Original Article

Breastfeeding and family life

Tina Lavender*, Catherine McFadden† and Lisa Baker†

*Department Midwifery Studies, University of Central Lancashire, Preston PR1 2HE, UK, †Liverpool Women's Hospital, Crown St, Liverpool L8 7SS, UK

Abstract

The problems faced by breastfeeding mothers are well documented. However, the influence of social networks has mainly received attention solely through the eyes of the women. Therefore, we explored the views of the family as a whole. This exploratory study utilizes semi-structured interviews, diaries and questionnaires. A purposive sample of 24 women and their families, from a hospital in the north-west of England were invited to participate. Questionnaire data were analysed descriptively. Diaries and interviews were analysed using an open coding mechanism to identify emergent themes. Twenty-three women and 27 of their family members participated. Questionnaire data showed that the majority of women ($n = 17$) expected to breastfeed for more than 3 months; 12 actually did this. Women anticipated that family members would provide the main source of breastfeeding support. Three main themes emerged from the interviews and diaries: 'moving with the times', 'marketable commodity' and 'disparate communications'. The authors conclude that multi-layered approach to breastfeeding promotion and support should be considered. Society needs to proactively encourage a positive breastfeeding culture, family members need direction on how to support a woman to breastfeed and women need to be able to articulate their individual requirements. Midwives could be instrumental in supporting such needs and facilitating change.

Keywords: breastfeeding, family, qualitative, support.

Introduction

The benefits of breastfeeding to mother and baby are universally accepted (Fairbank *et al*. 2000). Yet, despite initiatives and campaigns to improve breastfeeding rates, successive national surveys in the UK have shown that breastfeeding rates have remained lower compared with its European counterparts (Fairbank *et al*. 2004). The reasons suggested for such rates are complex, ranging from lack of appropriate education and support from health professionals (Dykes 1997), personal experiences and societal attitudes (Marchland & Morrow 1994). Additionally, adverse social reactions to breastfeeding in public have been shown to create stigma and embarrassment (Sullivan 1996; McIntyre *et al*. 1999). Socio-

Correspondence: Tina Lavender, Professor Midwifery and Women's Health, Department Midwifery Studies, University of Central Lancashire, Preston PR1 2HE, UK. E-mail: tinalav@yahoo.co.uk

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demographic factors such as age less than 18, level of education, maternal employment (Leffler 2000) and level of income (Fairbank *et al*. 2000) can also create barriers. Women whose babies have been on the neonatal intensive care unit are also reported to be less likely to successfully breastfeed (Kerstin 2005).

Negative social support is a further reason offered for poor breastfeeding rates (Raj & Pilchta 1998); earlier work suggests that breastfeeding is influenced by the woman's husband, family and friends (Lothian 1994). Fathers in particular are thought to have an influential role in women's breastfeeding experiences (Kessler *et al*. 1995; Jackson 2000; Swanson & Power 2005).

Women's daily lives are clearly affected by breastfeeding, partly due to the conflict between knowing what is best and the lived experience (Schmied & Lupton 2001). However, the impact of breastfeeding on the family is largely unexplored. Furthermore, as previously reported (Scott *et al*. 2004), studies that have explored the impact of family members on breastfeeding have either done this mainly through the eyes of the woman or targeted specific family members (Aubel *et al*. 2004; Wolfberg *et al*. 2004). We did not wish to explore individual family members in isolation, believing that women's social networks are complex and influential. Therefore, we conducted a study, which explored the views of the immediate social support network of each woman.

Aim

The primary aim was to explore, in-depth, the impact of breastfeeding on different family members and the influences of these members on the breastfeeding mother. A secondary aim was to explore the diversity and commonality of views between four different groups of families. To fulfil this aim, we adopted a past–modern approach, as described by Morgan (1999). Unlike other sociological approaches to researching the family (Haralambos *et al*. 2004), this approach focuses on practices, rather than structure. Therefore, the importance lies with what members actually do, and with the accounts they give of what they do. This approach recognizes the interplay between participants and the researchers, and considers the historical development of society as a whole. The characteristics of this approach determined the methodology.

Materials and methods

Sample and setting

The study was conducted in an inner city university hospital in the north-west of England, where approximately 8000 women give birth annually.

Participants

A stratified purposive sampling strategy was adopted to ensure that the views of different groups were represented. A sample size of 24 women was considered adequate to provide rich data on not only the women but also the members of their identified social network. This size also allowed us to explore six women from each of the following groups: (1) women classified as standard primigravidae (Cleary *et al.* 1996); (2) women living in areas with above average (>30) Under Privileged Area score (Jarman 1983); (3) teenage mothers; and (4) mothers with a baby admitted to the Special Care Baby Unit (SCBU) where they are breastfeeding on discharge from hospital.

Procedure

Permission to undertake the study was secured from the Trust and Local Research Ethics Committee. During a 3-month period, women were identified on the postnatal wards and approached to participate. Verbal and written information was supplied and written consent sought. Women were then asked to identify members of their social network with whom they had regular contact (at least weekly). Women facilitated contact with the identified network members, who were then approached to participate. Members were given written information, and written consent obtained.

Data collection

Demographic details were collected from computer records. Semi-structured questionnaires were then

administered to the women in the immediate postnatal period, to obtain baseline breastfeeding information. At this time, a reflective diary was also given to each woman and each participating member. Existing literature and local evidence (Lavender *et al*. 2005) contributed to the development of the semi-structured diary schedule. Participants were contacted fortnightly by telephone or mail to encourage them to write in the diaries. On completion of breastfeeding, individual semi-structured interviews were conducted with participants. The interview schedule gained content validity from previous research carried out by Lavender *et al*. (2005), and included questions related to the impact of breastfeeding on daily lives. The interviews were audio-recorded and pseudonyms used to protect the identity of the participants.

Analysis

Demographic and baseline data were entered onto SPSS (version 11.0) for descriptive analysis. Diaries and interviews were transcribed verbatim, and a qualitative software package WinMax Pro (version 98) (Kukartz 1998) assisted with data organization. Analysis was undertaken using an open coding mechanism to identify emergent themes. Although the woman was the pivotal unit of analysis, her responses were viewed in the context of the responses provided by the family, and vice versa. Two researchers (L.B., T.L.) viewed the data, and independently generated themes from the responses to minimize interpreter bias. These were then collated and individually discussed until a consensus was reached. Theoretical themes, from the different sources, were compared and analysed with existing literature and sociological theory. Summaries of findings were sent to interviewees for respondent validation to minimize interviewer bias.

Findings

Women

Thirty-nine women were approached, in order to obtain 24 consenting women, one of whom withdrew. Of these women, six were standard primigravidae, six were teenagers, six were from underprivileged areas and five had returned home with babies who had been on the SCBU. The demographic details of the women are illustrated in Table 1, indicating a range of participants from different social backgrounds. Twenty women returned questionnaires, 14 completed diaries and 16 provided an interview (Table 3).

Table 2 provides baseline details obtained from the questionnaires. Only three women had breastfed previously, but all women had discussed breastfeeding with someone prior to giving birth; in most cases, this was with a partner or female relative. The questionnaire data suggest that, in the main, women had high expectations, in terms of both their estimated duration of breastfeeding and their anticipation of support from friends and family.

Family members

In total, the 23 women identified 64 members of their social network, of which 53 consented to participate and 27 actually participated (seven male partners, nine maternal mothers, two partner's mothers, two maternal fathers, four maternal sisters, one female friend, one stepmother and one maternal grandmother). The main reasons for non-participation were: not believing that they had anything important to say and being too busy. Fourteen members completed a diary, 22 took part in an interview and nine did both (Table 3).

Main themes

The main themes were: 'moving with the times', 'marketable commodity' and 'disparate communications'. Differences between groups are highlighted in the text.

'Moving with the times'

Many participants commented on the fact that society has changed, yet breastfeeding is expected to continue in the same way as it always has been; this they felt was unrealistic. Two sub-themes were put forward as barriers to a breastfeeding culture: *breastfeeding*

Table 1. Baseline details

Group	Age (years)	Status	Under Privileged Area score*	Parity	Occupation	Ethnicity	Gestation at delivery (days)	Mode of delivery	Reason for SCBU	Duration of breastfeeding (weeks)
Primigravidae										
1	22	Cohabiting	30.02	1	Civil servant	White British	273	Elective Caesarean	N/A	13
2	23	Married	12.58	1	Administrator	Black British	284	Normal vaginal	N/A	32
3	22	Cohabiting	33.76	1	Student	White British	282	Normal vaginal	N/A	2
4	36	Cohabiting	–13.42	1	TV assistant	White British	272	Normal vaginal	N/A	6
5	26	Married	13.45	1	Nursery nurse	White British	277	Normal vaginal	N/A	4
6	32	Married	12.58	1	Teacher	White British	283	Normal vaginal	N/A	5
Teenager										
1	17	Cohabiting	30.46	1	Unemployed	White British	292	Normal vaginal	N/A	32
2	19	Cohabiting	–12.83	1	Unemployed	White British	277	Normal vaginal	N/A	4
3	19	Cohabiting	–11.35	1	Unknown	White British	279	Normal vaginal	N/A	18
4	18	Single	29.85	1	Student	White British	281	Instrumental	N/A	22
5	18	Single	13.45	1	Beautician	White other	285	Instrumental	N/A	14
6	18	Single	1.22	1	Student	White British	280	Normal vaginal	N/A	24
SCBU										
1	38	Married	46.79	1	Art curator	White British	212	Normal vaginal	Prematurity	12
2	32	Single	–0.90	1	Midwife	White British	282	Normal vaginal	Poor respiratory effort	16
3	35	Single	13.47	2	Unemployed	White British	231	Emergency Cesarean	IUGR/prematurity	6
4	31	Married	12.86	1	Supply manager	White British	238	Normal vaginal	Prematurity	17
5	36	Married	1.22	2	Pharmacist	White British	233	Emergency Cesarean	Prematurity	1
Underprivileged										
1	26	Married	56.67	1	Nanny	White British	287	Emergency Cesarean	N/A	16
2	30	Single	35.29	2	Unemployed	White British	299	Emergency Cesarean	N/A	10
3	35	Married	40.79	3	Housewife	White British	281	Normal vaginal	N/A	12
4	22	Cohabiting	43.38	1	Administrator	White British	278	Normal vaginal	N/A	4
5	30	Single	31.58	1	Computer operator	White British	284	Normal vaginal	N/A	2
6	30	Cohabiting	47.69	2	Housewife	White British	284	Normal vaginal	N/A	4

*Mean Under Privileged Area score for target population is 24, ranging from –11 (affluent) to +68 (underprivileged).
SCBU, Special Care Baby Unit; IUGR, intrauterine growth restriction; N/A, not available.

Table 2. Questionnaire findings

Question	Women's response	$n = 20$
Have you breastfed before?	Yes	3
	No	17
Who did you discuss your decision to breastfeed with?*	Maternal mother	10
	Mother-in-law	4
	Friend	7
	Partner	15
	Midwife	8
	Antenatal educator	1
	Family doctor	1
	NCT councillor	1
	Sister	1
	Hospital doctor	0
Have you seen a baby breastfeed before?	Yes	19
	No	1
How long do you intend to breastfeed for?	At least 1 year	4
	At least 6 months – <1 year	6
	At least 3 months – <6 months	7
	1 month – <3 months	1
	<1 month	0
	Unsure	2
Who do you think will give you the most support?*	Maternal mother	11
	Mother-in-law	2
	Friend	5
	Partner	14
	Midwife	10
	Antenatal educator	1
	Family doctor	1
	NCT councillor	1
	Sister	2
	Hospital doctor	1
Where you given help with your first feed?	Yes, midwife	10
	Yes, family member	5
	No	5
What help did the staff on the ward give you with breastfeeding?	I received no help	3
	They would pass me the baby and expect me to get on with it	1
	I got help latching on as I needed it	14
	She stayed in the room for the whole feed	2

*Respondents were invited to tick more than one answer.
NCT, National Child Trust.

not the norm and *integrating breastfeeding into daily living*.

Breastfeeding not the norm

Breastfeeding did not appear to be viewed as part of the normal process of life. Participants suggested devolution of breastfeeding, which they believed had occurred through changes in societal patterns. More satisfying activities were suggested as alternatives to breastfeeding, which was often viewed more as a chore than a pleasure:

Dawn is lucky. She has a car and people to visit. I think women who don't have family close by and feel they're stuck in a lot must get a little down especially as some days you feel like you've just sat on the couch all day feeding! (Partner 2 diary – underprivileged)

Table 3. Method of data collection from women and family members

Group	Questionnaire	Diary	Interview	Diary – family member	Interview – family member
Primigravidae					
1	Yes	Yes	Yes	Partner	–
				Mother	Mother
2	Yes	Yes	Yes	Partner	Partner
3	Yes	Yes	Yes	Partner	–
				Mother	Mother
4	Yes	Yes	Yes	–	–
5	Yes	Yes	Yes	Mother	Mother
6	Yes	Yes	Yes	–	Partner
				–	Mother
Teenager					
1	Yes	–	–	Mother-in-law	–
2	No	–	–	–	–
3	No	–	Yes	–	–
4	Yes	Yes	Yes	Mother	Mother
				Sister	Sister
				–	Father
				–	Grandmother
5	Yes	–	–	–	–
6	Yes	Yes	Yes	–	Mother
				–	Sister
SCBU					
1	Yes	Yes	–	–	–
2	Yes	–	–	–	–
3	Yes	–	–	–	–
4	Yes	Yes	Yes	–	Partner
5	Yes	Yes	Yes	–	–
Underprivileged					
1	Yes	–	Yes	–	Mother
				–	Sister
2	Yes	Yes	Yes	Female friend	–
3	Yes	Yes	Yes	–	Partner
4	Yes	Yes	Yes	Partner	Partner
				Mother	Mother
				Sister	–
				–	Father
				Stepmother	Stepmother
				–	Mother-in-law
5	Yes	–	Yes	–	–
6	No	–	–	–	Mother

SCBU, Special Care Baby Unit.

Similarly, one woman spoke negatively of the past when women remained at home:

In the past most babies were breastfed . . . when more babies were breastfed, wives were just in the 'bloomin' home all the time. (Woman 2 interview – primigravidae)

There was a general feeling among participants that targeting women alone was inadequate to improve breastfeeding rates. Family members acknowledged the impact that other people's views can have on the breastfeeding woman:

I think society needs to be educated about breastfeeding, not just mums. A mum needs to be comfortable and relaxed when feeding, not made to feel alien or as if she's doing something dirty. (Partner 3 diary – primigravidae)

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Integrating breastfeeding into daily living

Participants and their families clearly found it difficult to integrate breastfeeding into their daily activities. Breastfeeding was seen as an extra burden on already demanding lives. Changes in family roles and the lack of extended family support were suggested as barriers. For example, one woman said:

My little girl wanted me to color in with her and I had to stop to feed my baby. My little girl said 'it doesn't matter mum, she's all right, feed her when we've finished'. Obviously I couldn't . . . I feel it's all I'm doing and I haven't no time for anyone else . . . (Woman 2 diary – underprivileged)

Another said:

Some days my baby fed every couple of hours, which I found quite demanding when, I already have 2 other children to look after. (Woman 3 diary – underprivileged)

The fact that women are more likely to go out to work was regularly offered as a reason for breastfeeding difficulties. Continuing to breastfeed while at work was not considered to be an easy option due to the lack of facilities. One father said:

I would say a good 50% of the employees are women . . . and yet there is no Creche, there is no facilities at all . . . (Father 4 interview – teenager)

Furthermore, the increasing number of fathers adopting the role of primary child carer was considered to hinder breastfeeding.

There are many househusbands now that stay on as house partners. If they look after the baby, then breastfeeding is out of the question. (Father 4 interview – underprivileged)

Unsurprisingly, women and families whose babies had been on the neonatal intensive care unit expressed even more difficulties when trying to integrate breastfeeding into their daily lives. While the baby was in hospital, the women had a perception that bottle-fed babies developed more quickly and were subsequently discharged earlier:

I'll tell you another thing, when I was in the nursery, I got the impression, I mean, it might be the wrong impression, that the one's that were getting bottle fed were getting out quicker. (Woman 5 interview – SCBU)

Following hospital discharge, the travelling for regular clinical assessments also made it difficult to 'fit breastfeeding in'.

Teenagers appeared to find it easier to integrate breastfeeding into their lives than women in the other three groups. This appeared to be because they did not have the additional responsibilities of other children, work, a partner or housework. One teenager said:

It's great for me cos I can veg [vegetate] out on the couch all day and feed while my mum waits on me . . . I'm spoiled rotten. (Woman 3 interview – teenager)

'Marketable commodity'

Participants generally felt that breastfeeding was not positively marketed at. At a national level, it was mainly the media that was thought to be able to influence attitudes towards breastfeeding.

If you see people in the limelight breastfeeding and promoting breastfeeding, advertising does work . . . to get some big names involved is the only way the government has to go forward. (Mother 4 interview – underprivileged)

Participants also suggested that familiarity would prevent the public from viewing breastfeeding as something alien.

If they seen it all the time, say on TV, then seeing it in a local park or something or on a park bench, they would be used to the idea and, you know, they'd think nothing of it. (Stepmother 4 interview – underprivileged)

At a local level, participants felt that women who had successfully breastfed should be the ones to encourage others.

You don't see people breastfeeding and you don't even meet other mothers who go 'oh yes, look at my healthy, young, strapping lad, I breastfed him'. (Mother 6 interview – primgravidae)

Instead of encouraging women to breastfeed, family members who had failed to breastfeed their own babies actively discouraged it. When women were having difficulty feeding, some members used these problems to justify their own previous failings. For example, one of the women's sisters said:

If she's anything like me she won't be able to feed for long. I've told her she might as well put the baby on the bottle. (Sister 1 interview – underprivileged)

'Disparate communications'

There were often marked discrepancies in the views of individual family members and those of the women. These differences, which are presented within the categories of *embarrassment* and *fulfilment of expectations*, appeared to occur through a lack of communication between different family members.

Embarrassment

The most prominent feeling that emerged was that of embarrassment, in relation to breastfeeding in public. This was much less of an issue to the women in the study than it was to members of their support networks.

If my baby wants feeding I'm going to feed her, is my attitude now. Even in front of my partner's brothers' . . . I don't care. (Woman 2 diary – underprivileged)

Family members never said that they were embarrassed, but they always commented about someone else being embarrassed, for example,

It's the older generation who don't like breastfeeding . . . people are getting more acceptable of their bodies, but older people, they still cover up. (Woman 1 interview – primigravidae)

Another said:

Her best friend always left the room. She could have been more supportive. (Mother-in-law 4 diary – underprivileged)

This embarrassment was often presented as deflected towards the woman. For example, a partner said:

I felt embarrassed for her . . . I would just try and keep busy and out of the way and everything . . . (Partner 4 interview – underprivileged)

While her father said,

Yeh I think from a personal point of view, I just think in general women are more embarrassed about it than men would be.

Interestingly, the woman never once stated that she felt any embarrassment.

Some participants suggested that embarrassment was due to perceptions of breasts as sexual objects:

I know me mates would be looking, and they wouldn't be looking at the baby feeding. . . . But I just don't think they see them other than a sexual thing . . . me mates in work were saying does she breastfeed it or what? And when does she do it? What time can we come down? (Partner 4 interview – underprivileged)

Fulfilment of expectations

Women's expectations of family members centred on emotional support and practical help. Teenagers reported that they had the practical help, whereas women in the remaining groups did not. Family members indicated that they were being supportive by 'keeping out of her way' and they tended to 'leave her in peace whilst she breastfed'. This did not appear to be what the women wanted. Women indicated that small things could have made a difference:

My partner could of helped but he was out all the time. I always forget to get a drink . . . somebody there passing me drinks all the time would make this experience better. (Woman 2 diary – underprivileged)

By removing themselves from the breastfeeding environment, family members isolated the breastfeeding woman and marginalized the experience.

It was great when my mate came round and we just talked whilst I was feeding. It felt really natural. But some of my mates won't stay in the same room as me, which makes it feel like I'm doing something wrong. (Woman 6 interview – teenager)

The women particularly welcomed words of encouragement:

People saying 'it's really good feeding your baby . . . friends and family . . . it make's me feel proud. (Woman 3 interview – teenager)

However, women found that often others undermined breastfeeding:

People regularly saying 'isn't he on a bottle yet' or 'I don't know why you're bothering, mine was on bottles and it never harmed them'. (Woman 6 diary – primigravidae)

Some friends and family even suggested that they pitied the woman, thus reinforcing the fact that breastfeeding is viewed as atypical within today's society. Statements such as 'I feel sorry for her' were commonplace throughout the diaries and interviews of family members. Family members who did provide encouragement underestimated its importance. For example, one partner said,

I can't really do much, all I can do is tell her she is doing a good job and that I'm really proud of her. (Partner 4 SCBU – interview).

The woman wrote in her diary the same week, 'I was going to give up breastfeeding but my husband was so encouraging.'

Discussion

Uniquely, we explored a cohort of women and their families using mixed methods of data collection, to capture some of the complexities of breastfeeding in the community setting and provide a multi-layered, more valid picture. This proved to be valuable; confirming the authors' beliefs that viewing a breastfeeding woman in isolation is inappropriate. The impact on all family members was apparent, in terms of both disruption of daily lives (e.g. vacating the room, additional housework) and emotional consequences (recall of failed experiences and expressions of embarrassment). Positive impacts, such as feeling proud and bonding with baby, were also reported. Families were mainly white British and living in only one part of England; different communities may have revealed different findings, thus limiting the generalizability. However, formal and informal presentation of these findings has revealed strong resonance from other health professionals across the UK.

Despite many family members having good intentions, their lack of breastfeeding knowledge and inability to interpret the women's needs hindered the support they provided. This was compounded by the women's inability to articulate what they felt was conducive support. Although family members said that they were supporting the woman to breastfeed, many appeared to be overtly or covertly undermining her experience. The need for approval and emotional support, as identified in this study, is supported by the literature (Dykes 2003). Women also commented on the need for practical support. This was clearly demonstrated by the teenagers, who, contrary to previous literature (Dewan *et al*. 2002), successfully breastfed (according to their own expectations); this they attributed to being able to solely focus on this activity. Given that only six teenagers were included, this group may be atypical. Further research would be required to confirm these findings. Interestingly, in Amsterdam, where breastfeeding rates are comparatively high, home support, in the form of household duties, is offered to all women in the postnatal period (Kools *et al*. 2005).

Although the sample size was relatively small and not intended to be representative of the overall target population, a stratified purposive sample made it possible to explore the views of specific and diverse groups of families. The small proportion of consenting family members who actually participated was disappointing. Those who decided not to participate may have had different views from those who did participate. It is unclear why some of those who consented chose not to participate; however, men in particular were difficult to engage. This may be because men felt uneasy communicating one to one about breastfeeding with a female health professional. Even those men who were interviewed showed a degree of discomfort through their body language and persona. Lack of participation of both sexes may be because members felt embarrassed discussing breastfeeding or they did not believe that they had an active contribution to make. The women suggested this latter point, informally. This is paradoxical, given that it may be this detachment which is having a negative impact on the experience. Active communications between women, families and health professionals would clarify roles, disperse potential fears and optimize individual support.

Interestingly, family members never said that they were embarrassed, but always suggested that other members were. It is unclear whether members failed

to recognize their own embarrassment or deflected the embarrassment to hide personal feelings. Perhaps, this is unsurprising when members were trying to conform to a society that does not overtly support breastfeeding, and views breasts as sexual objects (Dykes & Griffiths 1998). As suggested by participants, we live in a media-driven society and may need to market breastfeeding as a desirable commodity. Unfortunately, it has been the marketing of artificial milks that, up to now, has had the greatest impact in industrial societies (Palmer 1993; Sokol 1997), although promotion of breastmilk as a product has previously been both advocated (Durdle *et al*. 1996) and challenged (Dykes & Williams 1999). Women whose babies were on the SCBU appeared to associate rapid recovery of illness and early return home with artificial milk, a factor that, according to earlier literature (Dykes & Williams 1999), may well be deeply embedded in today's culture.

However, promotion of breastfeeding alone is unlikely to have a huge impact on breastfeeding rates. We are now in the 21st century and, as suggested by participants, we need to move with the times. While female bodies were engineered for breastfeeding, the culture of a society is a powerful deterrent. In the UK, women no longer have extended families or positive breastfeeding role models. Furthermore, they are less likely to stay at home, and are more likely to have financial and social independence. Participants acknowledged these factors, which have a huge impact on the integration of breastfeeding into existing lifestyles.

To break down these cultural challenges, health professionals should adopt a wide range of strategies to engage with women and families, as has been suggested by others (Sheehan *et al*. 2003). Innovative educational approaches which are family centred and reflect individual learning needs and preferences should be employed. During sessions for couples, for example, the health professionals could inform the partner of his role and initiate and encourage discussions regarding breastfeeding expectations. Similarly, during sessions with influential family members, the health professionals can highlight the importance of verbal encouragement and practical support, pointing out that minor negativity can undermine the breastfeeding experience. The communication of positive norms by professionals to the women and their social networks has been shown to improve breastfeeding rates (Swanson & Power 2005), and should be encouraged. The coordination of local community peer supporters could offer further support, especially for those who feel isolated. Health professionals should also provide women with information about professional support and the provision of local breastfeeding facilities.

Conclusion

Previous work has demonstrated that single interventions to promote breastfeeding have been either ineffective or less effective than multiple interventions (Protheroe *et al*. 2003). This study suggests that interventions need to be multi-layered to include society, wider social networks, families and women. Clearly, changes need to be made on all levels; society needs to promote a positive breastfeeding culture, the family needs to know how to support a woman to breastfeed, and a woman needs to be able to articulate her individual needs. The professionals need to assist in facilitating these changes. When such synergies exist in the UK, breastfeeding rates are likely to improve.

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