, associations/groups etc., and what roles each played in decision making)

- Have you heard of the ABA or Australian Breastfeeding Association...what have you heard, have you ever rung or had contact with them, how was that, did it help?

- If breastfeeding; Did you want to keep on breastfeeding after the first few days, why, why not, how long did you think you would breastfeed for, and how long did you in the end?

At Home:

- And how were you feeding once you got home? What sort of things were easy/difficult, how were you feeling about it all, did your feeding patterns change, how and why?

- What about your partner, rest of the family, did they have an impact on your decisions?

- Did you seek help or advice, once you were home? Who from? Again did you have any books or information, did you Google or look at any websites, discuss it with friends, other mothers, what sort of questions did you want to ask/find answers to?

- Did you always find the answers to your questions? Were there any pressures that prevented you asking questions or obtaining answers?
Three Months on and as the child gets older:
- How were you going three months on, and after that? How were you feeding your baby?
- How often did you breast vs bottle feed? (Probe breastfeeders to see if exclusive or partial). Why was that?

If Committed
- Ok, What is your understanding of the term “exclusive breastfeeding”?
  Our recruitment suggests you all breastfed fairly exclusively with your last child for the first six months.

  - How difficult/easy was it to breastfeed exclusively? What difficulties did you encounter and how did you get round them?
  - What about expressing milk...did you have to do that, how often, how did you find it?
  - What sort of things encouraged you to keep going, did you ever think about giving up, what stopped you?
  - How did breastfeeding make you feel?
  - Do you think other people think it is a good thing to do?
  - How long did you think you would keep going?
  - Again what sort of help/advice did you get at this stage, what was most useful to you, and who did you take most notice of?
  - What would you tell someone who is intending to breastfeed exclusively, what sort of advice would you give them?

If Not exclusive/lapsed with last child
Our recruitment suggests that most of you did not breastfeed exclusively, or stopped breastfeeding ...

  - When did you breast/bottle feed, what sort of patterns did you have, why, what contributed to that?
  - Were you expressing milk at all, how was that?
• How and why did you decide to not breastfeed, or not breastfeed exclusively?
• What prompted your decision, was it a sudden change for some reason? Why? How did the change come about?
• Was it a difficult or easy decision to make, or did you not really make a decision instead just falling into the pattern?
• What did you weigh up when you were deciding what to do, did you look for any information or help, where, which was most helpful, did people offer information/opinions, who and what were they saying, what did you take notice of/was helpful?
• What sort of questions did you ask?
• How did you feel when you had cut back or stopped? Was it better for you, did you feel bad in any way?
• Did you want to breastfeed for longer? If yes, is there anything that could have helped you to breastfeed exclusively or for longer? E.g. information or support?

Ask All:
If someone came to you looking for advice about whether to breastfeed or not, what would you tell them? What advice would you give, based on your own experiences?

If more than one child
• How did you feed your previous children...was it the same as for your last one?
• What is the same, what is different?
• What about your first child, what were your experiences there?
• How did your prior experiences impact on what you did this time?
• What were the key learnings from your previous experience?
Imagery and Insight

Why do you feel this person might have reacted the way she did:

**Insight Test:** “Carolyn initially breastfed her baby exclusively, but after a couple of months she did so less frequently, and had pretty much stopped at the end of three months”

- Why did she make this decision, what was driving her, (probe beyond physical issues), how do you think she felt about breastfeeding vs formula, what did her partner/family think about this decision, what about other people generally, would it impact on the baby or the mother in any way, how?
- Do you think she was intending to breastfeed as much as she could, why?
- What do you think may have helped her in breastfeeding longer if this was what she wanted?
- Section 2: Ok, so what if I told you that feeding was actually working ok for both Carolyn and the baby, but she had still pretty much stopped by 3 months. What do you suppose her reasons might have been?

Myths and Misperceptions

- When you think of all the things you have been told about breastfeeding, in your opinion, what are the things you feel might just be myths, and what things do you feel are wrong, vs the things you really believe are right?

Perceived advantages and disadvantages - unprompted

**ROTATE BREAST AND BOTTLE**

a) Breast

- Regardless of what you chose to do, what would you say are all the advantages of breastfeeding including feeding the baby expressed milk in a bottle (probe for physical and emotional/psychological)
  - For the baby
  - For the mother
  - For the partner/family members
  - In general
• And what is the most important of those in your view?
• And what are all the disadvantages
  - For the baby
  - For the mother
  - For the partner/family members
  - In general

• And what is the most important of those disadvantages?
• Do you think it makes any difference to breastfeed exclusively (ie absolutely nothing else), or is it the same to just breastfeed a bit?

b) Bottle
• Again, regardless of what you chose to do, what would you say are all the advantages of bottle or formula feeding (probe for physical and emotional/psychological)
  - For the baby
  - For the mother
  - For the partner/family members
  - In general

• And what is the most important of those in your view?
• And what are all the disadvantages of bottle or formula feeding
  - For the baby
  - For the mother
  - For the partner/family members
  - In general

• And what is the most important of those disadvantages?

• Are you aware of any set guidelines or formal advice that has been put out about breastfeeding? What does it say, how credible or realistic are they?
Reactions to the benefits - prompted

Show Card

Various literature suggests there are some advantages to be gained from breastfeeding exclusively........which of these have you heard of, do you believe, are worth taking into account, or could help persuade you and/or others to breastfeed exclusively/more/at all (depending on group)....(by the way, we as researchers have no set view on this, we just want to hear how people feel about them, )

Show cards and go through each benefit individually, probing on reactions

Further Suggestions

• Should any more be done to support and encourage women like themselves in making decisions about how to feed their children (can ask the exclusive/committed feeders about feeding more or for longer)?
• If yes, what sort of things, and who should offer/run them?

Thanks and close

15.3 Health Professional and Influencer Topic Guide

1. Introduction

Thank for their time, explain the purpose of the study, i.e. that it is a study being conducted on behalf of the Dept of Health and Ageing, to help them better understand women’s needs regarding information and support in infant feeding.

All responses and views will be kept totally confidential, and we will only report on findings in an overall sense.
2. **Role Overview**
Firstly could I just understand a bit about your overall day-to-day role, and your involvement with pregnant women and/or mothers? What are the ages of the mothers’ babies you deal with? Probe for full description of the degree to which they are involved and why.

3. **What Advice is Sought/Offered, When and by Whom**
- And thinking specifically about infant feeding, do women discuss this aspect with you, or do you raise it with them?
- When do they tend to discuss it with you, at what stage in their pregnancy/baby’s life?
- Do they tend to ask you about particular issues to do with it? What are those issues? What do they tend to mostly ask you, and what are the things that come up occasionally? PROBE for differences in practical “how to” advice, versus any more intangible emotively based questions.
- In your view, what are the challenges that they appear to be facing in infant feeding? Do you ever get women who are having difficulty breastfeeding asking you for advice, what are the sort of difficulties are they having?
- Do you feel they know quite a bit about infant feeding generally, is their knowledge accurate in your view, what are the main gaps, what are the more common mistakes they make in your view?
- What about breastfeeding in particular, in your view do they tend to know a lot about that? What are the things they appear not to know so well?
- In your view, do you think there are a range of “myths” that are evident in regard to breastfeeding? What are the things that you hear said that you think are not correct?
- What have been the main changes you’ve seen with regards to infant feeding knowledge and practices over the years?
• **What Advice is Given, What Drives the Type and Extent of Advice Given?**
  - Overall, how much do you feel you know about breastfeeding and formula feeding? How confident do you feel about giving advice to pregnant women/mothers about infant feeding?
  - What sort of advice do you generally provide?
  - Do you tend to recommend one method over another, why is that? Are there times where you might advise the opposite to that, when is that? What guides you in your choice of recommendation for patients? Why is that?
  - What do you feel are the main benefits of formula feeding vs. breastfeeding, and vice versa? And what other benefits are there in your view?
  - What about the negatives, what are the main negatives of formula compared to breast, and vice versa?
  - What advice do you give women who are having difficulties breastfeeding in particular?
  - Is it hard to encourage them to keep trying to breastfeed? What do you feel are the main barriers for those women? How do you advise/help them, what do you feel is the best approach, what are the main barriers you pick up on, how easy are these to overcome?

4. **Support From Other Professionals**
   - What support is provided from other healthcare professionals? How do you work together on managing infant feeding issues?
   - What client information is held or passed on to you? What protocols are in place for sharing information with other healthcare professionals?

5. **Guidelines/Targets/Benefits of Exclusive Breastfeeding**
   - What set guidelines or formal advice are you aware of about breastfeeding? What does it say? How credible/realistic is it? What have been the changes in guidance / recommendations over the years?
   - What is your understanding of the term “exclusive” breastfeeding, do you think it brings extra benefits, what are these…for the mother, for the child?
• Are you aware of any goals/target rates for breastfeeding? How realistic or achievable are they?
• Do you, or anyone else, do any data collection follow-ups – e.g. to your knowledge is any data collected on breastfeeding outcomes at the local level?

SHOW BENEFIT CARDS
• Some experts have identified a range of benefits that are brought on by breastfeeding exclusively, I am just interested if you are aware of any of these and what your reaction is to them …GO THROUGH EACH CARD and discuss.
• Do you think more mothers would breastfeed exclusively if they knew these facts, why, why not, which facts do you think are most persuasive?

6. Information Sources / Material Used
• Where have you gained most of your information about infant feeding from, what are the main sources that you use, and what other sources have you used? How do you keep up with any changes in thinking?
• Are you aware of any training on infant feeding? Have you ever had any training? If so, what training and what did it consist of?
• What role do formula production companies have in providing information / material / samples? How do you use this? What is your view on this?
• Do you give your patients/clients any information on infant feeding, what do you give them?
• Do you tend to refer them on to anywhere else for help? Where?
• Are you aware of the Australian Breast Feeding Association, what do you know about their services, do you ever refer to them?

7. Gaps in Information, Further Information Required
• What particular gaps are there in the information you currently have and know about?
• Ideally, what sort of information do you think would be most useful for you to have access to, and what form should that take?
8. Preferred Methods/Channels for Information Dissemination (if time permits)

- How best should information about infant feeding be distributed or communicated to you, what sort of channels would be best?
- Are there any particular magazines, associations, Internet sites or other groups through which information about infant feeding could be provided?

9. Suggestions Regarding Information, Material or Tools that would help them in their Role

And finally, is there any particular material or “tools” that you might need to help you in advising about feeding, anything that you might need to give to people to help them, what sort of things do you suggest?

15.4 Infant Feeding Topic Guide – Partners (Existing dad/parent)

NB. Adjust conversation if partner is currently pregnant with 2nd, 3rd child, etc

Introduction: Put everyone at ease, go through the introduction sheet in a very informal way, that it is a study being done by the Department of Health and Ageing, to ensure they understand needs and the issues involved with parenthood and babies, and to ensure they can offer the right sort of support. Reassure that it is an open discussion, all comments welcome, definitely no right or wrong answers, that we believe everyone has the right to decide what is best for their own baby, and we don’t have a view on that one way or another. Also let them know that they have been grouped together with other dads/partners, so they can feel very open about saying how they feel at any time. Inform that people might be viewing, and that we will be recording for our purposes only.
Putting at ease/Collection of family composition
Just to start off as background, let’s just go round the room to introduce ourselves, and tell the group how many children you have, if partner is pregnant, etc…

Top of Mind Associations
As you know we are going to be mainly talking about infant feeding, and other baby related matters, so let’s just have a quick five minute sharing of the first five words that come into your head when you think of (ROTATE breast and bottle) breastfeeding your baby, regardless of whether you know much about it, or, or whether your partner and yourself plan to do it for this baby…. Who’s first…shout it out and we will scribble them on here (write on butchers paper, don’t allow time to think or discuss at this stage).
What about bottle or formula feeding? Again first five words,
That’s great…we might come back to some of those later!

Infant Feeding Experiences
Can we now talk about your own feeding experiences?
a) Information used prior to birth (of last child)
   - When did you (and/or your partner) first start thinking about how you would feed your baby, and when did you start to think more seriously?
   - Before you had the baby did you find out what was involved, did you look at any information (eg books, magazines, Internet, what sites, other)
   - What role did you have in this information seeking phase?, if any?
   - And who if anyone have you talked to about it? Probe for health professionals, family etc in detail (probe for detail about what they have heard, the type of information and advice from whom, and how frequent/how much notice is taken etc, eg family vs in-laws vs outside advice)?
   - What information or who were you most likely to listen to or take notice of at that stage?
   - What breastfeeding associations/groups etc are you familiar with? What have you heard about them, have you ever rung or had contact with any of them, how was that, did it help? (If not mentioned) Have you heard of
the ABA or Australian Breastfeeding Association? What have you heard etc.?  

• How were you feeling about breastfeeding before the birth? How did your partner feel about it – was it different to you?  
• (If applicable) Was it something you felt your partner would just try for a while, or were you pretty determined about it, did you think it would be easy/hard, why? Did you feel differently to your partner? Explain.  

b) After the Birth  
• Tell me about your partner’s very first experiences with feeding, the good things, the bad things? How did you and your partner feel? What was helpful, what was difficult? Probe for context here – eg hospital environment, baby and mother’s health etc  
• Who were you and your partner getting advice and help from at that stage, what were you being told?  
• How were you feeling about breastfeeding after the birth? Did your partner feel the same way? Did you want your partner to keep on breastfeeding, why, why not, how long did you think you would like your partner to breastfeed for? How do you think you partner will feel/felt about your views.  
• And how did you get on with feeding once you were home, what sort of things were easy/difficult, how were you both feeling about it all? Probe for context such as sleep/settling problems, reflux, baby weight gain etc.  
• What role did you have at this stage?  
• What about the rest of the family, do you think they had an impact on the decision to keep going or not?  
• Did you/your partner seek help or advice, who from? Again did you have any books or information, did you Google or look at any websites, discuss it with friends, other fathers, what sort of questions did you want to ask/find answers to?  
• Did you always find the answers to your questions? Were there any pressures that prevented you asking questions or obtaining answers?  

c) Three Months on and as the child gets older  
• How were you/are you going three months on, and after that? How often did your partner breast/bottle feed? Why was that?  
• What role did you/do you have? What specific tasks do you have?
If Committed

- What is your understanding of the term “exclusive breastfeeding”?

Our recruitment suggests your partners all breastfed fairly exclusively with your last child for the first six months.

- How difficult/easy is it/was it to breastfeed exclusively, how does your partner get round the difficulties, what do you/she like about it?
- What sort of things encourage her to keep going, do you and your partner ever think about giving up, what stops her? What tempts her?
- How does it/would it make you feel if your partner wanted to give up?
- Do you think other people think it is a good thing to do?
- How long did you/do you think you and she will keep going?
- Again what sort of help/advice did you/your partner get at this stage, what was most useful to you?

If Not exclusive/lapsed

Our recruitment suggests that for most of you, your partner did not breastfeed exclusively, or stopped breastfeeding ...

- When do/did your partner breast/bottle feed, what sort of patterns do you have, why, what contributes to that?
- Was it a difficult or easy decision to make, or did you/she not really make a decision instead just falling into the pattern,
- How did you feel about the decision to bottle feed? How do you think your partner felt? Did you discuss it at the time?
- What did you weigh up when you were deciding what to do, did you look for any information or help, where, which was most helpful/unhelpful, did people offer information/opinions, who and what were they saying?
- What sort of questions did you ask?
- Is there anything that you think would have made/would make your partner more likely to breastfeed exclusively, say at least for the first six months?

Ask All:

Myths and Misperceptions

- When you think of all the things you have been told about breastfeeding, in your opinion, what are the things you feel might just be myths, and
what things do you feel are wrong vs the things you really believe are right?

Advice
If someone came to you looking for advice about whether to breastfeed or not, what would you tell them? What advice would you give, based on your own experiences?

If more than one child
- How did you feed your previous children...was it the same as for your last one?
- What is the same, what is different?
- What about your first child, what were your experiences there?
- How did your prior experiences impact on what you did this time?
- What were the key learnings from your previous experience?

Imagery and Insight
Why do you feel this person might have reacted the way she did:
- **Insight Test:** “Carolyn initially breastfed her baby exclusively, but after a couple of months she did so less frequently, and had pretty much stopped at the end of three months”
- Why did she make this decision, what was driving her, (probe beyond physical issues) how do you think she felt about breastfeeding vs formula, what did her partner/family think about this decision, what about other people generally, would it impact on the baby or the mother in any way, how?
- Do you think she was intending to breastfeed as much as she could, why?
- What do you think may have helped her in breastfeeding longer if this was what she wanted?
- **Section 2:** Ok, so what if I told you that feeding was actually working ok for both Carolyn and the baby, but she had still pretty much stopped by 3 months. What do you suppose her reasons might have been?
Perceived advantages and disadvantages- unprompted

ROTATE BREAST AND BOTTLE FEEDING

a) Breast

- Regardless of what your partner and you chose to do, what would you say are all the advantages of breastfeeding including feeding baby expressed milk in a bottle (probe for physical and emotional/psychological)
  - For the baby
  - For the mother
  - For the partner/family members
  - In general
- And what is the most important of those in your view
- And what are all the disadvantages
  - For the baby
  - For the mother
  - For the partner/family members
  - In general
- And what is the most important of those disadvantages
- Do you think it makes any difference to breastfeed exclusively (ie absolutely nothing else), or is it the same to just breastfeed a bit?

b) Bottle

- Again, regardless of what you and your partner chose to do, what would you say are all the advantages of bottle or formula feeding (probe for physical and emotional/psychological)
  - For the baby
  - For the mother
  - For the partner/family members
  - In general
- And what is the most important of those in your view
- And what are all the disadvantages of bottle or formula feeding
  - For the baby
  - For the mother
  - For the partner/family members
  - In general
• And what is the most important of those disadvantages

• Are you aware of any set guidelines or formal advice that has been put out about breastfeeding? What does it say, how credible or realistic are they?

Reactions to the benefits - prompted
Show Card
• Various literature suggests there are a number of advantages to be gained from breastfeeding exclusively..............which of these have you heard of, do you believe, are worth taking into account, or could help persuade you and/or others to breastfeed exclusively:....(by the way, we as researchers have no set view on this, we just want to hear how people feel about them)

Go through each benefit individually, probing on reactions

Further Suggestions
• Should any more be done to support and encourage women like your partners in making decisions about how to feed their children (can ask the exclusive/committed feeders about feeding more or for longer)?
• What about you? Is there anything you feel would have been helpful, or that you wish you had known or had access to with regard to the decisions around feeding (again, can ask the exclusive/committed feeders about feeding more or for longer)?
• What sort of things, and who should offer/run them?
15.5 Infant Feeding Topic Guide - Partners (of pregnant women – with no other children)

Introduction: Put everyone at ease, go through the introduction sheet in a very informal way, that it is a study being done by the Department of Health and Ageing, to ensure they understand needs and the issues involved with parenthood and babies, and to ensure they can offer the right sort of support.

Reassure that it is an open discussion, all comments welcome, definitely no right or wrong answers, that we believe everyone has the right to decide what is best for their own baby, and we don’t have a view on that one way or another. Also let them know that they have been grouped together with other dads/partners, so they can feel very open about saying how they feel at any time.

Inform that people might be viewing, and that we will be recording for our purposes only.

Putting at ease/Collection of family composition
Just to start off as background, let’s just go round the room to introduce ourselves, and tell the group how many children you have, how far along your partner is etc…

Top of Mind Associations:
As you know we are going to be mainly talking about infant feeding, and other baby related matters, so let’s just have a quick five minute sharing of the first five words that come into your head when you think of (ROTATE breast and bottle) breastfeeding your baby, regardless of whether you know much about it, or, or whether your partner and yourself plan to do it for this baby…. Who’s first…shout it out and we will scribble them on here (write on butchers paper, don’t allow time to think or discuss at this stage).

What about bottle or formula feeding? Again first five words,
That's great…we might come back to some of those later!

**Feeding Knowledge and Expectations**

Can we now talk about what you know and feel at this point about feeding the baby.

**Information used prior to birth**

- Have you started thinking about how you and your partner will feed this baby initially and in an ongoing sense over the first six or so months?
- How have you and your partner found out about what is involved, have you looked at any information (eg books, magazines, Internet, what sites, other)
- Who did most of this ‘researching’ you or your partner? If partner, to what extent were you involved in this information seeking phase?
- And who if anyone have you talked to about it? Probe for health professionals, family etc in detail (probe for detail about what they have heard, the type of information and advice from whom, and how frequent/how much notice is taken etc, eg family vs in-laws vs outside advice)
- What information are you and your partner most likely to listen to or take notice of at this stage?
- What are the main things you know about infant feeding at this stage/what are the most important factors that need to be taken into account?
- Do you and your partner have the same or different views on how you will feed the baby at this point?
- What breastfeeding associations/groups etc are you familiar with? What have you heard about them, have you ever rung or had contact with any of them, how was that, did it help? (If not mentioned) Have you heard of the ABA or Australian Breastfeeding Association? What have you heard etc.
- If someone came to you for advice (eg another dad to be) about whether to breast feed and how much, what would you tell them.
• And what advice would you give someone who was really determined to breastfeed?

Feeding Intentions prior to birth of this child
• What do you understand by the term ‘exclusive breastfeeding’?
• How are you feeling about feeding the baby you are having, do you think your partner will breastfeed, or bottle feed, (if breast feed), will she breastfeed exclusively (ie no other food or liquid)/almost exclusively, half-half etc, why is that, what might change your and her views as you go along?
• What role do you think you will have? What do you think you will do to help? What tasks? (eg, get baby, get glass of water, stay awake?)
• How do you think you’ll feed if your partner does not breast feed – at all? For 3months? For 6months or more?
• What role/influence do you think you will have in the decision to breast versus bottle feed?
• Do you feel you know enough about infant feeding and what to do at this stage? What do you feel confident about and what do you feel concerned about? What else do you think you would like information about or help with?

Myths and Misperceptions
• When you think of all the things you have been told about breastfeeding, in your opinion, what are the things you feel might just be myths, and what things do you feel are wrong, vs the things you really believe are right?

Imagery and Expectations
Why do you feel this person might have reacted the way she did:
• Insight Test: “Carolyn initially breastfed her baby exclusively, but after a couple of months she did so less frequently, and had pretty much stopped at the end of three months,
• Why did she make this decision, what was driving her, (probe beyond physical issues) how do you think she felt about breastfeeding vs formula,
what did her partner/family think about this decision, what about other people generally, would it impact on the baby or the mother in any way, how,

- Do you think she was intending to breastfeed as much as she could, why,
- What do you think may have helped her in breastfeeding longer?
- Section 2: Ok, so what if I told you that feeding was actually working ok for both Carolyn and the baby, but she had still pretty much stopped by 3 months. What do you suppose her reasons might have been?

**Summary of perceived advantages and disadvantages-unprompted**

Ok, lets just summarise on this butchers paper...

**ROTATE BREAST AND BOTTLE**

a) Breast

- Regardless of what your partner and you choose to do, what would you say are all the advantages of breastfeeding including feeding the baby expressed milk in a bottle (probe for physical and emotional/psychological)
  - For the baby
  - For the mother
  - For you/other family members
  - In general
  - And what is the most important of those in your view
- And what are all the disadvantages
  - For the baby
  - For the mother
  - For you/other family members
  - In general
  - And what is the most important of these disadvantages

- Do you think it makes any difference to breastfeed exclusively (i.e. absolutely nothing else), or is it the same to just breastfeed a bit, or does it really make no difference
b) Bottle

- Again, regardless of what you and your partner chose to do, what would you say are all the advantages of bottle or formula feeding (probe for physical and emotional/psychological)
  - For the baby
  - For the mother
  - For you/other family members
  - In general
- And what is the most important of those in your view
- And what are all the disadvantages of bottle or formula feeding
  - For the baby
  - For the mother
  - For you/other family members
  - In general
- And what is the most important of those disadvantages?

- Are you aware of any set guidelines or formal advice that has been put out about breastfeeding? What does it say, how credible or realistic are they?

Reactions to the benefits - prompted

Show Card

- Various literature suggests there are a number of advantages to be gained from breastfeeding exclusively............which of these have you heard of, do you believe, are worth taking into account, or could help persuade you and/or others to breastfeed exclusively:....(by the way, we as researchers have no set view on this, we just want to hear how people feel about them, )

Go through each benefit individually, probing on reactions

Further Suggestions

- Should any more be done to support and encourage women like your partner in making decisions about how to feed their children (can ask the exclusive/committed feeders about feeding more or for longer)?
• What about you - is there anything you feel would be helpful with regard to the decisions around feeding (again can ask the exclusive/committed feeders about feeding more or for longer)?
• If yes, what sort of things should be done to help, and who should offer/run them?

15.6 Infant Feeding Topic Guide- Pregnant Women, First Child

Introduction: Put everyone at ease, go through the introduction sheet in a very informal way, that it is a study being done by the Department of Health and Ageing, to ensure they understand women’s needs and the issues involved with motherhood and babies, and to ensure they can offer the right sort of support. Reassure everyone that it is an open discussion, all comments welcome, definitely no right or wrong answers, that we believe everyone has the right to decide what is best for their own baby, and we don’t have a view on that one way or another. Also let them know that they have been grouped together with people who have relatively similar attitudes, so they can feel very open about saying how they feel at any time.
Tell them group members can feel free to let us know if they are uncomfortable in any way, and to get up and go to the loo etc.

Inform that people might be viewing, and that we will be recording for our purposes only.

Putting at ease/Collection of family composition
Just to start off as background, let’s just go round the room to introduce ourselves, and tell the group how far along you are, how you have been feeling etc…

Top of Mind Associations:
As you know we are going to be mainly talking about infant feeding, and other baby related matters, so let’s just have a quick five minute sharing of the first five words that come into your head when you think of (ROTATE breast and bottle) breastfeeding your baby, regardless of whether you know much about it, or, or whether you plan to do it for this baby…. Who’s first…shout it out and
we will scribble them on here (write on butchers paper, don’t allow time to think or discuss at this stage).

What about bottle or formula feeding? Again first five words,

That’s great…we might come back to some of those later!

**Feeding Knowledge and Expectations**

Can we now talk about what you know and feel at this point about feeding the baby

**a) Information used prior to birth**

- Have you started thinking about how you would feed this baby initially and in an ongoing sense over the first six or so months,
- How have you found out about what is involved, have you looked at any information (eg books, magazines, Internet, what sites, other)
- When did you start thinking, and when did you start looking at things more seriously?
- And who if anyone have you talked to about it? Probe for health professionals, family etc in detail (probe for detail about what they have heard, the type of information and advice from whom, and how frequent/how much notice is taken etc, eg family vs in-laws vs outside advice)
- Did you ask for the information or was it something that you were approached with?
- What information are you most likely to listen to or take notice of at this stage?
- What are the main things you know about infant feeding at this stage/what are the most important factors that need to be taken into account?
- What breastfeeding associations/groups etc are you familiar with? What have you heard about them, have you ever rung or had contact with any of them, how was that, did it help? If not mentioned have you heard of the ABA or Australian Breastfeeding Association? What have you heard etc.
b) Feeding Intentions prior to birth of this child

- What do you understand by the term ‘exclusive breastfeeding’?
- How are you feeling about feeding the baby you are having, do you think you will breastfeed, or bottle feed, (if breast feed), will you breastfeed exclusively (ie no other food or liquid)/almost exclusively, half-half etc, why is that, how strongly do you feel about it, what might change your view as you go along?
- How easy do you think it will be to breastfeed (including expressing milk to feed by bottle)...and what about to do it exclusively, i.e. no other liquids or solids? Do you think any difficulties might arise? What might they be?
- Do you feel you know enough about infant feeding and what to do at this stage? What do you feel confident about and what do you feel concerned about? What else do you think you would like information about or help with?

Imagery and Expectations

Why do you feel this person might have reacted the way she did:

- Insight Test: “Carolyn initially breastfed her baby exclusively, but after a couple of months she did so less frequently, and had pretty much stopped at the end of three months,
- Why did she make this decision, what was driving her, (probe beyond physical issues) how do you think she felt about breastfeeding vs bottle feeding, what did her partner/family think about this decision, what about other people generally, would it impact on the baby or the mother in any way, how,
- Do you think she was originally intending to breastfeed for longer, why,
- What do you think may have helped her in breastfeeding longer if that’s what she was aiming for?
- Section 2: Ok, so what if I told you that feeding was actually working ok for both Carolyn and the baby, but she had still pretty much stopped by 3 months. What do you suppose her reasons might have been?
Myths and Misperceptions

• When you think of all the things you have been told about breastfeeding, in your opinion, what are the things you feel might just be myths, and what things do you feel are wrong, vs the things you really believe are right?

Summary of perceived advantages and disadvantages - unprompted

ROTA T E BREAS T A N D BOTTLE

c) Breast
• Regardless of what you chose to do, what would you say are all the advantages of breastfeeding including feeding the baby expressed milk in a bottle (probe for physical and emotional/psychological)
  - For the baby
  - For the mother
  - For the partner/family members
  - In general
• And what is the most important of those in your view
• And what are all the disadvantages
  - For the baby
  - For the mother
  - For the partner/family members
  - In general

• And what is the most important of those disadvantages
• Do you think it makes any difference to breastfeed exclusively (i.e. absolutely nothing else), or is it the same to just breastfeed a bit, or does it really make no difference

d) Bottle
• Again, regardless of what you chose to do, what would you say are all the advantages of bottle or formula feeding (probe for physical and emotional/psychological)
  - For the baby

w o o l c o t t • r e s e a r c h
- For the mother
- For the partner/family members
- In general

• And what is the most important of those in your view
• And what are all the disadvantages of bottle or formula feeding
  - For the baby
  - For the mother
  - For the partner/family members
  - In general

• And what is the most important of those disadvantages

• Are you aware of any set guidelines or formal advice that has been put out about breastfeeding? What does it say, how credible or realistic are they?

Reactions to the benefits - prompted

Show Card

• Various literature suggests there are some advantages to be gained from breastfeeding exclusively............which of these have you heard of, do you believe, are worth taking into account, or could help persuade you and/or others to breastfeed exclusively/more/at all (depending on group)...(by the way, we as researchers have no set view on this, we just want to hear how people feel about them, )

Go through each benefit individually, probing on reactions.

Further Suggestions

• Should any more be done to support and encourage women like themselves in making decisions about how to feed their children (can ask the exclusive/committed feeders about feeding more or for longer)?
• If yes, what sort of things should be done to help, and who should offer/run them?
15.7 Infant Feeding Topic Guide - Pregnant Second or Subsequent Child

**Introduction:** Put everyone at ease, go through the introduction sheet in a very informal way, that it is a study being done by the Department of Health and Ageing, to ensure they understand women’s needs and the issues involved with motherhood and babies, and to ensure they can offer the right sort of support. Reassure everyone that it is an open discussion, all comments welcome, definitely no right or wrong answers, that we believe everyone has the right to decide what is best for their own baby, and we don’t have a view on that one way or another. Also let them know that they have been grouped together with people who have relatively similar attitudes, so they can feel very open about saying how they feel at any time.

Tell them they can feel free to let us know if they are uncomfortable in any way, and to get up and go to the loo etc.

Also inform that people might be viewing, and that we will be recording for our purposes only.

**Putting at ease/Collection of family composition**

Just to start off as background, let’s just go round the room to introduce ourselves, and tell the group how many children you have, what ages they are, how far along you are etc...

**Top of Mind Associations**

As you know we are going to be mainly talking about infant feeding, and things such as breast and bottle feeding and other baby related matters, so let’s just have a quick five minute sharing of the five first words that come into your head when you think of (ROTATE breast and bottle) breastfeeding, regardless of whether you know much about it, or, or whether you plan to do it for this baby…. who’s first….shout it out and we will scribble them on here (write on butchers paper, don’t allow time to think or discuss at this stage).
And what about bottle or formula feeding, first five words...

That’s great…we might come back to some of those later!

**Infant Feeding Experiences**

Can we now talk about your experiences with feeding your previous baby/ies...and how you decided what to do when...

### a) Before the birth of first child

- Can you remember when you first started thinking about how you would feed your child?
- Before you had the baby how did you find out what was involved in feeding, did you look at any information (eg books, magazines, Internet, what sites, other, what were you looking for), how long before the birth did you start to think seriously
- And who did you talk to about it?...Probe for health professionals, family etc in detail (probe for detail about what they have heard, the type of information and advice from whom, and how frequent/how much notice is taken etc, eg family vs in-laws vs outside advice)
- Did you ask for the information or was it something that you were approached with?
- What information or who were you most likely to listen to or take notice of at that stage?
- How were you feeling about breastfeeding vs bottle feeding before the birth, was breast feeding something you felt you would just try for a while, or were you pretty determined about it, did you think it would be easy/hard, why?

### b) After the Birth

- Tell me about your very first experiences with your first child (focusing on feeding of course), the good things, the bad things, how you felt, what was helpful, what was difficult, (go through the first hours, days). Was that (feeding outcome) what you wanted to happen?
- What was the hospital like that you were in, what was their attitude toward feeding, did that influence you
• Who were you getting advice and help from at that stage, what were you being told, what was most useful, what sources did you most trust, or take most notice of. Probe for family member, mother in law vs mother, others involved, as well as medical etc.
• If breastfeeding in the early days: Did you want to keep on breastfeeding after the first few days, why, why not, how long did you think you would breastfeed for, and how long did you?
• What breastfeeding associations/groups etc are you familiar with? What have you heard about them, have you ever rung or had contact with any of them, how was that, did it help? If not mentioned have you heard of the ABA or Australian Breastfeeding Association? What have you heard etc.

c) At Home
• And how were you feeding by the time you got home? How did you get on, what sort of things were easy/difficult, how were you feeling about it all,
• What sort of feeding patterns did you have, tell me about the sort of routine you got into ...did that change as you went along, how? (Probe for breast vs bottle, whether exclusive if breast, expressing etc)
• What about your partner, rest of the family, did they have an impact on your decision to keep going or not
• Did you seek help or advice, once you were home? Who from? Again did you have any books or information, did you Google or look at any websites, discuss it with friends, other mothers, what sort of questions did you want to ask/find answers to?
• Did you always find the answers to your questions? Were there any pressures that prevented you asking questions or obtaining answers?

d) Three Months on and as the child gets older
• How were you going three months on, and after that? How were you feeding the baby by that time? How often did you breast/bottle feed? Tell me the sort of routine you had then Why was that?
• What do you understand by the term exclusive breastfeeding?

e) Subsequent children
• Did you do the same things with your second/subsequent children, how did things change and why?
• Knowing what you know now, if someone came to you looking for advice about whether to breastfeed or bottle feed, what would you tell them, how would you help them?

Feeding Intentions prior to birth of this child

• How are you feeling about feeding the baby you are having this time, will you do the same as with your previous child/children? Why, why not. What would you do differently, why?
• What are all the key things you have learnt from the last time that will impact on what you do this time,
• So tell me how you plan to feed from the early stages through to when the baby is six months or older, i.e. Do you think you will initially breastfeed, or bottle feed, (if breast feed), will you breastfeed exclusively (i.e. no other food or liquid)/almost exclusively, half half etc, why is that, what might change your view or patterns as you go along? (Probe for when the baby is first born, ie first few hours, through days, weeks and months and how they will change over time).
• Do you feel you know enough about infant feeding and what to do at this stage? What else do you think you would like information about or help with? What do you know now that you wish you knew with earlier babies? Where/how did you find this out?

Myths and Misperceptions

• When you think of all the things you have been told about breastfeeding, in your opinion, what are the things you feel might just be myths, and what things do you feel are wrong, vs the things you really believe are right?

Imagery and Insights

Why do you feel this person might have reacted the way she did:
• Insight Test: “Carolyn initially breastfed her baby exclusively, but after a couple of months she did so less frequently, and had pretty much stopped at the end of three months”
• Why did she make this decision, what was driving her, (probe beyond physical issues) how do you think she felt about breastfeeding vs formula, what did her partner/family think about this decision, what about other people generally, would it impact on the baby or the mother in any way, how,
• Do you think she was intending to breastfeed more than she ended up doing, why?
• What do you think may have helped her in breastfeeding longer if that’s what she wanted to do?
• Section 2: Ok, so what if I told you that feeding was actually working ok for both Carolyn and the baby, but she had still pretty much stopped by 3 months. What do you suppose her reasons might have been?

Perceived advantages and disadvantages - unprompted

ROTATE BREAST AND BOTTLE FEEDING

a) Breast

• Regardless of what you chose to do, what would you say are all the advantages of breastfeeding including feeding the baby expressed milk in a bottle (probe for physical and emotional/psychological)
  ➢ For the baby
  ➢ For the mother
  ➢ For the partner/family members
  ➢ In general

• And what is the most important of those in your view
• And what are all the disadvantages
  ➢ For the baby
  ➢ For the mother
  ➢ For the partner/family members
  ➢ In general

• And what is the most important of those disadvantages

• Do you think it makes any difference to breastfeed exclusively (ie absolutely nothing else), or is it the same to just breastfeed a bit?

b) Bottle
• Again, regardless of what you chose to do, what would you say are all the advantages of bottle or formula feeding (probe for physical and emotional/psychological)
  ➢ For the baby
  ➢ For the mother
  ➢ For the partner/family members
  ➢ In general
• And what is the most important of those in your view
• And what are all the disadvantages of bottle or formula feeding
  ➢ For the baby
  ➢ For the mother
  ➢ For the partner/family members
  ➢ In general
• And what is the most important of those disadvantages

• Are you aware of any set guidelines or formal advice that has been put out about breastfeeding? What does it say, how credible or realistic are they?

Reactions to the benefits - prompted
Show Card
• Various literature suggests there are some advantages to be gained from breastfeeding exclusively.............which of these have you heard of, do you believe, are worth taking into account, or could help persuade you and/or others to breastfeed exclusively/more/at all (depending on group)...(by the way, we as researchers have no set view on this, we just want to hear how people feel about them, )

Go through each benefit individually, probing on reactions

Further Suggestions
• Should any more be done to support and encourage women like themselves in making decisions about how to feed their children (can ask the exclusive/committed feeders about feeding more or for longer)?
• What sort of things, and who should offer/run them?
15.8 Infant Feeding Topic Guide – Grandmothers of Children Under Two

Introduction: Put everyone at ease, go through the introduction sheet in a very informal way, that it is a study being done by the Department of Health and Ageing, to ensure they understand women’s needs and the issues involved with motherhood and babies, and to ensure they can offer the right sort of support. Explain that we are talking to grandmothers to help us understand their role and level of involvement in their daughters or daughters in law infant feeding decisions and practices.

Reassure everyone that it is an open discussion, all comments welcome, definitely no right or wrong answers, that we believe everyone has the right to decide what is best for their own baby, and we don’t have a view on that one way or another. Also let them know that they have been grouped together with people who have relatively similar attitudes, so they can feel very open about saying how they feel at any time. Also inform that people might be viewing, and that we will be recording for our purposes only.

Putting at ease/Collection of family composition
Just to start off as background, let’s just go round the room to briefly introduce ourselves, and tell the group about the grandchildren you have, and what ages they are.

Top of Mind Associations:
As you know we are going to be mainly talking about infant feeding and other baby related issues, so let’s firstly just have a quick five minute sharing of the first five words that come into your head when you think of breastfeeding in particular, (ROTATE breast and bottle) regardless of whether you know much about it, or whether you or your daughters/daughters in law have had experience with it…. who’s first….shout it out and we will scribble them on here (write on butchers paper, don’t allow time to think or discuss at this stage).
And what about bottle or formula feeding, the first five words that come into your head

That's great...we might come back to some of those later!

**Grandmothers' Own Feeding Experiences**

- We just firstly want to find out about your own feeding experiences, ...and how you decided what to do with your own children, so I want you to think back if you can...
- Tell me what you can remember about your first experiences with feeding your first child, how was it for you, what did you do, where did you get help?
- Did you initially breast feed or bottle-feed your first child, why did you do that initially?
- And how did you continue? Tell me what you can remember about your experiences feeding in the first few days, weeks, and then after that?
- What worked well, what did you have difficulty with, how were you feeling about it all?
- PROBE for change points, and if and when they tended to change from breast to bottle, how and what prompted the change,
- What sort of help or advice were you getting that you can remember, and from whom, what were you being told about breast versus bottle feeding, which advice were you most likely to listen to then?
- Do you understand what is meant by “exclusively” breast-feeding...what would that involve?
- Exclusively breast feeding is feeding nothing else, but breast milk, and excluding water ...how do you feel about that?
- Did you exclusively breastfeed at all? When and for how long? Why did you stop?
- And what about for subsequent children if you had them, how did you tend to feed them? (Again Probe for points when the way they were feeding changed, and why)
- What (other) sort of things were influencing the way you fed those children?
Experiences with their Daughter/Daughter in law.
Let’s talk now about your daughters/daughters in law, and their experiences with infant feeding...starting with the last one to have a child (your youngest grandchild):
(Determine whether it is daughter/in-law that they are talking about below, and whether it is a first child.)
Tell me firstly about the sort of involvement you might have had with the parents and the baby during pregnancy and in the first six months of the baby’s life:
- Overall what sort of contact did you have and how often?
- When do you feel involvement of grandmothers is usually the greatest?

I would like to now go through the different stages of the baby’s first six months, and if and how you might have been involved over that time:

a) Before the Birth
- So thinking back to before the birth of your last grandchild, how do you think the mother planned to feed the baby before the birth, what was her intention at that stage?
- What did you think of her plans?
- And did you become involved at all then...did she ask for your advice, did you suggest things to her?
- If yes, how long before the birth did you start to talk about it?
- What sort of questions did she ask, what sort of advice did you give at that stage?
- Was she getting advice from other sources, which ones, how did you feel about the advice she got from other sources?

b) After the Birth
- And tell me what you know about her very first experiences with feeding, in hospital, what did she do, who was she getting advice and help from at that stage?
• How involved were you then, did she ask you about what to do, or for help, what advice did you give, did she take that advice, why, why not, how did you think she felt about it?
• Was she breast-feeding at that stage or using a bottle? Why/why not, What do you think of her decision?,
• What about her partner, did you talk to him about any of these things? To what extent?

c) At Home
• And how was she feeding once they got home? Do you remember what sort of things she was finding easy/difficult, did you give any suggestions then, how did she take them, did she ask you about things?
• Was she breastfeeding all or some of the time, how was she going, did she change or stop at any point, why and how was the decision made?
• Do you feel you had an impact on that decision? In what way?
• Were you worried about anything she was doing, why, why not, did she want/did she do things differently to what you were suggesting?
• How did you go about giving suggestions, did you find it easy to do so?
• Did you talk to the father about it at all then?
• (If mother stopped breast feeding/ or introduced some formula) ...How did you feel about that decision?
• Were you basing the advice you gave mainly on your own experiences, or did you look for any other information or help? Where from?
• Was the mother getting any help at that stage from the Midwife or lactation specialist, or anyone else? Do you think they were helpful? Who and What was most helpful,
• Have you ever heard of the ABA or Australian Breastfeeding Association? Did you or your daughter/daughter in law contact them at all? When and why did you/your daughter/daughter in law contact them? What was the experience of dealing with them? What do you know about them?

d) Three Months on and as the child gets older
• How was the feeding going three months on, and after that? How was she feeding the baby then?
• How often did she breast vs. bottle feed?
• If Daughter/in law was generally breastfeeding, ask.. As we discussed earlier, exclusive breastfeeding is only feeding breast milk, do you think your daughter/in-law breastfed exclusively? How did you feel about that?
• Did the way she was feeding change at any point, after those first three months, how and why did she change, what prompted it?
• How did you feel about these changes? Did you advise her in any way then?

If more than one daughter/daughter in law with children under two

What about for the other grandchildren:
• Were you involved in the same way (feeding specifically)?
• What was the same, what was different and why?
• Did you give any particular advice then?
If Yes,
• Did the advice you gave differ with them, how when and why?

General Feelings about Providing Advice

• Overall how did you feel about giving advice, or helping the mother and/or father in making decisions about things such as how and what to feed? Is it easy or difficult to do?
• Does that differ between daughters and daughters in law? How is it different?
• In summary, what do you were the main things that you took from your own experiences that you felt were important to pass on to your daughter/in-law?

Perceived Changes in Feeding Patterns Today

• Do you think things have changed in the way mothers think about feeding babies today, or in what they are advised to do?
• In what way have they changed, and why?
• Do you think that is a good thing or not?
• Generally, how would you advise a woman who came and asked you about whether they should bottle or breastfeed their baby?
And what sources would you suggest they use to get advice and help about what to do?

Imagery and Insight
Why do you feel this person might have reacted the way she did:
- **Insight Test**: “Carolyn initially breastfed her baby exclusively, but after a couple of months she did so less frequently, and had pretty much stopped at the end of three months”
- Why did she make this decision, what was driving her, (probe beyond physical issues) how do you think she felt about breastfeeding vs formula,
- What did her partner/family think about this decision,
- Would her mother or mother in law have had anything to do with this decision, in what way,
- Do you think she was intending to breastfeed as much as she could, why?
- What do you think may have helped her in breastfeeding longer if this was what she wanted?
- **Section 2**: Ok, so what if I told you that feeding was actually working ok for both Carolyn and the baby, but she had still pretty much stopped by 3 months. What do you suppose her reasons might have been?

Myths and Misperceptions
- When you think of all the things you were told about breastfeeding when you had your children, in your opinion, what are the things you feel might just be myths, and what things do you feel are wrong, vs the things you really believe are right?

What about the things you hear mothers being told today or that you may have been told more recently, are there any other myths or particular pieces of information around today that you think are not right?

Perceived advantages and disadvantages - unprompted

**ROTATE BREAST AND BOTTLE**

- **e) Breast**
- Regardless of what you or your daughter/daughter in law chose to do, what would you say are all the advantages of breastfeeding **including**
feeding the baby expressed milk in a bottle (probe for physical and emotional/psychological)?

- For the baby
- For the mother
- For the partner/family members
- In general

- And what is the most important of those in your view?

- And what are all the disadvantages?
  - For the baby
  - For the mother
  - For the partner/family members
  - In general

- And what is the most important of those disadvantages?

- Do you think it makes any difference to breastfeed exclusively (ie absolutely nothing else), or is it the same to just breastfeed a bit?

f) Bottle

- Again, regardless of what you or your family chose to do, what would you say are all the advantages of bottle or formula feeding (probe for physical and emotional/psychological)?
  - For the baby
  - For the mother
  - For the partner/family members
  - In general

- And what is the most important of those in your view?

- And what are all the disadvantages of bottle or formula feeding?
  - For the baby
  - For the mother
  - For the partner/family members
  - In general

- And what is the most important of those disadvantages?
• Are you aware of any set guidelines or formal advice that has been put out about breastfeeding? What does it say, how credible or realistic are they?

Reactions to the benefits - prompted

Show Card

• Various literature suggests there are some advantages to be gained from breastfeeding exclusively…………which of these have you heard of, do you believe, are worth taking into account, or would you use to help persuade mothers to breastfeed exclusively/more/at all (depending on group)…(by the way, we as researchers have no set view on this, we just want to hear how people feel about them, )

Show cards and go through each benefit individually, probing on reactions

Further Suggestions

• What (more) could be done to help support mothers in making decisions about feeding their babies?

• And as grandmothers, what could be done to help or assist you and others like you in further supporting our daughters or daughters in law in making decisions about feeding?
15.9 Show cards

Breastfeeding helps protect against diarrhoea, respiratory and ear infections in babies.

Breastfeeding helps protect babies against obesity and chronic diseases in later life.

Breastfeeding benefits a mother’s health by reducing the risks of breast cancer, ovarian cancer, type 2 diabetes and osteoporosis.

Carolyn initially breastfed her baby exclusively, but after a couple of months she did so less frequently, and had pretty much stopped at the end of three months.
15.10 Screener questionnaire

Good ….. My name is ..... from Woolcott Research. We have been
commissioned by the Department of Health and Ageing to conduct a
confidential study amongst pregnant women, mothers and partners about some
of the issues associated with raising a baby such as infant feeding decisions. This
feedback will be used to help the government understand how women feel
about this and to provide better support for women and their families.

The study consists of one-on-one depth interviews and mini-group discussions
involving up to 5 people with similar circumstances to yourself.

You can check the validity of this study by calling Trinette Kinsman, at the
Department of Health and Ageing on (02) 9263 3733.

The discussions will be held in comfortable surroundings and if you attend a
mini-group then sandwiches and refreshments will be available. If you are
pregnant then suitable food will be served e.g. no soft cheese, seafood etc. If
you need to, you can bring babies, although unfortunately older children cannot
attend as there will not be childcare available on the premises. You may take
breaks or stop the interview whenever you wish. If you take part in a group you
will be with people who have similar attributes to you so you can feel quite
comfortable about talking about these issues.

Firstly, can I just check that you do not work in the following professions?

<table>
<thead>
<tr>
<th>Market Research</th>
<th>CLOSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthcare profession, e.g. Nurse, Doctor</td>
<td>CLOSE</td>
</tr>
</tbody>
</table>

And when did you last take part in a market research group?

<table>
<thead>
<tr>
<th>Never</th>
<th>Continue</th>
</tr>
</thead>
<tbody>
<tr>
<td>Over 6 months ago</td>
<td>Continue</td>
</tr>
<tr>
<td>In the last 6 months</td>
<td>CLOSE</td>
</tr>
</tbody>
</table>
We are aiming to include a mix of people in the research so can I just ask you a few questions?

**Q1. Record gender**

<table>
<thead>
<tr>
<th>Male</th>
<th>Go to Q11</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>Go to Q2</td>
</tr>
</tbody>
</table>

**Pregnant women**

**Q2. Are you currently pregnant?**

<table>
<thead>
<tr>
<th>Yes</th>
<th>Go to Q3</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>Go to Q6</td>
</tr>
</tbody>
</table>

**Q3. Is this with your first child or do you already have children?**

<table>
<thead>
<tr>
<th>First child</th>
<th>Go to Q4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Already have children</td>
<td>Recruit to spec</td>
</tr>
</tbody>
</table>

**Q4. Are you 5 months pregnant or over?**

<table>
<thead>
<tr>
<th>Yes</th>
<th>Recruit to spec</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>CLOSE</td>
</tr>
</tbody>
</table>

**Q5. What is your age?**

<table>
<thead>
<tr>
<th>Under 25</th>
<th>Recruit to spec</th>
</tr>
</thead>
<tbody>
<tr>
<td>25-35</td>
<td>Recruit to spec</td>
</tr>
<tr>
<td>35+</td>
<td>Recruit to spec</td>
</tr>
</tbody>
</table>
Mothers with children under 2

Q6. Do you have children under the age of 2?

<table>
<thead>
<tr>
<th>Yes</th>
<th>Go to Q7</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>CLOSE</td>
</tr>
</tbody>
</table>

Q7. At what age did you have your last child?

<table>
<thead>
<tr>
<th>Under 25</th>
<th>Recruit to spec</th>
</tr>
</thead>
<tbody>
<tr>
<td>25-35</td>
<td>Go to Q8</td>
</tr>
<tr>
<td>35+</td>
<td>Go to Q8</td>
</tr>
</tbody>
</table>

Q8. How many children do you have?

<table>
<thead>
<tr>
<th>One</th>
<th>Recruit to spec</th>
</tr>
</thead>
<tbody>
<tr>
<td>More than one</td>
<td>Recruit to spec</td>
</tr>
</tbody>
</table>

Q9. Which of the following best describes what you did with your last child?

READ OUT

| I started breast feeding but did not do it exclusively for the first 6 months | Non exclusive | Recruit to spec |
| I started breast feeding but switched to bottle feeding before the end of the first 6 months | Lapsed | Recruit to spec |
| I breast fed exclusively or almost exclusively for at least the first 6 months | Committed breastfeeder | Recruit to spec |
| I did not start breastfeeding (or I tried in the first week but stopped) | Never | Recruit to spec |
Q10. Would you consider yourself to be a single mother?

<table>
<thead>
<tr>
<th>Yes</th>
<th>Recruit to spec</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>Recruit to spec</td>
</tr>
</tbody>
</table>

**Partners**

Q11. Is your partner currently pregnant?

<table>
<thead>
<tr>
<th>Yes</th>
<th>Go to Q12</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>Go to Q14</td>
</tr>
</tbody>
</table>

Q12. Is this with your first child or do you already have children?

<table>
<thead>
<tr>
<th>First child</th>
<th>Go to Q13</th>
</tr>
</thead>
<tbody>
<tr>
<td>Already have children</td>
<td>Recruit to spec</td>
</tr>
</tbody>
</table>

Q13. Is your partner 5 months pregnant or over?

<table>
<thead>
<tr>
<th>Yes</th>
<th>Recruit to spec</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>CLOSE</td>
</tr>
</tbody>
</table>

Q14. Do you have children under the age of 2?

<table>
<thead>
<tr>
<th>Yes</th>
<th>Go to Q15</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>CLOSE</td>
</tr>
</tbody>
</table>

Q15. Which of the following best describes what your partner did with your last child? READ OUT

<p>| She started breast feeding but did not do it | Non exclusive  | Recruit to spec |</p>
<table>
<thead>
<tr>
<th>exclusively for the first 6 months</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>She started breast feeding but switched to bottle feeding before the end of the first 6 months</td>
<td>Lapsed</td>
<td>Recruit to spec</td>
</tr>
<tr>
<td>She breast fed exclusively or almost exclusively for at least the first 6 months</td>
<td>Committed breastfeeding</td>
<td>Recruit to spec</td>
</tr>
<tr>
<td>She did not start breastfeeding (or tried in the first week but stopped)</td>
<td>Never</td>
<td>Recruit to spec</td>
</tr>
</tbody>
</table>

You will be given $[insert incentive] to cover your time and expenses.

The interview/discussion will take place at [insert location] at [insert time] and will last for [insert duration].

Please call this number if for any reason you cannot attend [insert number].

Thanks