Views of breastfeeding difficulties among drop-in-clinic attendees

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Abstract

Breast-milk is the optimum form of nutrition for the first 6 months of life. However, breastfeeding rates in the UK are low and static compared to other European countries and those in the North-west of England in the UK are even lower. Of the women who initiate breastfeeding, many cease in the first month following the birth for reasons that might be avoided. To try and prevent this, UNICEF Baby Friendly Hospital Initiative (BFHI) 'Ten Steps to Successful Breastfeeding' state that maternity facilities should foster the development of support groups for breastfeeding women. The aim of the present study was to describe breastfeeding difficulties reported by women who attended the infant feeding clinic at a Women's Hospital in the North-west of England. During the study period, the clinic was attended mainly by primiparous mothers who were educated beyond 18 years of age and of higher socio-economic status. They presented with a variety of problems including baby not latching on, concerns about baby's weight gain/loss, sore nipples and advice about expressing milk in preparation for return to work. The women highlighted the importance of meeting other mothers and having someone to talk to who understood what they were going through. Inconsistent information/lack of detailed knowledge from health professionals was cited as contributing to breastfeeding difficulties. A number of women reported that expert hands-on, one-to-one support, was invaluable and many felt they were able to continue breastfeeding but without the support, they may have given up.

Keywords: breastfeeding, support, infant feeding clinic.

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Introduction

It is widely recognized that human breast-milk is optimal for the normal healthy growth and development of the infant (WHO 2001). Recommendations in

most European countries (Kaftos and Codrington 2001) closely relate to those in the Innocenti Declaration (WHO/UNICEF 1990) advising exclusive breastfeeding for the first 6 months after birth. Breastfeeding initiation and continuation rates in the UK however, are amongst the lowest in Europe, especially when compared to Scandinavian countries where the incidence is over 90% (Yngve and Sjöström 2001). In comparison, the most recent Infant Feeding Survey in the UK (Hamlyn *et al*. 2002) describes an initiation rate of 69%. Breastfeeding initiation and duration rates in the North-west of England in the UK are even lower. The present study took place in the Women's Hospital (WH) in a North-west city (population 440 000) having the fourth lowest under privileged area (UPA) score in the UK (the lower the score, the more deprived the area). Only 45% of women here breastfeed at delivery, falling to 35% when discharged. One month later, only 25% of women are still breastfeeding. There are 6000 births at this hospital per year, so a substantial number of babies are not receiving the benefits of their mother's milk; the future health implications of this are substantial.

As very few women are physically unable to breastfeed (Neifert 2001), it is increasingly being recognized that breastfeeding decisions and experiences are complex and are constructed and practised within the social setting in which women live (Dettwyler 1995). The reasons why many women are unwilling or unable to persist with breastfeeding are multiple and complex (Bysshe 1997). Culture profoundly influences health knowledge, attitudes and behaviour (Backett and Davison 1995) and this is particularly true of infant feeding practices (Wilmoth and Elder 1995). Numerous studies have shown that the initiation and duration of breastfeeding depends on a number of factors including socio-demographic, psychosocial, or health care related factors. A woman's physical health, the health of her baby, the needs of her other children and family members, the family's living conditions and other demands on the woman's time and energy will all influence her infant feeding decisions (Carter 1995; Hoddinott and Pill 1999a; Murphy 1999). In the UK, breastfeeding rates are highest among older women of higher socio-economic status who are more likely to be primiparous, educated beyond 18 years of age, married or cohabiting and a non-smoker (Hamlyn *et al*. 2002).

Further, those mothers who choose to breastfeed may face difficulties in initiating or continuing breastfeeding, and cite numerous reasons for discontinuing, with insufficient milk, painful nipples and breasts, and refusal of the baby to suck or latch on to the breast being the most common (Livingstone 1995; Hamlyn *et al*. 2002). These problems have been widely documented and can be alleviated by appropriate positioning and attachment of the baby at the breast and unrestricted feeding (Bick *et al*. 1998). It may also be possible that the reasons given by women are a substitute for other reasons that women are unwilling or unable to articulate (Bates 1996). If mothers do not breastfeed or discontinue because of these difficulties, they may feel unsuccessful, and feelings of failure may, in turn, produce long-lasting emotional ill effects (West 1980; La Leche League International 1991; Bryant *et al*. 1992).

There is also accumulating evidence that early cessation of breastfeeding is largely because of negative influences within the cultural and social environment (Bergh 1993; Armstrong 1995; Bick *et al*. 1998; Heath *et al*. 2002). Bottorff 1990) indicates that British mothers most likely to succeed in breastfeeding are those who are highly motivated and willing to persist when they encounter any kind of problem or difficulty. Such motivation can be engendered by the nature of the support or education that the mother receives.

Breastfeeding is a learned skill and, in the absence of a breastfeeding culture in which skills are passed from female relatives and members of the close community, and where there has been a decline of the extended family as a means of support and advice, success may depend upon the skilled support of health care professionals during the postnatal period. The large proportion of mothers who discontinue breastfeeding do so at a time when the input from health professionals is at it's greatest, i.e. in hospital and the first few weeks following the birth (Hamlyn *et al*. 2002). This is attributed in part to conflicting professional advice (The Audit Commission 1998; Simmons 2002a), for example midwives teaching

women different ways to breastfeed, and is widely documented as a source of confusion (DoH 1988; Garforth and Garcia 1989; Rajan 1993; Bick *et al*. 1998; Green *et al*. 1998; Tarkka *et al*. 1998; Dykes and Williams 1999). Hospital shift patterns can result in women seeing different midwives, with implications for consistency of advice and support. Furthermore, many new mothers return home confused by their newborn's behaviour and unable to carry out what was taught in hospital (Broadfoot *et al*. 1999; Locklin and Jansson 1999). Problems associated with teaching the skills required to correctly position and attach an infant to the breast are highlighted by Whelan and Lupton (1998). The issue that midwives 'do rather than teach' was cited frequently by the women studied as this did not enable them to implement the skills once they were home. They also concluded that the high and persistent proportion of women who suffered the physical symptoms of incorrect attachment indicated that midwives did not always recognize this. These findings are reflected by other studies (Vogel and Mitchell 1998; Inch and Fisher 1999).

Even when a pro-breastfeeding policy is in place in hospital, mothers may still be subjected to poor practice (Beeken and Waterston 1992). For example, according to Woods *et al*. (2001) midwives who have not benefited from recent updating in breastfeeding may have inaccurate perceptions of how a baby should be positioned and attached at the breast. Simmons (2002b) also found evidence of poor professional practice, and UK infant feeding surveys have shown a strong association between poor practice and reduced duration of breastfeeding (White *et al*. 1992; Foster *et al*. 1997; Renfrew *et al*. 2000). Hall Moran *et al*. (2000) demonstrated that breastfeeding support skills were significantly improved when midwives from four geographic areas within the UK completed the 20-h WHO/UNICEF breastfeeding management course as evaluated by the Breastfeeding Support Skills Tool.

Improving breastfeeding rates in the UK remains a challenge. With only a modest improvement in the initial incidence of breastfeeding being achieved, 66% in 1990 compared to 69% in 2000 (Hamlyn *et al*. 2002), supporting and encouraging breastfeeding is a priority. The Eurodiet core report on nutrition and diet (Kaftos and Codrington 2001) states that for a longer duration of breastfeeding, reinforcing factors are important especially those found in the support systems that already exist; peer-support groups, social network support, workplace support, maternity leave benefits and media advocacy. A systematic review of support for breastfeeding mothers (Sikorski and Renfrew 1999) found that interventions which appeared most likely to be successful were those including face-to-face contact with a supporter with appropriate training and expertise in breastfeeding, although they do not expand on what this is. In the review, it is acknowledged that there is a need for fundamental qualitative research exploring the different elements of breastfeeding support strategies and that controlled studies are required to identify the most effective method and how it can be organized and delivered.

The equity issue of young, low-income, poorly educated women, who breastfeed less than their peers is a matter of great concern. This is especially important as this situation has a tendency to perpetuate itself when these women live in a social context where breastfeeding is not the norm. The decision not to breastfeed has the potential to widen an already existing gap in health and life expectancy between people from low socio-economic groups and those who are more affluent (Acheson 1998). The UK Department of Health (2003) suggests that the groups of women most in need of consistent and appropriate professional support are not always receiving it in the current system.

In the UK, various strategies have been implemented to try and increase both the uptake and duration of breastfeeding, especially in socially and economically deprived areas where breastfeeding rates tend to be lower. Peer support programmes are one such strategy. They offer the opportunity of contact over time with a woman who has successfully breastfed. These experienced and/or trained peers have been shown to increase the numbers of women breastfeeding (NHS 2000). Graffy *et al*. (2004) found that women valued the support of a counsellor in breastfeeding, but the intervention did not significantly increase breastfeeding rates, perhaps because some women did not ask for help. Graffy *et al*. (2004)

suggest that cultural barriers may have made some women from manual social class groups reluctant to ask for help, thus highlighting the importance of having peer counsellors who work within rather than across cultural groups (Morrow *et al*. 1999; McInnes and Stone 2001; Dennis 2002). In addition, breastfeeding support centres have been found to be beneficial, particularly informal drop-ins that primarily facilitated network support between women combined with the 'background' availability of a health professional and/or qualified breastfeeding counsellor (DoH 2003).

The WH provides a drop-in clinic one morning a week to support women who are having problems/need advice with any aspect of infant feeding (breast, bottle feeding and weaning). A telephone help line is also provided, and women can be seen by an infant feeding advisor during the week if necessary. These advisors (midwives at the hospital) will have undergone the UNICEF UK Baby Friendly Initiative Breastfeeding Course (Lang and Dykes 1998) as well as lactation consultant courses and some have taken the International Board Certified Lactation Consultant examination. The drop-in clinic is held in the antenatal parentcraft room. This is a large room; women all sit together, and screens are provided for privacy should women require it.

This study aimed to describe breastfeeding difficulties and experiences reported by women who attended the infant feeding clinic at the WH.

Methods

Permission for the study was granted from the University and Local Research Ethics Committees.

A short (25-item) questionnaire was devised to identify reasons why women attended the clinic. These reasons pertained either to the baby (not latching on properly, not taking enough milk, advice about making up bottles, advice about what formula to use, advice about weaning or other), or to the mother (cracked/sore nipples, mastitis/breast abscess, not producing enough milk, advice about expressing milk, advice about own diet, or other), and women could tick as many responses as were appropriate. The questionnaire also asked about number of visits to the clinic, whether the support was helpful, questions relating to the baby (i.e. how old, when born, birth weight), how the baby was being fed, and demographic questions relating to the mother. Socioeconomic status was classified by the occupation of the mother according to the Registrar General's classification of occupations (OPCS 1991). Where the mother did not work, the occupation of her partner (if applicable) was used. The questionnaire was assessed for face and content validity by a state registered dietician and the head infant feeding coordinator at the WH. It was then piloted at the clinic during one of the drop-in sessions by eight mothers. Following the pilot, no changes were judged necessary to the questionnaire.

The researcher attended the drop-in clinic between May and September 2003 (21 weeks). All women attending the clinic for the first time during the study period were approached to complete the questionnaire once they had been seen by one of the infant feeding team at the clinic. At this time, an information sheet about the study was given to the mothers to read and informed consent was gained. All women were assured of confidentiality and were given code numbers to maintain their anonymity. They were also assured that they were free to refuse to take part and this would not affect the nature of care they would receive either now or in the future. The researcher stayed in the room whilst the women completed the questionnaire, this was to maximize the number of women asked to complete questionnaires (with it being a drop-in clinic, women were arriving throughout the morning). It is possible that this may have affected the responses given, i.e. the women had just been seen and their infant feeding problems had been alleviated, so they may have been more likely to respond positively about the clinic, rather than giving more full, reflective or frank responses. As a result of the informal nature of the clinic, some of the women also took this opportunity to talk to the researcher about their experiences with feeding, or just about life with a new baby in general, and their comments were noted after asking permission to do so. Because of the exploratory nature of this research, any comments made were analysed thematically (Green and Thorogood 2004). Codes were assigned according to

emerging themes, and as relatively few women gave comments (35 in total), this categorization was completed manually rather than with computer software. The two main emerging themes were the atmosphere of the clinic and the support given. The theme of support was further categorized under types of support, i.e. networking with other mothers, confidence building, information giving and practical.

Results

During the study period (21 weeks), there were 198 attendances by 108 women at the drop-in clinic (mean 9 women per week, range 2–16). In total, 80 of the 108 women completed questionnaires (74% of all attendees). The remaining 28 women did not as a result of language difficulties or because the clinic was busy and the researcher had no chance to ask them. All women who were asked to complete a questionnaire did so. Of the 80 women who completed questionnaires, the number who attended the clinic only once was 40, the remainder returned more than once. Women were only asked to complete a questionnaire the first time they attended during the study period (to prevent duplication of results).

The demographic characteristics of the women are shown in Table 1.

The mean age of women attending the clinic who completed questionnaires was 31 years (SD 4.9 range 18–41); this is similar to the mean age of all women delivering at the WH (29 years). The majority of women (70%) were primiparous; their mean age was 30 (SD 5.1, range 18–41). This is slightly higher than all primiparous women delivering at the WH (mean age 27, range 15–44).

The women were a well-educated group with 59% being educated to degree level or higher, and 74% of a higher socio-economic status (figures were not available from the WH for comparison). Most of the women (95%) were white European; this compares with 90% of all women delivering at the WH being white European.

The majority of women attending the clinic (55, 69%) were giving their baby only breast-milk, 23 (29%) were giving mixed feeds of breast and formula milk and 2 (3%) were giving their baby formula feeds exclusively. Only 5 (6%) women had started introducing other foods to the baby's diet (most of the babies were under 5 months old). The average age of baby was 34 days (ranging from 4 days to 5 months). The average birth weight was 3.563 kg (ranging from 2.325 to 4.827 kg).

Table 1. Demographic characteristics of respondents

	Total	
	n	%
Age		
Under 30	24	30
30 and over	56	70
Education		
None	1	1
School	21	26
Vocational	11	14
Degree or above	47	59
Work status		
Not working	14	18
Working full time	14	18
Full time but on mat leave	36	45
Working part time	2	3
Part time but on mat leave	14	16
SE status		
High (SE I & II)	59	74
Middle (SE III & IV)	15	19
Low (SE V & not working)	6	8
Ethnicity		
White	76	95
Black	1	1
Asian	2	3
Other	1	1
Marital status		
Single/separated	5	6
Married/living together	75	94
Number of children		
1 child	56	70
More than 1 child	24	30

Percentages may not sum due to rounding.
SE, socio-economic.

Reasons for attendance

Table 2 shows the reasons for attendance at the clinic. Women could tick as many responses as applied, therefore percentages do not sum to 100.

As Table 2 shows, nearly half the women attending (46%) were concerned that their baby was not latch-

Table 2. Reasons for attendance at clinic

	All women		Primiparous women	
	n	%	*n*	% of all women
Relating to baby				
Not latching on properly	37	46	25	68
Not taking enough milk	11	14	9	82
Advice on making up bottles	1	1	1	100
Advice on what formula to use	0		0	
Advice about weaning	4	5	4	100
Other	29	36	20	69
Relating to mother				
Cracked/sore nipples	26	33	15	58
Mastitis/breast abscess	3	4	1	33
Not producing enough milk	12	15	7	58
Advice about expressing milk	26	33	20	77
Advice about own diet	4	5	3	75
Other	15	19	11	73

Table 3. Other reasons given relating to baby

Reason	*n*
Poor weight gain/loss	8
Thrush	4
Colic/wind	4
Feeding too often	4
Feeding not enough	1
Baby refuses bottle	2
Baby refuses breast	2
Baby not settling	1
No reason given	2
Total	28

ing on properly, the majority of whom (68%) were primiparous. Of the 37 women who experienced difficulties with latching on, 17 (46%) also experienced sore nipples and 8 (22%) were concerned their baby was not taking enough milk.

'Other' reasons for attendance at the clinic relating to the baby are shown in Table 3. The majority of mothers were concerned about their baby's rate of weight gain. The concern about rate of weight gain was evidenced by the mothers wanting to get their babies weighed, indeed, one mother said she used the clinic for this sole purpose.

Table 4. Other reasons given relating to the mother

Reason	*n*
Thrush	6
Returning to work	1
Relactation	1
Breastfeeding in public	1
Managing with other children	1
Did not think was breastfeeding properly	1
No reason given	4
Total	15

Reasons for attendance relating to the mother were mainly because of cracked/sore nipples or advice about expressing milk. First time mothers were more concerned about soreness and whether they were producing enough milk. Few women were concerned about their own diet and few had experienced mastitis or a breast abscess.

'Other' reasons relating to the mother are shown in Table 4. The majority of women cited thrush (on the nipples) as being the reason for visiting the clinic. Many of these women had been advised by their General Practitioner (GP) or health visitor to get this checked at the clinic, as these midwives see cases of it frequently. One mother with thrush returned to the clinic over a period of eight consecutive weeks, however, the other five women with thrush visited the clinic only once or in one case twice.

Themes

The two main themes that emerged were the atmosphere of the clinic and the support available. Frequently used words to describe the clinic and its staff were: 'friendly', 'relaxed', 'comfortable', 'respectful', 'open-minded', 'understanding' and 'welcoming'. One woman (a 29-year-old primiparous housewife) said that this meant it was 'very easy to ask for advice'.

The support given was frequently cited as being 'useful', 'helpful' and 'valuable'. Further analysis of the type of support offered revealed four main subthemes.

Networking with other breastfeeding mothers

The fact that the room was large and women were all seen together (rather than being seen in individual rooms or cubicles) facilitated the mothers being able to talk freely with one another and meet other mothers. One woman said that it was 'good to meet other breastfeeding mums', whilst another stated that it was 'very useful talking to other mums'.

It was also important for these women to meet other mothers who were either having similar problems or had overcome problems with feeding, as verbalized by one 38 years old: 'Made me want to carry on trying, especially seeing other mothers and hearing problems being overcome'. Similarly, a 28-year-old primiparous mother stated that she 'felt a lot better knowing that I was not the only person who was unsure about breastfeeding'.

Meeting other breastfeeding mothers seemed to counter the feelings of isolation that some of the breastfeeding women felt. One primiparous mother stated that she 'didn't have any breastfeeding friends so felt a bit isolated – didn't know what was normal'.

Not knowing what was normal with regards breastfeeding led to the second theme of support identified.

Imparting of information

Several women commented that the clinic was 'informative', offered 'good advice and ideas', 'helpful advice' and 'excellent advice'. One woman stated that she had 'now learnt that as well as my baby having thrush in his mouth, it goes through his body and that is why his bottom is a bit sore'. Knowing that you were being seen by health professionals who had detailed knowledge was important as acknowledged by one mother: 'Whilst my health visitor was great, didn't feel she had specific detailed knowledge'. Another woman commented that she was 'in hospital for five days but staff on the ward were not very helpful'. Her experience was echoed by another woman who felt that 'inconsistency of advice regarding breastfeeding caused initial problems before leaving hospital'.

The way that information was imparted led to the third theme of support.

Practical support

Women were observed feeding their baby, and shown how to correctly attach, position and detach the baby from the breast. One woman applauded this 'practical hands-on help' that she received, which was done sensitively and 'very respectfully'. Women were also taught to observe feeding cues from their babies, for example when they had received enough milk or were comfort feeding. One woman stated that because of this, she 'felt better about breastfeeding'.

The impartation of information and practical support led to the fourth theme of support.

Esteem/confidence building

Receiving reassurance was very important for this group of women who expressed that they received 'lots of reassurance', 'reassurance in regards to baby's weight gain', 'found it very reassuring to know the support is available'. It was also important to feel listened to as expressed by one young woman who stated that by attending the clinic, it was 'a chance to talk to people who understand what I'm going through'. Whilst this study did not investigate whether attendance at the clinic increased breastfeeding duration, some women stated that they would not have continued: 'without this clinic, I would have found it difficult to continue', 'instilled confidence and made me want to carry on trying'.

Discussion

Whilst the majority of women attending the clinic were older, educated beyond 18 years of age and of higher socio-economic status, this may not be surprising as these are the typical characteristics of breastfeeding women (Hamlyn *et al*. 2002). Therefore the findings of the present study can only be generalized to this population of women. With regard to breastfeeding, quantitative survey approaches may also oversimplify what is generally accepted to be a very complex phenomenon (Maclean 1989). The reasons behind the responses given in surveys are seldom well understood, and may, in fact, reflect socially acceptable rationalizations (Van Esterik and Greiner 1981).

As the present study was exploratory in nature, a quantitative approach was considered to be the best method. In future, a more in depth qualitative approach could address the findings of this study by putting breastfeeding in the context of women's everyday lives, rather than treating it as a discrete event; reducing it to a series of variables (Taylor and Bogdan 1998).

During the study period of 5 months, 108 women attended the clinic. This compares to 2500 births at the WH during that time of which 35% of mothers left hospital breastfeeding (875 women), and 25% were breastfeeding 1 month later (625 women). From these figures, it can be calculated that between 12 and 17% of breastfeeding women visited the infant feeding clinic. This raises the question of whether the remainder do not encounter any problems and carry on breastfeeding, whether they get support from elsewhere (friends, relatives or other community health professionals), whether they do not have access to any support and perhaps switch to formula feeding instead or whether they do not know that the clinic is available. Women were not asked directly how they had heard about the clinic although some volunteered that they had been referred by their midwife/health visitor/GP, heard about it through parentcraft classes/breastfeeding workshop, were recommended by a friend, read the details in the hospital discharge pack or had already seen one of the team on the ward during their postnatal stay.

The hospital setting may have prevented some women accessing the clinic. Simmons (2003) states that hospital settings facilitate hierarchical relationships between professionals and their clients, leading to lack of meaningful communication whereas effective positive communication is an essential element in supporting breastfeeding mothers (Simmons 2003). BFHI 'Ten Steps' (UNICEF 1998) emphasizes the importance of empowering women through fostering community level breastfeeding support groups, but at this level hospitals rarely have effective outreach and existing social structures may not be suitable for mother-to-mother help. In recognition that not all women will access the hospital clinic for whatever reason, satellite infant feeding clinics are being set up around the study city, mostly in deprived areas. An evaluation of these, in addition to local peer support programmes would be a useful area of further research.

That women in this study accessed the clinic would suggest they were highly motivated to persist with breastfeeding despite difficulties encountered. These findings reflect those in the Infant Feeding Survey 2000 (Hamlyn *et al*. 2002) where mothers classified in higher socio-economic groups were more likely to report feeding problems compared to those in lower groups (21% compared to 13%). This may be because such women are able to articulate what they are experiencing and have the confidence and motivation to seek out help. Many of the women had high profile careers such as solicitor, National Health Service manager, pharmacist, osteopath, barrister, company director, bank manager and senior lecturer. They may approach breastfeeding in the same way as they approach their careers – as something to excel at and get 'right'. If problems occur, then they will seek out support and advice in order to alleviate those problems. Bottorff (1990) states that to breastfeed in a society where exposure of breasts is only acceptable at the beach, 'there is a need to succeed, to be tenacious of purpose and to remain determined'. When women talk of their breastfeeding experience, they have frequently recognized the importance of being persistent. Other researchers have recognized the importance of this concept of 'commitment to breastfeed' (Hoddinott and Pill 1999a; Sheehan *et al*. 2003), Commitment is required to make the decision to breastfeed in the face of the reality that breastfeeding is not always easy and can be problematic. Sheehan *et al*. (2003) found that one woman stated she would give breastfeeding 100% even if she encountered problems whilst the knowledge that breastfeeding could be difficult and problematic made another woman fearful and added to her concerns about breastfeeding. She was willing to start breastfeeding but was not prepared to persevere if problems arose. Recognizing one's need for support and finding support is an important part of being persistent (Bottorf 1990).

Types of problems encountered

Typical problems encountered by breastfeeding women in the present study included baby not latch-

ing on, concerns about how much milk the baby was getting and its weight gain, painful nipples/breasts and advice about expressing milk. These problems are well documented (Hamlyn *et al*. 2002) and can be alleviated by support and correct advice. Armstrong (1995) states that this 'must be as accessible as the tin of formula'.

There was a major emphasis (from the mothers) on getting their baby weighed. Because breastfeeding mothers cannot physically see how much milk their baby is getting, and because they may not trust their own instincts as to whether their baby is content and developing well, weight gain is seen as important reassurance. This may be likely to be so if their baby is being compared by friends or relatives to another baby who is formula fed (and therefore likely to be putting weight on quicker). Women need to be made aware that breastfed babies will gain weight at a different rate to formula fed babies and that this pattern of weight gain is healthier for long-term health (Butte *et al*. 1990; Dewey *et al*. 1992). Health visitors and GPs may exacerbate this preoccupation with weight gain as infant growth charts are currently based on growth patterns of formula fed babies, and some women in the present study state they were told to 'put their baby on the bottle' as they were falling below the prescribed growth curve. This problem is being remedied with the World Health Organization currently undertaking to draw up growth curves based on breastfed infants. These are not yet available.

Emerging themes

The importance of the type of support offered was similar to the themes identified by Dykes *et al*. (2003) in their study of adolescent mothers.

In the present study, the importance of network support was important as a feeling of isolation was verbalized by many of the mothers attending the clinic and they valued the chance to meet other breastfeeding mothers. Following the birth, women have private rooms unless they have had complications and so may not get to meet other mothers, especially those who are breastfeeding (as they are in the minority).

Many women attending the infant feeding clinic found it very reassuring to discover that their baby was not the only one that followed a particular pattern of feeding or sleeping, and they enjoyed talking to mothers whose babies were older and therefore had passed the particular stage they were going through. Knowing that you are not the only one who is going through something can be empowering, hence the many support groups in existence for problems as diverse as drinking, smoking, dieting or illness/bereavement. Bottorrf (1990) describes the 'aloneness' of breastfeeding experienced by mothers, and the importance of talking and being with other breastfeeding mothers, promoting a connectedness with others which strengthens oneself.

Feeling supported and able to talk to someone who understood what they were going through was very important for the mothers in the present study. Although the women were not asked whether they were originally born in the study city or had moved there at a later stage, it was evident that many did not originate from this city, and thus did not have their families close by to give support and advice. In the absence of this support, and in the absence of friends or neighbours who were breastfeeding, talking to someone who appreciated what you were experiencing was invaluable.

Impartation of information and receiving practical hands-on support was also highlighted as important to this group of women. Hospital stays can be short with primiparous mothers being discharged within 24 h, and others discharged in as few as 6 h. This gives little time to practice optimal techniques for breastfeeding (it takes 4–6 weeks to establish successful breastfeeding), or ask questions or solve problems. Midwives may be busy and some women may feel that they cannot ask for help, especially if they need assistance with each feed. However, the length of post-partum stay alone has not been shown to affect breastfeeding duration rates (Winterburn and Fraser 2000). Other studies have concluded that length of stay is less important than the quality and consistency of support and encouragement available to mothers while in hospital (Gagnon *et al*. 1997; Mandl *et al*. 1997; Quinn *et al*. 1997; Svedulf *et al*. 1998). Women require effective support and clear information

before they go home; this needs to be offered within an increasingly short time frame (Woods *et al*. 2001). If a mother can gain breastfeeding skills during her hospital stay she will be more likely to succeed afterwards (RCM 2002).

Inconsistent advice/lack of knowledge in health professionals has frequently been highlighted as an area of distress for breastfeeding mothers with conflicting advice reinforcing a woman's lack of self-confidence in her ability to breastfeed (Simmons 2002b). This was noted in the present study, even though the WH is going through the process of becoming Baby Friendly accredited and has a breastfeeding policy in place. All nurses and midwives must complete an 18-h breastfeeding course (Lang and Dykes 1998), and Health Care Assistants attend a 1-day course. The training covers the BFHI 'Ten Steps' (UNICEF 1998; WHO 1998) and the *International Code of Marketing of Breast-Milk Substitutes* (WHO 1981). Following this course the staff undergo clinical supervised practice with an Infant Feeding Advisor and should attend an annual update. However, inconsistencies were apparent and some staff did not appear to agree that 'breast is best', or provide support in the most appropriate way. For example, one young primiparous woman recounted how when she was in hospital for 1 week (her baby had jaundice), she needed help breastfeeding in the night and called for a midwife. A health care assistant came in. She did not check positioning at the breast, just said 'yeah, that looks OK' and asked whether the baby preferred chocolate or strawberry milk depending on which breast he was going on. This was not helpful to this mother who was struggling, not just with breastfeeding, but with lack of sleep and having to spend so long in hospital. Woods *et al*. (2001) states that much care in the postnatal ward area may be provided by Health Care Assistants who may lack confidence and experience in the support required by breastfeeding mothers.

The final theme that emerged from the present study was that of esteem/confidence building. Words of encouragement and reassurance seemed to prompt the women to keep on trying with breastfeeding. Qualitative research has highlighted that women often lack confidence in their ability to breastfeed (Hoddinott and Pill 1999a,b) and in particular their capacity to provide sufficient milk for their babies (Dykes and Williams 1999; Dykes 2002). The issue of support and confidence building is therefore extremely important. Armstrong (1995) states that the challenge remains to move from motivating women to ensuring access to practical and confidence-building support. The infant feeding clinic was an excellent way of achieving this.

Conclusion

Whilst this study focused on only a small group of women, the results suggest the importance of providing support in the form of networking with other mothers, receiving correct information and hands-on practical support, and confidence building. Promotion, protection and support should be provided to all breastfeeding women and their babies, in order not to perpetuate today's situation where a child may be denied the benefits of breastfeeding depending on nationality, economic circumstances, and their mother's educational level and age. However, provision of effective and consistent breastfeeding support is a challenge.

Health care providers have opportunities to help breastfeeding mothers, but the support they give must be the kind of support mothers want. The infant feeding clinic at the WH provides a warm, relaxed, friendly atmosphere with hands-on, one-to-one advice and support by experienced staff.

This study has demonstrated that not all women are accessing the support available. This was a hospital based clinic; this may not be the best way of addressing the needs of the most vulnerable patients who would potentially benefit most from breastfeeding. This is currently being addressed by the addition of satellite infant feeding clinics around the city, especially in many deprived areas.

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