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Supporting teenage mothers to initiate breastfeeding
and developing a support intervention to increase
breastfeeding rates in a vulnerable group – the
importance of place

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award of Doctor of Philosophy from the University of West
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Foreword

Biographical resume by the author

I have worked as a midwife in the UK NHS for ten years. During that time, I have predominantly been based in the community. For a short period I worked in a deprived, inner city area with a high rate of teenage conceptions. During this time I helped facilitate a weekly group for pregnant and mothering teenagers, and started an antenatal clinic for young mothers in the local Children's Centre. As I became known as someone who worked with young mothers, colleagues started to stop me in the corridor to give advice. These conversations generally started with them saying 'what your teenagers need is...' Breastfeeding support featured prominently in the suggestions that followed. I felt uncomfortable that 'my' teenagers' needs regarding breastfeeding support were being conjectured without any reference to the young women themselves, so I decided to go and ask them what they wanted. The results of that investigation are presented in this thesis.

This work was supervised by Dr Julia Magill-Cuerden and Professor Christine McCourt, and their contribution, guidance and support is duly acknowledged.

Abstract

Background Not being breastfed is internationally considered to have a lifelong impact on morbidity and mortality. In the UK and other developed nations, adolescent mothers are among those least likely to breastfeed and require additional support to do so due to their unique developmental position. Evidence indicates that many young mothers who intend to breastfeed never initiate breastfeeding or stop soon after giving birth, and there may be factors in the UK health system or wider society preventing the success of breastfeeding support interventions. These considerations led to a two-phase investigation which aimed to study the context of breastfeeding support and evaluate a targeted breastfeeding support intervention for young women.

Methods A realist evaluation framework was used. 83 UK health professionals responded to an e-questionnaire. Focus groups and interviews were conducted with 15 young mothers (aged 16-20) in Oxford, England. A breastfeeding support package was then developed and implemented on a UK postnatal ward for six months. A concurrent mixed methods evaluation was carried out. Each component of the investigation was analysed thematically using inductive content analysis. Ethical approval was received.

Findings Young women appear motivated to breastfeed to show that they are good mothers. However, breastfeeding can alienate them from their families at a time when they need to be accepted in their new mothering role.

Young mothers can feel disempowered after birth and like 'fish out of water' on the postnatal ward. A need was identified for proactive breastfeeding support from health professionals focusing on relational care, particularly as some maternity professionals displayed negative attitudes to teenage mothers and breastfeeding. Despite staff training developing a more positive and enabling attitude towards young women, much of the proposed support package proved impossible to implement in a busy, task-orientated, medical environment where time, convenience, control, and individual staff beliefs were used as yardsticks to determine the acceptability of different aspects of care.

Conclusion This study highlights the importance of proactive, relational breastfeeding support for young mothers. Such support requires a facilitative environment in order to be implemented successfully. It is suggested that such an environment could be created on the postnatal ward if midwives and MSWs created workplace communities and claimed ownership of their time and space. Action Learning may facilitate this process.

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Chapter one

Introduction

The research undertaken for this thesis developed from an observation that young mothers in the UK appeared to have particular difficulties initiating breastfeeding in hospital after giving birth. The research is divided into two phases. Phase one explored the early postnatal experiences of a group of UK teenage mothers who intended to breastfeed, and canvassed the opinions of health professionals caring for young mothers as to why initiating breastfeeding is problematic for this population and what could be done to support them, particularly on the postnatal ward. Based on the accounts and recommendations gathered, and a review of relevant literature, in phase two an intervention was designed which aimed to provide targeted support on the postnatal ward to young mothers wanting to breastfeed. This intervention was implemented on a postnatal ward in a large UK tertiary maternity unit, typical of the hospital wards in which many young mothers are cared for after giving birth. A concurrent evaluation of this implementation was carried out, focussing specifically on the impact that the culture and environment of the ward had on the delivery of the intervention.

This introductory chapter outlines the necessity and rationale for this research, summarising the evidence demonstrating the importance of breastfeeding, particularly for disadvantaged groups such as young mothers, and discussing international and national policies and guidelines in this regard. Recent statistics of breastfeeding rates in the UK are also presented, in order to highlight the particularly low initiation and continuation rates among teenage mothers. Challenges faced in providing breastfeeding support are then briefly discussed before the research presented in the following chapters is introduced.

The impact of breastfeeding

The World Health Organisation (WHO) recognises that breastfeeding is ‘an unequalled way of providing ideal food for the healthy growth of infants’ (WHO 2003, p7). WHO (2003) further state that not being breastfed is an important risk

factor for infant and childhood morbidity and mortality which can have a lifelong impact on health and social prosperity. According to Renfrew et al (2012 p2),

‘few health behaviours have such a broad-spectrum and long-lasting impact on population health, with the potential to improve life chances, health and wellbeing’.

Breastfeeding is known to protect babies from gastroenteritis and lower respiratory tract infections (Wilson et al 1998, Kramer et al 2001, Ip et al 2007, Quigley et al 2007); middle ear infections (Aniansson et al 1994, Ip et al 2007), urinary tract infections (Marild et al 2004); necrotising enterocolitis (Ip et al 2007, Henderson et al 2009) and atopic disease where a family history of this is known (Fewtrell 2004). Worldwide, suboptimal breastfeeding is responsible for 45% of deaths from neonatal infections, 30% of deaths from diarrhoea and 18% of deaths from acute respiratory infection in children under five years of age (WHO 2012). Having been breastfed in the early months of life also offers protection against juvenile onset insulin-dependent diabetes (Sadauskaite-Kuehne et al 2004); raised blood pressure and obesity (Fewtrell 2004); and adult diseases such as coeliac and cardiovascular conditions (Ip et al 2007, Quigley et al 2007). It also appears to result in fewer cases of Sudden Infant Death Syndrome (Hauck et al 2011), improved cognitive development and better behavioural outcomes (Kramer et al 2008), although the role of breastfeeding is harder to establish in these cases. Furthermore, the act of breastfeeding protects mothers from ovarian cancer, breast cancer and hip fractures in later life (Rosenblatt and Thomas 1993, Beral et al 2002, Ip et al 2007). Research by the United Nations Children’s Fund (UNICEF 2012) looked at a limited number of conditions from which breastfeeding is known to offer protection to mothers or babies and estimated that, in relation to the treatment of these conditions alone, a moderate increase in breastfeeding rates in the United Kingdom (UK) would result in a saving to the National Health Service (NHS) of around £40 million per year.

International and UK policy on breastfeeding

Because of its manifold advantages, efforts have been made both internationally and within the UK to promote and protect breastfeeding, particularly in the face of the increasing enculturation of formula milk feeding in developing nations and among disadvantaged populations within developed countries such as the UK (Mahon-Daly and Andrews 2002). Internationally, WHO have produced, and continue to lobby for the wholesale implementation of, the International Code for Marketing of Breastmilk Substitutes (WHO 1981) and the Global Strategy on Infant and Young Child Feeding (WHO 2003). These documents challenge all governments to promote and protect breastfeeding, declaring that every infant should be exclusively breastfed for the first six months of life, with breastfeeding remaining an important element of an infant's diet for the first year and continuing until the age of two and beyond. In 2012, WHO set a target for at least 50% of babies to be exclusively breastfed for the first six months of life by 2025. The WHO/UNICEF Baby Friendly Hospital Initiative, launched globally in 1991 and as the Baby Friendly Initiative (BFI) in the UK in 1994, provides a set of evidence-based standards for health care providers to implement in order to encourage and enable the mothers in their care to breastfeed (UNICEF 2013).

Breastfeeding is promoted in policy documents in all four UK countries (Dyson et al 2006, Hoddinott et al 2010). Within England, where the research carried out for this thesis is set, the Department of Health's priorities and Planning Framework 2003-6 (Department of Health (DH) 2003) set a target for breastfeeding rates to be increased by two percentage points per year, particularly among women from disadvantaged groups. Breastfeeding is also included as an indicator in the Public Health Outcomes Framework for England 2013-2016 (DH 2012), although no specific target breastfeeding rates are set in this document. Support for breastfeeding is further advocated in the National Institute for Health and Care Excellence (NICE) postnatal guidelines (NICE 2006), which stipulate that the UNICEF BFI should be implemented as a minimum standard in the NHS and that healthcare professionals should have sufficient time, as a priority, to support mothers as they initiate and continue

breastfeeding. However, UK legislation has fallen short of embracing all the principles of the International Code for Marketing of Breastmilk Substitutes (WHO 1981) and formula milk is widely advertised and promoted to UK mothers and health professionals.

Breastfeeding rates in the UK

Despite embedding the promotion and protection of breastfeeding within policy documents and guidelines, breastfeeding rates in the UK are amongst the lowest in the world, particularly among disadvantaged groups such as teenage mothers, and fall far short of the WHO target of 50% of babies being exclusively breastfed for the first six months of life (Dyson et al 2006, McAndrew et al 2012). Figures from the latest quinquennial UK Infant Feeding Survey indicate that, although breastfeeding rates are rising - 81% of all mothers initiated breastfeeding in the UK in 2010 (83% in England), and 69% of mothers initiated exclusive breastfeeding at birth - only 1% of all mothers were exclusively breastfeeding their babies at six months (McAndrew et al 2012). Furthermore, the highest incidences of breastfeeding in the UK were among mothers who were either aged over 30, from ethnic minority groups, had stayed in education until they were at least 18, were in managerial or professional occupations and/or lived in the least deprived areas (McAndrew et al 2012). Across the UK there was a strong association between the initiation and duration of breastfeeding and the age of the mother, with rates lowest among mothers aged under 20: 56% of mothers aged less than 20 initiated breastfeeding in 2010, compared to 87% of those aged 30 or more (The NHS Information Centre 2012). Two days after giving birth, breastfeeding rates among those under 20 had declined more sharply than those for older mothers, with 51% of those under 20 still breastfeeding compared to 84% of mothers aged 30 or more (The NHS Information Centre 2012). This trend continued over time, until at six months women aged 30-34 were four times more likely to be offering their babies any breastmilk (43%) than women aged under 20 (11%) (McAndrew et al 2012). Age has also been shown to be an important variable in infant feeding practices in other developed nations - in their 2007 literature review, Feldman-Winter and Shaikh discovered that in the US, the greatest risk factor for low initiation and

duration of breastfeeding is simply being an adolescent mother, even after controlling for modifiable risk factors such as low socio-economic status. The UK Infant Feeding Survey also indicates that mothers in managerial and professional occupations who breastfed were more likely to receive help with breastfeeding from health professionals than those who had never worked (73% versus 52%) – a concerning statistic, even though those who had never worked were more likely to say that they did not want help (McAndrew et al 2012).

The low rates of exclusive breastfeeding in the UK are considered to reflect social and cultural norms, underpinned by media portrayal of formula milk feeding as normal and safe, breastfeeding as problematic, and breasts as inherently titillating and sexual (Mahon-Daly and Andrews 2002, Dyson et al 2006, Henderson et al 2010, McAndrew et al 2012). It is also suggested that breastfeeding rates are affected by the increasing employment of women outside the home, although this is contested by some (Mahon-Daly and Andrews 2002, McAndrew et al 2012). A great deal less money is spent on promoting breastfeeding compared to the promotion of formula milk, and the subsequent widespread acceptance of formula milk feeding affects policy makers and health professionals as well as mothers (UNICEF 2013a). Furthermore, many health professionals are not adequately prepared to support breastfeeding mothers, and operate within a medicalised mindset that seeks to control and regulate natural processes (Dyson et al 2006, McAndrew et al 2012). Findings presented in this thesis will suggest that medicalisation has had far reaching consequences for breastfeeding support, and that some health professionals lack confidence in the process of lactation. The fact that 85% of mothers who stopped breastfeeding in the first two weeks would have liked to carry on for longer; and that the main reasons given for stopping were real or perceived problems such as painful breasts or nipples, insufficient milk and the baby rejecting the breast, all of which could have been prevented with better information and support, suggests that breastfeeding support in the early postnatal period is not currently meeting mothers' needs (McAndrew et al 2012, Renfrew et al 2012).

There is some evidence to suggest that teenage mothers, like their older counterparts, are willing to and intend to breastfeed, but are not always able to

realise this ambition after giving birth. This is suggested by the rapid discontinuation rate found in the Infant Feeding Survey (NHS Information Centre 2012), and by an audit carried out among teenage mothers prior to the research for this thesis, which found that 81% of respondents had wanted to breastfeed, 48% actually initiated breastfeeding and 31% were still breastfeeding on discharge from hospital after giving birth (Hunter 2008). It is acknowledged internationally and nationally that, if they are to be enabled to breastfeed successfully, teenage mothers will need additional, targeted support (WHO 2003, DH 2004, Dyson et al 2006, Bolling et al 2007, MacGregor and Hughes 2010). The low initiation and rapidly increasing breastfeeding cessation rate among young mothers is likely to add to the health inequalities already experienced by this group and their children, and perpetuate the cycle of deprivation in which they are often caught (Dyson et al 2006). Although teenage motherhood is not currently subject to the level of media and government scrutiny that resulted in the last Labour government's Teenage Pregnancy Strategy (Social Exclusion Unit 1999), the UK still has the highest number of births to teenage mothers in Western Europe (Office for National Statistics 2011) and being a teenage mother is consistently associated with poverty and disadvantage (Wilson & Huntington 2005, Imamura et al 2007, Stapleton 2010). Supporting more young mothers to breastfeed could therefore improve the health and life chances of some of the most vulnerable in society.

Breastfeeding support challenges

Much is in fact already known about the breastfeeding support that mothers in general need. In addition to the established effectiveness of the support advocated in the UNICEF BFI (Bartlington et al 2006), Cochrane reviews have found that both breastfeeding education and additional support are effective means of increasing breastfeeding rates (Dyson et al 2005, Renfrew et al 2012). In particular, structured programmes offering proactive support using face-to-face rather than telephone interactions are more likely to succeed (Beake et al 2012, Renfrew et al 2012). It is increasingly acknowledged that skilled and sensitive help in the early postnatal period is important to women and crucial to breastfeeding success (Dyson et al 2006, McInnes and Chambers 2008,

Redshaw and Henderson 2011, Shortt et al 2013). Women want this help to be given in a facilitative style by health professionals who make time to build relationships with new mothers and provide empathy, responsiveness and reassurance (Beake et al 2005, Schmied et al 2009, Redshaw and Henderson 2011).

Given that the constituents of good breastfeeding support have been established, it may seem unnecessary to investigate the breastfeeding support needs of young mothers. It is however perhaps legitimate to ask why, despite this knowledge, more young mothers are not breastfeeding in the UK. There are a number of points to make in answer to this question. Firstly, although we know what type of support would benefit women in general, less is known about whether groups such as teenage mothers require a different sort of support in order to be able to breastfeed (Dyson et al 2006). Indeed, very little is known about how teenage mothers conceptualise and experience breastfeeding, and this needs to be explored before support can be tailored to their needs. Secondly, there is evidence to suggest that women are not receiving adequate support with breastfeeding (not least in the numbers of women turning to formula milk feeds in the early days and the reasons they give for doing so, which were discussed above), especially during the early days in hospital – this indicates that strategies known to succeed are not being employed in practice. It has also been noted that young mothers are less likely to receive support from health professionals than their older counterparts (McAndrew et al 2012). Thirdly, that none of the nine randomised trials of breastfeeding support interventions conducted in the UK and reported since 2000 have shown a significant improvement in breastfeeding rates (Hoddinott et al 2011). This suggests that there are perhaps factors in the UK health system or wider environment that are uniquely hostile to attempts to improve breastfeeding outcomes. It may be that knowing what works is not enough – the settings in which care is given may also need to be modified in order to allow good practice to flourish (Schmied et al 2009). However, trials of complex interventions such as breastfeeding support initiatives often provide insufficient data on the setting in which the trial takes place to be able to explain any negative outcomes (Medical Research Council (MRC) 2006, Oakley et al 2006, Hoddinott et al 2010a). It would appear, therefore, that further research is

required to explore the impact of the settings in which breastfeeding support takes place.

An overview of the research undertaken in this thesis

Aims

The research undertaken for this thesis aimed to do two things. Firstly, it sought to establish why so many young mothers in the UK intend to breastfeed but formula feed their babies after birth, and then use this information to develop an intervention to improve breastfeeding support for young mothers in the early postnatal period. The breastfeeding support needs of young mothers were specifically targeted because they are less likely to initiate breastfeeding than older women and yet breastfeeding could mitigate some of the health and social disadvantages experienced by many young mothers and their children (Dyson et al 2006). Furthermore, it is suggested that young women have additional support needs, that they are less likely to receive support than older mothers, and that the current hospital experiences of many young mothers are discouraging those who intended to breastfeed from doing so (WHO 2003, DH 2004, Hunter 2008, McAndrew et al 2012). Secondly, the research for this thesis sought to implement the proposed breastfeeding support intervention on a postnatal ward in order to identify any factors in the ward environment that militated against its success. By exploring elements in the care setting that support or block breastfeeding interventions, this study could have wider implications for the implementation of hospital breastfeeding support interventions for all mothers, as well as identifying any barriers to meeting the breastfeeding support needs of young mothers.

Objectives

- Conduct a literature review, and seek out the opinions of both young mothers and the health professionals looking after them as to the barriers to breastfeeding and possible ways of overcoming them.
- Use the results of this process to develop a breastfeeding support intervention for use with young mothers on the postnatal ward.
- Following discussion with practitioners and infant feeding experts local to the implementation site and training of relevant staff,

implement the intervention on a single site and carry out a concurrent evaluation.

- Identify lessons from this initial and local implementation and modify the intervention for a wider scale implementation.

A realist evaluation framework was selected as ideally suited to achieving the research aims because it seeks to establish what works, for whom, in what circumstances (Rycroft-Malone et al 2010). The realist evaluation framework is a four-stage process consisting of exploring theory (what is happening now and why?), hypothesis (what might happen if?), observation (what happens when?) and revised programme specification (what works, for whom, in what context). The realist philosophy underpinning this framework emphasises the impact of organisations, structures, cultures and interrelationships on the implementation of an intervention and the outcomes observed (Ogrinc and Batalden 2009, Hoddinott et al 2010a). The realist evaluation framework seeks to elucidate and explain this impact using a variety of research methods, including both theoretical (for example literature searches) and practical (primary research) approaches (Pawson and Tilley 1997). As the different activities undertaken in the current enquiry all sit within a realist evaluation framework, the philosophy and concepts underpinning this approach are discussed at the beginning of the thesis, in chapter two.

Phase one of the thesis focused on the theory stage of the realist evaluation framework, answering the question 'what is happening now and why'. This question is firstly addressed theoretically, initially in chapter three, by examining the literature and UK policies relating to teenage motherhood in order to elicit and critique the discourses informing attitudes and beliefs around teenage motherhood in the UK. These attitudes and beliefs ultimately inform the content and nature of breastfeeding support offered to young mothers. This process established that young mothers are variously portrayed here as a risk to society; an at-risk group; or members of disadvantaged yet supportive communities making a positive life choice. However, these discourses ignore the unique developmental features of adolescence as a period that bridges childhood and adulthood. This thesis will argue that breastfeeding support for young mothers

must recognise and address the developmental challenges they are facing. In other words, in order to create the 'right circumstances' demanded by the realist paradigm, the specific needs of the clientele must first be understood. In particular, pregnant and mothering teenagers express a desire to be judged, and to be integrated into their families and communities, as good mothers (McDermott et al 2004, Graham and McDermott 2006, Wilson and Huntington 2006, Arai 2009, Alexander et al 2010).

The examination of the different discourses of teenage motherhood is followed in chapters four and five by a review of studies pertaining to teenage mothers and breastfeeding. This aimed to explore current understanding of the challenges faced by young mothers in relation to breastfeeding, and to expose gaps in current knowledge which would need to be addressed. The review indicated that young women's views and experiences of breastfeeding reflected an interplay between the environments in which they were situated (both in their everyday lives and when receiving care) and their developmental situation. In particular, appropriate professional support in the early postnatal period emerged as crucial to breastfeeding success but appeared difficult to obtain on the postnatal ward, where many young mothers felt watched and judged (Benson 1996, Dykes et al 2003). The primary research conducted for phase one of this study therefore set out to explore the interplay between the early infant feeding experiences and behaviours of young mothers and the environment encountered on the postnatal ward, both by consulting the maternity professionals caring for the young mothers and the young women themselves. Both of these investigations were conducted using a qualitative, constructivist perspective that privileges and attempts to draw out the perspectives and lived experiences of the players in a particular environment, in order to understand how these dictate the ways in which different people act (Charmaz 2000, Schwandt 2000). Constructivism is ideally suited to a realist evaluation as it seeks to illuminate the cultural beliefs and understandings that dictate behaviour, including, in the current instance, the perception and acceptability of different actions on the postnatal ward. The research philosophy and methodology is discussed in chapter six.

The views of maternity professionals about teenage mothers' breastfeeding experiences on the postnatal ward were elicited via an e-questionnaire distributed nationally in the UK via a Teenage Pregnancy Midwives' group, and locally within the hospital Trust where the resulting support intervention would be implemented. It was envisaged that maternity professionals would be able to point to any problems in the health service that might be preventing young mothers from receiving adequate breastfeeding support, identify any real or perceived characteristics of young mothers that militated against their receiving support, and suggest ways in which breastfeeding support for young mothers might be improved. Responses to the e-questionnaire revealed that maternity professionals regard teenage mothers as 'fish out of water' on the postnatal ward, and consider that they are unlikely to persevere with breastfeeding. This view leads some carers to feel that it is not worth spending time giving breastfeeding support to young women. Maternity professionals appeared keen to promote peer support as a means of improving breastfeeding help for young mothers, probably because they did not consider they had the time or resources available to do anything more themselves. Normalising breastfeeding, time, encouragement and confidence boosting emerged as important components of teenage breastfeeding support. These responses suggest that maternity professionals are aware of the support young mothers require but do not feel able to implement it. The finding that some health professionals consider providing breastfeeding support to young mothers to be a waste of time presents a very real barrier to efforts to increase breastfeeding rates among this group. The findings from the e-questionnaire form the focus of chapter seven of this thesis.

The early postnatal infant feeding experiences of young mothers themselves are discussed in chapters eight and nine, and were elicited through focus groups attended by 15 young mothers who had intended to breastfeed. Focus groups were selected as an ideal medium through which to promote discussion and reflection among the young women. The resultant discussions revealed that young mothers see themselves as rookie mothers, trying to find their feet in a new and unfamiliar world. As such they lack confidence and feel self-conscious and exposed, particularly in the alien and public environment of

the postnatal ward. The findings from the focus groups develop and in some cases challenge previous research by specifically linking an intention to breastfeed with a young mother's desire to be seen as a good mother. Furthermore, the findings reveal ways in which a desire to demonstrate her mothering credentials through breastfeeding creates tensions with a young woman's family and community, and can prevent her being integrated into these social structures as a good mother.

The findings of phase one of this study indicate that, in common with older mothers, young mothers require proactive, empathetic breastfeeding support on the postnatal ward which both reassures and encourages them. The findings add to what is already known by highlighting the importance of understanding and giving due regard to the needs and challenges young women face as adolescents, and by suggesting that the environment encountered on postnatal wards in the UK is not conducive to young mothers establishing breastfeeding.

Phase two of this study moves on to the next stages of the realist evaluation framework, firstly answering the question 'what might happen if' by designing a breastfeeding support intervention package to answer the needs of breastfeeding young mothers elicited in phase one. This is outlined in chapter ten. The proposed support package consisted of training midwives and maternity support workers (MSWs) to deliver structured, proactive breastfeeding support using a series of three checklists. A section of the ward was to be set aside specifically for young women to stay in, and the support given by the ward staff was to be supplemented by visits from known community support workers. Following consultation with the Trust in which the intervention was to be implemented, encouragement to attend an existing 'Baby Café' for breastfeeding support and advice was added to this mix. It was hypothesised that this intervention package would address any shortcomings in the knowledge and attitudes of maternity professionals and result in young mothers feeling more knowledgeable, comfortable and confident, thereby enabling them to begin to establish breastfeeding during their postnatal hospital stay. In order to address stage three of the realist evaluation framework – 'what happens when' – the support package was implemented on a postnatal ward and a concurrent

evaluation was carried out. As befits the realist evaluation process, a variety of methods were used to evaluate the support package, including questionnaires, observations of practice and semi-structured interviews with staff.

Pre- and post-course questionnaires used before and after the training for health professionals corroborated the findings of the e-questionnaire in phase one, in that midwives and MSWs considered that young mothers had 'mixed views' about breastfeeding, were 'more likely' to formula feed their babies and tended to 'give up very easily' if they breastfed. There was also some indication that MSWs in particular found communicating with and relating to young mothers to be challenging. However, exploring and questioning these views during the training session appeared to result in attendees adopting a more sympathetic and positive attitude towards young mothers that persisted over time. The findings of the evaluation process are discussed in chapters eleven and twelve.

Despite the training providing a positive start, chapters eleven and twelve reveal that the challenges posed by the culture and environment on the postnatal ward resulted in the support package only being partially implemented. The implementation process was thwarted by an inability or unwillingness on the part of those who had attended the training session to challenge the existing structures on the ward and implement the intervention; a busy, chaotic and stressful working environment over which midwives and MSWs had little control; and a lack of shared beliefs about the value and worth of breastfeeding and breastfeeding support in general, and providing targeted breastfeeding support to young mothers in particular.

The findings of the evaluation process highlight the importance of place in facilitating support interventions. They suggest that simply knowing what should work is not enough – support interventions need to be embedded in an enabling, facilitative environment in order to succeed. In chapter thirteen it is argued that the situation encountered on the postnatal ward is the result of an individualistic, task-oriented approach to care which has evolved over years of midwives being browbeaten and midwifery care being undervalued by an overburdened medical system that looks on women's bodies as defective machines and evinces a deep

mistrust of natural processes such as lactation. It is suggested that midwives need to take control of the time and space in which they work in order to create an environment conducive to introducing changes to midwifery care. The final stage of the realist evaluation process – a revised programme specification – is therefore less about changes to the programme and more about proposing how the environment on the ward might be changed to enable the intervention to succeed. Action learning, whereby groups of midwives and MSWs are facilitated to challenge and change their environment, is put forward as a potential mechanism for change.

Chapter fourteen concludes this thesis by reiterating the main arguments and findings and outlining their implications for research, policy and practice. Firstly, young mothers choose to breastfeed to demonstrate their credentials as good mothers, and the support they require to breastfeed must recognise this and their need as fledgling adults and mothers to be integrated into and validated by their families and communities. In attempting to target breastfeeding support to meet the needs of a vulnerable group who are least likely to initiate breastfeeding yet potentially stand to gain the most by doing so, the research has also exposed the importance of place both for those giving and receiving care. Place dictates what is possible. In particular, a postnatal ward in a large tertiary maternity unit proved unable to host and sustain a breastfeeding support intervention. This failure is attributed to a chaotic regimen overburdened with medical tasks and routines, in which breastfeeding and the supportive relationships necessary to sustain it are not prioritised. It is suggested that, in order for midwifery breastfeeding research interventions to succeed on the postnatal ward, midwives need to take control of this environment and work towards transforming it into both a positive and rewarding place to work and an enabling and nurturing environment capable of providing all new mothers with proactive, empathetic breastfeeding support.

Chapter two

An exploration and critique of realist evaluation, and presentation of the realist evaluation framework

Introduction

This thesis follows the format of a realist evaluation framework, and is underpinned by a realist philosophy. This chapter therefore explains the philosophy and rationale behind the realist approach. Realist methodology is discussed, the stages in the cyclical realist evaluation framework are described, and their application in this study is outlined. A change is suggested to the formula developed by the founders of realist evaluation, Pawson and Tilley, to summarise their theory, in order clearly to differentiate between the different components of realist evaluation theory.

As a research philosophy, realism seeks to

‘determine the merit and worth of human service programmes, and to improve these services in the circumstances of practice’ (Kazi 2003, p42).

It also holds that establishing the nature and underlying rationale of both current practice and client behaviour is a prerequisite for developing and introducing effective change (Pawson and Tilley 1997). This focus on an engagement with the perspective of those receiving care, as well as the care providers, combined with a very practical objective to create a practice environment which promotes and enables improvement and change, made realism an ideal approach for this study. The realist evaluation framework provided a structure to the investigation, mandating firstly an exploration of the experiences and breastfeeding support needs of teenage mothers during their postnatal hospital stay through both an investigation of relevant literature and primary research. The next stages of the framework required a breastfeeding support intervention for this group to be developed, tested and evaluated. The realist emphasis on investigating and exposing elements of current care that supported or prevented the success of the

intervention was particularly important given that previous trials of breastfeeding support interventions in the UK have not resulted in an increase in breastfeeding rates (Hoddinott et al 2011).

Realist Philosophy

Pawson and Tilley published their realist manifesto in 1997. Its philosophical base sits between the extremes of positivism and relativism, acknowledging both the existence of an external reality and social constructions of reality, and holding that the two are interdependent and subject to change (Pawson and Tilley 1997, Kazi 2003, Rycroft-Malone et al 2010). All human actions are embedded within and interact with a wider range of social processes, reflecting absolute and socially constructed truths (Kazi 2003). For example, disability can be understood as an interplay between the reality of physiological impairment, the constraints that are often placed on people with disabilities and the cultural attitudes towards disability within which these structures are embedded (Williams 1999).

Pawson and Tilley (1997) proposed that their approach is 'real', in that it deals with external, concrete actualities such as institutions and programmes which shape and limit people's choices, and 'realist', in that that it promotes detachment and objectivity - there are facts and truths which exist independently of our ability to conceive of, experience and explain them (Kazi 2003, McEvoy and Richards 2003, Wilson and McCormack 2006). It differs from traditional approaches in its insistence that outcomes are always dependent on context – external realities interact with, change and are changed by the contexts into which they are introduced. Evaluation should therefore consider both the intervention and the context into which it is set in order to work out why certain outcomes are generated. It is thus 'realistic' in that it is rooted in practice – aiming to discover how interventions act and what results they produce in real-life circumstances, and using a flexible approach in which the methods chosen serve the evaluation rather than the other way round (Pawson and Tilley 1997).

Realist strategy

Unlike positivist experimental approaches, which set up 'closed systems' in which confounding variables are controlled for, realist evaluations take place within the open, messy, unpredictable reality of practice and aim not just to measure effectiveness but work out what works, for whom and in what circumstances (Pawson and Tilley 1997, Kazi 2003, Rycroft-Malone et al 2010). For Pawson and Tilley, it is inconceivable that intervention A will inevitably lead to outcome B, as intervention A is mediated not through controlled conditions but a multi-layered, 'stratified' reality, subject to 'the interplays of individual and institution, of agency and structure, of micro and macro social processes' (Pawson and Tilley 1997, p63). They thus consider it 'futile' for researchers to ignore and anonymize the contexts of their programmes.

A realist evaluation, then, seeks to understand why intervention A in context B leads to outcome C – it aims to identify the underlying processes or mechanisms triggered when intervention A is introduced into context B that produce outcome C. Only by understanding the mechanisms that promote or inhibit change can we hope to adapt and apply interventions to different settings. Importantly, Pawson and Tilley note that the conditions in which a programme will have positive results might be relatively rare – for example, high crime rates prevail in certain contexts because those contexts (although inadvertently) support, propagate and protect criminal behaviour. Interventions that discourage crime might find it less easy to succeed in the same contexts. Pawson and Tilley summarise their approach with the formula 'mechanism + context = outcome' (1997, p. xv). The term 'mechanism' in this equation is perhaps a little misleading – it implies that a 'mechanism' is equivalent to an intervention, and indeed this is how it has been understood by some realist commentators and researchers (for example Wilson and McCormack 2006, Lhussier et al 2011, Brimdyr et al 2012). It is clear from Pawson and Tilley's writing, however, that a mechanism is not an intervention or variable but a theory about the processes that lead to an outcome (Pawson and Tilley 1997, Kazi 2003, Rycroft-Malone et al 2010). As such it may not itself be directly observable, but be a hypothesis based on observed effects (McEvoy and Richards 2003). Within realist evaluation, there are different layers

of mechanisms that need to be identified: the ones already at work before an intervention is introduced, that produce and support the status quo; the hypothetical mechanisms that might be produced by the intervention and lead to the desired outcome; and the actual mechanisms triggered when the intervention is introduced, which lead to the outcomes observed or act to maintain the status quo. In order clearly to differentiate between an intervention and a mechanism, the following formula might be a better summary of the realist approach:

$$\text{Intervention} + \text{context} \longrightarrow \text{mechanism} + \text{outcome}.$$

Manipulating either of the variables on the left side of the equation will alter the results on the right side of the arrow. This formula makes it clear that it is not possible fully to understand why an intervention has succeeded or failed without considering the context into which it was placed. Furthermore, it illustrates the theory that an outcome can only be replicated if the mechanisms producing it are triggered when the intervention is placed in a particular context. To maximise the likelihood of this being the case, the mechanisms underpinning change must be identified and understood.

Because realist evaluation looks at events in open systems, the outcomes observed are not fixed but subject to change as the interplay between intervention and context develops, generating new mechanisms and producing different outcomes (Pawson and Tilley 1997, Kazi 2003). This process may be deliberate, as interventions are adapted in an attempt to produce more favourable outcomes, or organic, as a context changes over time. Equally, if an intervention is placed in a different context, a different mechanism + outcome configuration will be produced. Within the realist paradigm it is also true to say that our understanding of mechanisms is constrained by own cultural context and outlook, and this also may change over time (Pawson and Tilley 1997).

The changeable nature of outcomes means that research is seen as a cyclical process, whereby layers of knowledge are built on, and also that interventions can rarely be transferred directly from one context to another and achieve the same results. Rather, the context and intervention combinations that

trigger a successful outcome can be identified and presented as a set of general principles for promoting change. Pawson and Tilley argue that systematic reviews of randomised controlled trials, which rarely provide a unanimous 'answer' for best practice, are in fact asking the wrong question. Rather than concentrating solely on outcome, reviewers should look at the contexts in which interventions are delivered, in order to abstract underlying principles about what works in which circumstances. These principles can then be applied in order to adapt an intervention for different contexts (Pawson and Tilley 1997, Pawson et al 2004).

Realist methodology

Within the realist paradigm, the aim of an evaluation is to identify the mechanisms for change triggered by an intervention, establishing how these counteract or utilise pre-existing social processes (Pawson and Tilley 1997). There is no standard methodology for achieving this aim: rather, researchers are urged to use quantitative or qualitative, contemporary or historical, cross-sectional or longitudinal designs, and inductive or deductive analysis, depending on which suits the situation at hand (Pawson and Tilley 1997, Kazi 2003). It does tend to be a feature of realist evaluation that a combination of data collection approaches is used however, in order to come to a more complete understanding of the mechanisms triggered when an intervention is introduced (McEvoy and Richards 2003, Ogrinc and Batalden 2009). For example, in their realist evaluation of protocol-based care, Rycroft-Malone et al (2010) used non-participant and participant observation; interviews with staff being observed, key stakeholders and patients; patient journey tracking; and document and field note reviews. Observation of practice has been found to be a particularly useful tool in realist evaluation, giving the researcher a first hand view of the dynamics of a particular context and determining how and if interventions are being applied in practice (Wilson and McCormack 2006, Rycroft-Malone et al 2010).

Despite the lack of a clear methodology, Pawson and Tilley (1997) do provide a clear outline of the steps involved in the realist evaluation process. The first step is to identify the pre-existing mechanisms sustaining the problem or behaviour being addressed. Pawson and Tilley (1997) tend to draw on existing

research or question practitioners in order to do this – in fact researcher/practitioner partnerships are central to their approach (Kazi 2003, Rycroft-Malone et al 2010). In the current study, an exploration of the wider literature on teenage pregnancy in the UK, and a comprehensive review of the literature around teenage mothers and breastfeeding were used to investigate the current experiences and treatment of young mothers in general and with respect to breastfeeding. This was followed by a survey of practitioners, in order to gain their perspective on the challenges faced by young breastfeeding mothers. It is perhaps a weakness in Pawson and Tilley's approach, however, that they do not seek out the perspective of service users, who could provide vital information about the mechanisms underpinning their choices, or the way in which the current context directs their behaviour. In the current study, therefore, focus groups with teenage mothers are also used to investigate the mechanisms underpinning low breastfeeding initiation rates among young mothers.

Step two involves identifying a potential intervention and forming hypotheses of the potential mechanisms that it will trigger or employ in a given context to achieve the desired outcome or outcomes (Pawson and Tilley 1997). This process involves identifying mechanisms in the current context that might either enable the intervention to work (enabling mechanisms) or subvert, block and disable it in order to maintain the status quo (disabling mechanisms) (Kazi 2003, Wilson and McCormack 2006). Realist evaluation therefore accounts for the political milieu in which interventions may succeed or fail depending on whether people have the necessary resources to bring about change, and whether their efforts are thwarted by other groups with more power and/or more resources (Pawson and Tilley 1997). In the current study, a breastfeeding support package was developed which aimed to address the disabling mechanisms identified in step one, and create enabling mechanisms such as increased practitioner skill that would promote breastfeeding initiation among young mothers.

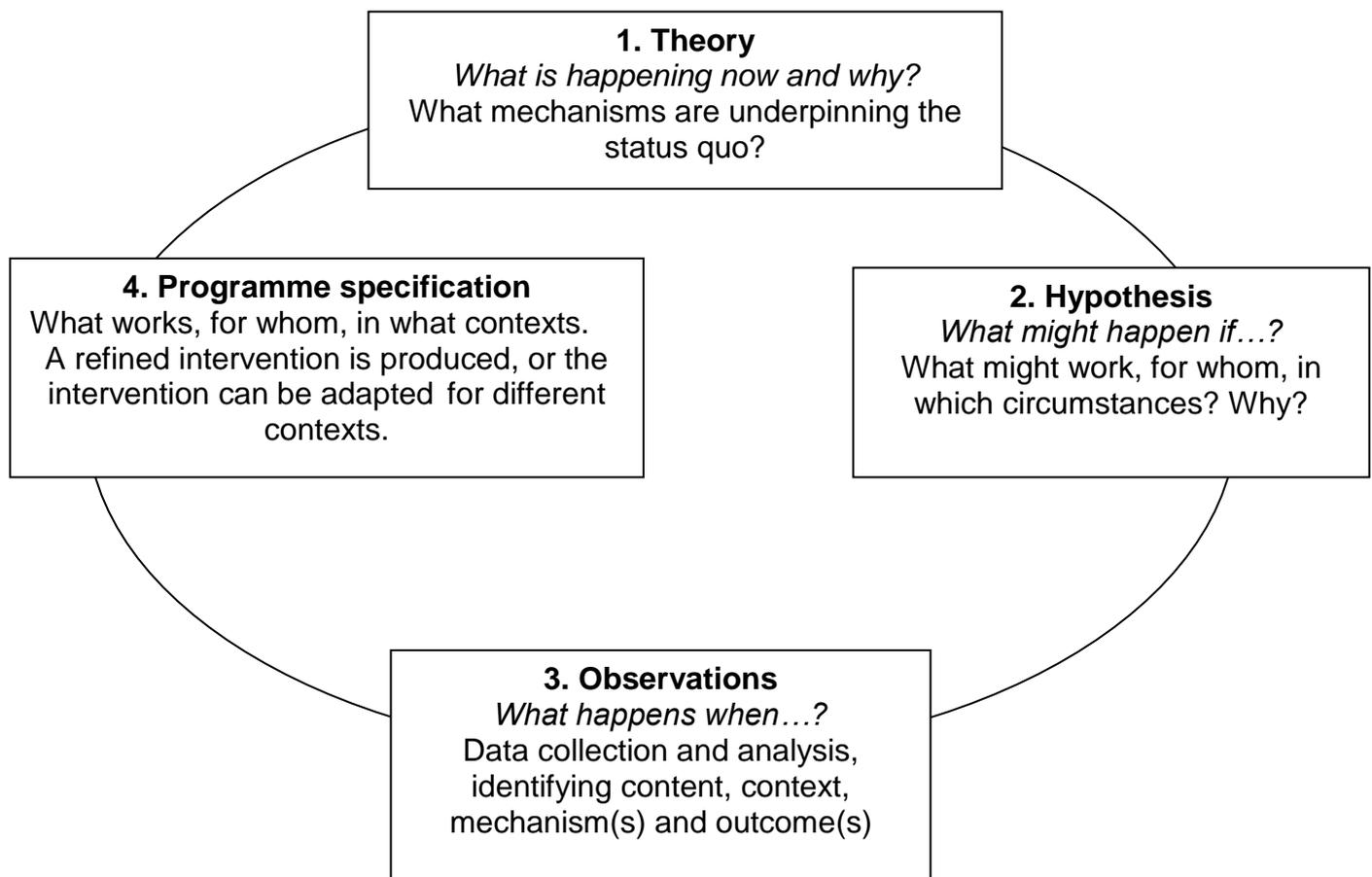
The next step in the process is to introduce an intervention and observe its effects, testing and adapting the hypotheses formulated in stage two (Pawson and Tilley 1997). The process of observation and analysis in realist evaluation,

which seeks to elucidate causal mechanisms and establish the conditions under which certain outcomes will or will not be realised, has been termed 'retroduction' (Pawson and Tilley 1997, Kazi 2003). Techniques such as practitioner observation, record checking and semi-structured interviews were used to gather data for the retroduction process in the current study. Retroduction should focus on unintended as well as intended outcomes, as what doesn't work can reveal just as much about the workings of an intervention and context as a 'positive' result (Jeyasingham 2008, Ogrinc and Batalden 2009). Unintended or disappointing outcomes may result from the effects of new or previously unidentified mechanisms, a misunderstanding of the mechanisms responsible for the original problem, or be a reflection of a weakness in or incomplete application of the intervention design. If disabling mechanisms are identified, it is within the remit of realist evaluation to take steps to remove them (Wilson and McCormack 2006). Retroduction is therefore a concurrent and constantly evolving process – the intervention can be modified and strengthened in response to outcomes and developing theories about their underlying mechanisms (Kazi 2003, Pawson et al 2004, Rycroft-Malone et al 2010). In the current project, for example, midwives working in a ward Baby Café, which all mothers were invited to attend for breastfeeding support, agreed to provide proactive support for young mothers at the bedside when it became apparent that young mothers were unwilling to access the café.

The aim of the retroduction process is to understand what works, for whom, in the contexts under consideration. From this, theories can be extrapolated as to what might work in different contexts, or what sort of contexts might be necessary to support a given intervention, allowing targeted programme specifications to be developed. The process is cyclical – these theories will then need to be tested, taking us back to step one. Thus progress is achieved through a process of theory building and theory testing - in 'each cycle, a better approximation of reality is obtained, as compared with the previous cycle' (Kazi 2003, p5). The retroduction process in the current study exposed the postnatal ward as an environment inhospitable to the support required by young breastfeeding mothers.

Figure 2.1 below represents the cyclical realist evaluation framework, and has been adapted from those developed by Pawson and Tilley (1997, p85) and Kazi (2003, p29).

Figure 2.1. The realist evaluation framework



A number of limitations to the realist approach have been identified. Principally, a mechanism is only ever a theory, and as such is dependent on the mindset, outlook and cultural assumptions of the researcher (Kazi 2003). Furthermore, culturally-bound assumptions may limit the form and scope of interventions developed to address a particular context (McEvoy and Richards 2003). However, as theories are developed and tested, and more cycles of evaluation are undertaken in different contexts and by different authors, a broader understanding and better fit between intervention and context should be obtained.

Conclusion

This chapter has outlined the precepts of a realist evaluation, and developed the realist 'mechanism + context' formula in order clearly to differentiate interventions and mechanisms, and emphasise the importance of context in determining intervention outcomes. The realist evaluation framework described in this chapter provides a structure for the two-phase research process in this thesis. The following chapters therefore report the methods used to address the different stages of the framework, and the results obtained. Phase one of the research answers the question posed in step one of the framework – what is happening now and why – through a literature review and primary research. This process begins in chapter three with a theoretical investigation of the literature and policy on teenage pregnancy in the UK, in order to identify the mechanisms underpinning the current treatment and behaviour of young mothers here.

Chapter three

Discourses of teenage motherhood – finding a framework that enables the provision of appropriate support

Introduction

Teenage motherhood has attracted disapprobation since the 1970s in the UK, when, as increasing numbers of more prosperous women gained access to further education and financial independence, young mothers replaced unmarried mothers in being regarded as placing a moral and financial burden on society (Arai 2009). Since that time, policies aiming to reduce teenage conceptions and (more rarely) to support teenage mothers have been situated within and shaped by a number of different discourses or frameworks of meaning. This process culminated in the 1999 Teenage Pregnancy Strategy (TPS), which situated teenage pregnancy within a discourse of social exclusion and set ambitious targets, to be met by 2010, for the reduction of teenage conceptions and the provision of support to teenage mothers through access to education, employment and training (EET) (Social Exclusion Unit 1999). The discourses used to make sense of teenage pregnancy dictate the extent and nature of breastfeeding, and indeed any, support afforded to young mothers, and therefore form a backdrop to ‘what is happening now and why’ – the investigation of which constitutes the first stage of the realist evaluation cycle being applied in this study. This chapter considers the different discourses that have been employed to make sense of, and in many cases judge, teenage mothers, and explores alternative conceptualisations of young motherhood which may enable midwives and other health professionals to offer young women more appropriate breastfeeding support. Firstly, the discourses that preceded, existed alongside and underpinned the TPS are discussed. As the figures for teenage conceptions in England and Wales in 2010 have recently been published, the successes and shortcomings of the TPS are then explored, particularly in respect of its underlying rationale and assumptions and the way in which these guided the support provided to teenage mothers. The chapter considers whether the social exclusion discourse on which the TPS was based is in fact an appropriate and

realistic lens through which to view and address teenage motherhood. Alternative discourses of teenage motherhood are then discussed in order to ascertain whether and in what sense teenage motherhood remains an issue in need of attention today. It is argued that future policy and support for teenage mothers, both generally and with respect to infant feeding, needs to consider the situational context of young motherhood and the unique developmental transitions and challenges of adolescence.

Teenage mothers: undeserving poor or victims of circumstance?

The underpinnings of the Teenage Pregnancy Strategy

Teenage pregnancy is, above all else, consistently associated with poverty and disadvantage (Wilson and Huntingdon 2005, Imamura et al 2007, Stapleton 2010). Whilst it cannot be disputed that, in the UK, young women in the lowest social class are around ten times more likely to become pregnant, and less likely to choose a termination, than those at the top end of the social scale (Swann et al 2003, Carter and Coleman 2006), there is some disagreement over whether becoming pregnant at a young age causes, or is a consequence of, disadvantage. Different discourses variously portray young mothers as a risk to society, an at risk group, or members of disadvantaged yet supportive communities making a positive life choice. These discourses are important because our understanding of the causes and effects of young motherhood and the context in which young mothers live their lives and feed their babies shapes both overarching policies and individual health professionals' attitudes and approaches to pregnant and mothering teens. Furthermore, if a discourse distorts reality, it is unlikely to give rise to appropriate and sustainable solutions and support mechanisms. This premise is demonstrated below in relation to the social exclusion discourse and the TPS.

Teenage mothers as a risk to society

As a 'risk to' society, young mothers are seen as a threat to social order. They are blamed for many of society's ills, including family breakdown, poor parenting, rampant sexuality, and even being poor (Selman 2003, Arai 2009, Duncan et al 2010). This discourse is perpetuated through sensationalist media

reporting, and feeds off widespread resentment of undeserving individuals supposedly living off the State (Selman 2003, Arai 2009, Duncan et al 2010). In fact, as Selman (2003) points out, mothers under the age of 16 are not eligible for income support, and single mothers under the age of 18 receive relatively low rates of benefits. It is also worth noting that the roots of the 'risk to society' discourse have been traced back to somewhat unsavoury eugenic concerns over people in working class communities having more children from an earlier age than their middle and upper class counterparts, thus adding to their numbers and threatening the status quo (Arai 2009, McNulty 2010). This idea is particularly evident in the work of Murray, who popularised the theory of a British underclass, raising their children to have values that are 'contaminating the life of entire neighbourhoods' (Murray 1990 p4). It can also incorporate a racist element – in the US it has been found that teenage pregnancy is more strongly condemned where it is more prolific in non-white communities (Wilson and Huntingdon 2005). The notions of social mobility and cohesiveness are somewhat conspicuous by their absence here.

Linked to the social order discourse is the idea that young parenthood is the result of sexual behaviour at an inappropriately young age, which will ruin the (female) perpetrator's life (Selman 2003, Arai 2009). Proponents of this view seek to ignore or reverse the downward trend in mean age at first intercourse (which was 16 among 16-19 year olds as far back as 2004 (Dennison 2004)). They project popular notions of childhood innocence beyond childhood in to adolescence, labelling anyone who does not fit the picture as 'bad', 'immoral' and even 'ugly' (Arai 2009, Edwards et al 2010, Stapleton 2010). This discourse can be seen at work in calls in 1994 for a Department of Health 'Pocket Guide to Sex' for young people to be withdrawn, and in demands for a Glasgow Boots store planning to introduce a contraceptive clinic for young people to be boycotted at Christmas (Selman 2003).

The social exclusion discourse and the TPS

The New Labour government of 1997 onwards situated teenage pregnancy within a discourse of social exclusion. This discourse is very much about teenagers being 'at risk' from the consequences of young motherhood,

rather than being a risk to society. Nevertheless, as a result of its perceived manifold negative outcomes, teenage pregnancy is still seen as a risk to society in general which needs to be addressed (Arai 2009). The social exclusion discourse uses statistics from quantitative investigations to argue that young motherhood poses health and social risks to teenagers and their children, and prevents them from making a meaningful contribution to society without state intervention (Wilson and Huntingdon 2005, Duncan 2007). It argues that teenagers become pregnant not because they are morally corrupt, but because they lack knowledge about sexual health, relationships and contraception; receive mixed messages about sex from the media; are not able easily to access contraception and have low expectations regarding future life prospects (Carter and Coleman 2006, Duncan et al 2010). Having adopted this discourse, New Labour sought to integrate socially excluded teenagers and young mothers into society through the TPS, which aimed to halve the rate of under 18 conceptions by 2010 (from a baseline in 1998), set a downward trend in conception rates for the under 16's, and raise the number of teenage mothers engaged in employment, education or training (EET) to 60% over the same period (Social Exclusion Unit 1999). This was to be achieved by improving sex and relationships education, improving access to contraception, providing clear, consistent messages in the media and providing support to enable teenage mothers to participate in EET (Social Exclusion Unit 1999).

Outcomes and critique of the Teenage Pregnancy Strategy

Figures released by the Office for National Statistics (ONS) in 2012 show that, between 1998 and 2010, the conception rate per 1000 women under the age of 18 fell by 24.6%, rather than the 50% that the TPS was aiming for. The conception rate to women under the age of 16 had indeed established a downward trend, with a drop of 22% over the same period. The percentage of young mothers in England engaged in EET at the end of 2009 was 28.4 (Public Health Intelligence Team 2011) - again somewhat short of the 60% the TPS set out to achieve. There are a number of possible reasons for the TPS targets being missed. The first is that they were perhaps somewhat ambitious – a 50% drop in the under 18 conception rate is a huge decrease, and the 2010 conception rate of

35.5 per 1000 young women is in fact the lowest since 1969 (although still represents the highest rate in Western Europe) (ONS 2012). Similarly, Alldred and David (2010) point out that, at 60%, the target for young mothers in EET is actually higher than the proportion of older mothers in the workplace.

Another reason for the TPS failing to meet its targets may be that the premise on which it is built is flawed. In situating teenage pregnancy within a discourse of social exclusion, the strategy assumes that the health and social consequences of teenage pregnancy are overwhelmingly negative. It further assumes that young mothers are free to embark on EET and see it as a way of improving their lives. It is increasingly argued that these assumptions are based on flawed evidence and ignore the restricted choices available to young women as a result of their often impoverished circumstances.

Health and social premise of the TPS

As regards health and social outcomes, it has been pointed out that much of the evidence presented in the TPS was old and methodologically unsound (Allen et al 2007). Additionally, in presenting its argument using carefully selected statistics, the TPS acquired a scientific, evidence based sheen that masked the political ideology embedded within its pages. For example, the strategy claims that the babies of teenage mothers are 25% more likely to be of low birth weight, and 60% more likely to die before the age of one, than babies born to all mothers (DH 2004, 2010). These figures are taken from an analysis of the 1996 infant and perinatal mortality statistics for England and Wales (Botting et al 1998). While the figures are correct, Botting et al's report also shows that the offspring of lone mothers of any age are 30% more likely to be of low birth weight than those of all mothers (making them an even more at risk group), and that in fact for lone mothers being under the age of 18 is protective against low birth weight, as the babies of lone teenage mothers were only 16% more likely to be small at birth. The Department of Health were still using the 1996 figure for increased infant mortality (60%) in 2010, despite the fact that since 1996 the increased likelihood of the child of a teenage mother dying before the age of one, when compared to the children of all mothers considered together, had been falling year on year – in 2010 the actual figure was 33% (ONS 2012a). Additionally, in Botting et al's

report, women over the age of 25 are presented as a single category. In the 2010 ONS data, however, they are subdivided into smaller age bands, revealing that the infant mortality rate is higher to women over the age of 40 than to women under the age of 18 (the rates are 5.8 per thousand and 5.6 per thousand respectively) (ONS 2012a). Furthermore, it should be remembered that it is difficult to make meaningful comparisons between the infant mortality rates to women of different ages, as the figures are mercifully small. Other factors, such as the place of birth of the mother, appear to have a far higher impact on infant mortality – while the overall infant mortality rate per 1000 births in England and Wales is 4.2, the rate for babies born in England and Wales whose mothers were born in central Africa is 8.9 (ONS 2012a).

According to the TPS, the health risks of pregnancy and birth for young mothers themselves include hypertension, anaemia and obstetric complications. However, by their own admission these risks mirror those for other socially excluded women and those on low incomes (DH 2004). More recent UK research suggests that the obstetric risk attached to primiparous teenagers is low, with the exception of the risk of pre-term birth for the youngest teenagers (Gupta et al 2008). There is even some evidence that teenage pregnancy may confer health benefits for the mother, including protection against breast cancer and diabetes, and that young women experiencing a straightforward pregnancy are less likely than older women to require obstetric intervention in labour (Stapleton 2010).

Many of the social disadvantages attributed to teenage pregnancy and motherhood by the TPS, such as poverty and low educational achievement (for both the mothers and their children) are in fact the result of pre-existing factors and not caused by young motherhood itself (Selman 2003, Duncan 2007, Arai 2009, Hawkes 2010). Although there is some evidence from qualitative studies to suggest that teenage parenthood might compound pre-existing problems and make it more difficult to escape a disadvantaged life course (Graham and McDermott 2006), British and American longitudinal studies have shown that, when teenage mothers are compared with other young women from a similar background, young motherhood has little impact on qualifications, employment and income over the long term (SmithBattle 2000, Ermisch and Pevalin 2003,

Duncan 2007). As regards the children of young mothers, Hawkes (2010) looked at data from the UK Millenium Cohort Study regarding a range of cognitive and health outcomes and found that, after differences in family circumstances had been taken into account, young motherhood had no discernible impact on any measure except hyperactivity, and that was measured by reports from the mothers themselves.

It would seem reasonable to conclude, therefore, that the health and social consequences of teenage pregnancy and motherhood are not as wide ranging as suggested by the social exclusion discourse and in the TPS. In fact, in a report for the labour government's Teenage Pregnancy Unit, Dennison (2004) cited an increased likelihood of having a partner who was poorly qualified and therefore more likely to be unemployed as the main consequence of teenage birth. It is not the age of the mother, but her family circumstances, that impact negatively on her own and her children's lives. Simply becoming pregnant at an older age is very unlikely to make any difference to health and social outcomes. In presenting poverty and disadvantage as an outcome of teenage pregnancy, however, the TPS assumes that they could have been avoided if the pregnancy had not occurred (Duncan et al 2010).

Shortcomings in the strategy adopted by the TPS

Because the social exclusion discourse dictated that preventing teenage pregnancy was a solution to disadvantage, the focus of the TPS was on reducing teenage conceptions rather than offering support to young mothers. Yet even the approach adopted to curb the conception rate is open to criticism. The TPS aimed to reduce teenage pregnancy rates through the provision of better sex and relationships education and increasing young people's ease of access to contraception (SEU 1999). This strategy was largely based upon American research (DH 2010). However, there is evidence to suggest that teenagers in the UK are not, and were not at the outset of the strategy, particularly ignorant about sex and contraception, and that increasing knowledge about and access to contraception makes little difference to the conception rate (Graham and McDermott 2006, Arai 2009, Duncan et al 2010). Imamura et al's 2007 systematic review of European literature found no significant relationship between pregnancy

and knowledge of either the timing of emergency contraception or how to access contraception and sexual health services. Furthermore, a national UK survey in 2000 found that 83% of males and 80% of females aged 16-19 reported using a condom at first intercourse (Dennison 2004, Arai 2009). Despite this, in 2010 the government was still insisting that increased provision of education was the way forward, and suggesting that teenagers' parents should take a leading role in providing this (DH 2010).

In keeping with the New Labour government's belief in the transformative power of work, the aim of support offered to young mothers in the TPS was to enrol them in EET (Wilson and Huntingdon 2005, MacDonald 2007). However, this approach has been criticised for disregarding both the extent of the barriers to young women from disadvantaged backgrounds entering the workforce and their identities, needs and priorities as mothers (Alldred and David 2010, McNulty 2010, Stapleton 2010). McNulty's research in particular highlights the difficulties of young women negotiating their way into employment areas unknown to their families, in overcoming misinformation or a lack of information about accessing appropriate training, and facing interruptions to their education caused by disruption at home or absence due to caring responsibilities (McNulty 2010). Moreover, a 2006 review concluded that participation in education or training did not necessarily increase young mothers' chances of finding employment (Harden et al 2006). Even without having a child, working class young women have been identified by the Equality and Human Rights Commission as among the most disadvantaged by an education system that fails to widen choice and challenge stereotypes (McNulty 2010). If they do manage to gain the relevant qualifications, finding suitable childcare and jobs with flexible hours further militate against young mothers securing work (Alldred and David 2010).

It can be argued that the TPS failed to meet its targets because the social exclusion discourse on which it was based was so fundamental to New Labour's ideology that, in the end, facts were selected to suit the discourse, rather than the discourse being adapted to reflect reality. Reducing the teenage conception rate was a priority, therefore teenage pregnancy must be a negative event. Teenage mothers must not be seen to be supported by the State, hence getting them into

the workforce was of paramount importance. However, by insisting that teenage pregnancy was the cause of social disadvantage, despite evidence to the contrary, the social exclusion discourse does not identify and address the real causes of difficulty and hardship in young people's lives. It does, however, neatly absolve the rest of society of any responsibility by making young mothers the architects of their own downfall. Alternative discourses of teenage pregnancy that account for the situational and developmental context of young mothers' lives will now be considered, in order to establish whether they provide a more realistic framework within which to support and nurture teenage mothers.

Situational discourses of teenage pregnancy

The teenage pregnancy discourses prior to and embedded within the TPS have a predominantly individualistic outlook – teenagers are held to be responsible for their situation either through wilful disregard of social expectations, immorality or ignorance. An alternative viewpoint, however, portrays teenage pregnancy and motherhood as a path followed by those to whom society has provided very few alternative options. This is the stance taken by the American SmithBattle in her seminal paper on the vulnerabilities of teenage mothers (SmithBattle 2000). SmithBattle argues that teenage mothers are victims of circumstance – trapped in disadvantaged communities, families and neighbourhoods, they are not free to choose a decent education or career, and motherhood therefore offers a relatively appealing option. SmithBattle argues that it is an 'illusion that the self can create a world on its own by consciously choosing...attitudes, values, beliefs and actions' (p30). Young women are not free to make different choices unless fundamental changes are made to the societies in which they live. Giving them knowledge is not enough. According to this discourse, the way to reduce the number of teenage pregnancies is to improve the infrastructure in run-down neighbourhoods and increase the life opportunities available to all young people facing poverty and disadvantage. SmithBattle's argument resonates with the realist understanding of the importance of context in determining outcomes – a central theme of this thesis.

This more relational and situational view of teenage pregnancy and motherhood has been modified in a relatively recent discourse which underplays the hardship and disadvantage prevalent in deprived communities and sees teenage motherhood as a meaningful, rewarding life option for some young women (Duncan 2007). According to this view, in some communities young motherhood is a recognised route to a valued social role and identity (Carter and Coleman 2006, Duncan 2007, Arai 2009). At its most extreme, this discourse questions whether teenage motherhood is at all problematic for young mothers themselves, claiming that qualitative research shows that many young mothers express positive attitudes to motherhood and describe it as an impetus to change their lives for the better (Duncan 2007). This rather rosy picture is bolstered by the claim that most teenage mothers have supportive family networks and partners keen to play an active role in their children's lives (Duncan et al 2010). However, while few would argue that some teenage mothers do indeed live fulfilling lives, this view ignores the negative aspects of teenage motherhood, also evident in qualitative research, in which teenage mothers describe poverty, hardship and stigmatisation as the overriding motifs of everyday living (McDermott et al 2004, Graham and McDermott 2006). It also overlooks those without a supportive or indeed any family or community network. Painting young motherhood in a wholly positive light denies vulnerable people help and support, and is perhaps just as pernicious as discourses portraying teenage pregnancy in purely negative terms.

Another situational discourse describes two separate trajectories to adulthood – the 'fast' and 'slow' lanes (Graham and McDermott 2006). Those in the slow lane generally come from more privileged backgrounds. They stay in education long enough to gain the qualifications necessary to begin a career, and do not become parents until they feel financially and emotionally secure (Graham and McDermott 2006). Those at the other end of the social scale, however, living in disadvantaged neighbourhoods with lower life expectancies and little or no expectation of a meaningful career, tend to embark on their adult lives at a younger age (Stapleton 2010). Graham and McDermott point out that life in the fast lane is insecure and unpredictable – its inhabitants are no longer assured of work, and taking on a low paid job is now very rarely a stepping-stone to a better

future. The fast/slow lane discourse highlights the fact that those judging or seeking to reduce the 'problem' of teenage motherhood are usually doing so from the vantage point of the slow lane. They assume that, prior to becoming parents, young mothers were on the same upwardly mobile life path as their middle class peers, when in fact this is usually far from the case (SmithBattle 2000, Wilson and Huntingdon 2005, Graham and McDermott 2006, Duncan 2007).

Where to next?

Situational discourses challenge traditional conceptions of teenage motherhood as leading to negative outcomes for individuals and society, and acknowledge the importance of the environment in determining an individual's life course. However, although some situationists acknowledge that young mothers face hardship and disadvantage, in proposing that the answer lies in improving the life chances of entire communities these discourses suggest that young mothers per se are not in need of any additional support. The implication is rather that we should cease to address the 'problem' of teenage pregnancy and instead address the issues of disadvantage in society for mothers of all ages. Furthermore, although situational discourses can improve our understanding of the restricted life choices available to young women in disadvantaged communities, they do not provide health professionals with a framework within which to offer young mothers appropriate support. In order to address this, it is perhaps necessary to consider the unique developmental challenges of adolescence.

A developmental discourse: teenage mothers as adolescents

Adolescence is the period between childhood and adulthood, during which young people forge new individual and social identities (Leishamn 2007). It is a period of growth and development, ambiguity and transition, involving major physical and psychological adjustment (Frydenberg 1997, Coleman and Hagell 2007). More recently, as children in developed nations reach puberty at younger and younger ages, but work is harder to come by and adolescents are spending longer in education and living in their parental home, it has been postulated that there is a widening gap between the physical and psychological maturation of today's adolescents (Feldman-Winter and Shaikh 2007, Edwards et al 2010).

Much of the psychological turbulence of adolescence stems from the holding of and working through a series of dichotomous identities, such as child/adult, isolated/related, and invincible/vulnerable. Writing about the child/adult dichotomy, the psychologist Frankel (1998, p4) observes that

‘caught between the pulls of dependency and responsibility, no longer a child, but not yet an adult, the adolescent bears the tension of the opposites in a dramatic way’.

In order to enter adulthood, an adolescent sheds family dependencies and becomes increasingly self-directive, looking to peers or mentors outside their immediate family for moral and behavioural reference points (Frydenberg 1997, Frankel 1998, Coleman and Hagell 2007). During this time, childhood certainties are questioned and parents are often viewed in a less idealized light (Frankel 1998). This can create a sense of loss and uncertainty, perhaps even more acute for those lacking a stable base from which to depart. An adolescent has left childhood, but does not yet have the life experience and skills to negotiate adulthood with confidence and certainty. A period of progression and regression therefore ensues, as demands to be treated like an adult coexist with yearnings for childish dependence, and adolescents often revert to childlike behaviour when under stress (Raphael-Leff 1994, Frankel 1998, DH 2008).

Adolescents crave acceptance as adults, yet in order to protect their emerging identities they will often erect defensive barriers to relationships (Frankel 1998, Feldman-Winter and Shaikh 2007). However, it is only through relationships that an adolescent is able to test and refine a new persona and adopt an adult role (SmithBattle 2000). Most adolescents will choose to do this within a peer group, feeling that with peers they can escape the pressure and conflict apparent in relationships with adults and families (Frydenberg 1997).

Much has been made of teenage years being marked by a sense of invincibility, often accompanied by risk-taking or anti-social behaviour. It is increasingly acknowledged that taking risks and testing boundaries is an essential part of maturation (Coleman and Hagell 2007, Hagell 2007). The extent

of indulgence in risky and anti-social behaviour is, however, perhaps exaggerated by society at large – Hagell (2007) points out that, despite the attention it receives in the press, crime among young males has in fact been falling for a number of years. Perhaps less often acknowledged, is the extreme vulnerability and stress inherent in the changes and transitions wrought during adolescence (Frydenberg 1997). A feeling that things are coming apart, decaying and falling away is an inevitable part of the process of change (Frankel 1998). Furthermore, becoming an adult in today's complex and fast-moving world can be incredibly challenging, added to which stress tends to be internalised as society offers fewer and fewer ways with which it can be dealt (Frydenberg 1997). Increasing numbers of young people, particularly those coming from less stable backgrounds and heading towards more uncertain futures, are finding the stress of entering adulthood overwhelming (Frydenberg 1997, Coleman and Hagell 2007, O'Brien and Scott 2007). Frydenberg (1997) linked the increased pressures and uncertainties of late 20th century life with an increase in adolescent suicide.

Teenage motherhood perhaps needs to be understood within the context of the transitions and uncertainties of adolescence. A developmental lens can shed light on the reasons behind much of the behaviour that health and social professionals find perplexing and challenging, and point the way towards standards of care that will enable young people to embark on their adult lives. Regardless of age, the transition to motherhood is well known to be a rite of passage requiring significant adjustment (Wilkins et al 2009). An adolescent mother, however, is having to deal with these changes at a time when they are already going through a turbulent period of change and identity formation (Raphael-Leff 1994, 2011; Wahn et al 2005). Qualitative research has shown that young mothers can feel torn between the competing demands of their identities as mothers and adolescents, leading to feelings of anxiety, alienation and depression (Clemmens 2003). In particular, motherhood can alienate young women from their peers at a time when peer relationships are extremely important, and place a young woman in a position of dependence on her own mother at the very point at which she is seeking to establish a separate identity (Clemmens 2003, Raphael-Leff 2011).

The unique challenges faced by teenage mothers clearly make them in need of support that recognises the process in which they are engaged (Raphael-Leff 2011). Although parenthood can be experienced as a positive entry to adulthood and an act of social inclusion (Alexander et al 2010), many young people will need significant support if this is to be the case (SmithBattle 2000, Formby et al 2010). In particular, adolescents need to be nurtured as they build new identities and helped to identify and express the needs which their emerging personas sometimes struggle to articulate (Wahn et al 2005). It has been suggested that this is best done through developing self-efficacy (a belief in one's own potential which leads to persistence in the face of obstacles) and providing young people with coping strategies (Frydenberg 1997). These attributes can be developed in the context of supportive relationships which acknowledge an adolescent's need to be treated and accepted as an adult whilst at the same time nurturing the skills that will enable them to overcome the challenges of adult life (Coleman and Hagell 2007). A similar approach has been introduced in the US, where interventions to prevent teenage pregnancies have combined an emphasis on sex and relationships education with self-esteem building through voluntary work, educational support and sports and arts activities (Dennison 2004). Recent UK policy has also acknowledged a need to provide enabling support for young mothers through the adoption of the Family Nurse Partnership scheme (FNP) and the piloting of supported housing projects (DH 2010). Through the Family Nurse Partnership, vulnerable young mothers are offered a series of structured home visits from a Family Nurse, beginning in early pregnancy and continuing until their child is two years old (DH 2010, Sanders et al 2011). The visits focus on health and emotional wellbeing and aim to reduce risky behaviours, enhance protective factors and improve mothering abilities (Sanders et al 2011).

The Good Mother narrative

Young mothers themselves have in fact identified a narrative within which positive adaptation can be nurtured in the 'good mother' identity that has emerged so strongly through qualitative research. Time and time again, young women's narratives emphasise the importance they place on being, and being seen to be, a good mother (McDermott et al 2004, Wilson and Huntington 2005,

Graham and McDermott 2006, Arai 2009, Alexander et al 2010). A good mother is someone who is approved of and has status within society, and being recognised as such is a source of great pride, enhancing self-esteem and enabling resilience in the face of material deprivation and societal condemnation (Clemmens 2003, McDermott et al 2004, Graham and McDermott 2006). Conversely, young mothers have linked the negative responses of others to their having children to diagnoses of depression (Formby et al 2010).

Assisting young mothers to attain the necessary skills and resources to build an identity as a good mother should perhaps be the focus of care in the perinatal period. It has been suggested that the provision of support for young mothers has a stronger relationship to maternal well-being than any other independent variable (Bunting and Mauley 2004). Teenage mothers need support that recognises their status as adolescents without judging them to be unable to care for their children due to their age (Camarotti et al 2011). Acknowledging and strengthening a young person's mothering abilities provides them with the acceptance they crave as new adults and mothers. Openly discussing mothering challenges and promoting the development of coping strategies further enables young mothers to develop resilience for the future (Wilson and Huntington 2005). In order for this to happen, three different sorts of social support have been identified as key: emotional, informative and instrumental (Frydenberg 1997, Wahn et al 2005). Emotional support consists of encouraging a sense of personal value through accepting and placing confidence and trust in an individual, while informative support constitutes the giving of appropriate advice and guidance (including the development of coping strategies), and instrumental support facilitates access to sources of information and practical help (Frydenberg 1997, Wahn et al 2005). Instrumental support can also be seen to include the facilitation of the peer relationships that are so crucial to this stage of development (Formby et al 2010) – a factor that is perhaps overlooked in the FNP.

A supportive and enabling approach to teenage mothers is perhaps particularly important in a UK environment in which pregnant teenagers are acutely aware of being judged negatively by society at large and expect to attract disapproval and hostility from health professionals and other service users when

accessing health care (McDermott et al 2004, Graham and McDermott 2006, Triveldi et al 2007, Alldred and David 2010, Duncan et al 2010, Owen et al 2010, Stapleton 2010). Similarly, policies which explicitly set out to reduce the numbers of pregnant teenagers reinforce negative stereotypes and do nothing either to improve the lives of young women living in impoverished and challenging circumstances or to provide them with viable alternative life choices. Although it is undoubtedly the case that social inequalities should be addressed, policy makers and practitioners also need to provide young mothers with support that recognises the unique challenges and stresses of their situation and enables them to become competent and confident mothers.

Conclusion

This chapter has considered the different discourses which have shaped the treatment and understanding of teenage mothers, and used the TPS to illustrate the theory that a discourse which does not reflect the lived reality of young mothers' lives is unlikely to offer meaningful and appropriate support. Rather, discourses of teenage pregnancy need to consider and address the environmental constraints and unique needs of young mothers as adolescents in a period of transition and change. Support for young mothers needs to recognise and build on the good mother identity that has emerged as being of such importance to young mothers, in particular by providing them with the emotional, informative and instrumental support necessary to build meaningful, sustainable and resilient identities as they begin their adult lives.

The focus of this enquiry will now narrow to consider the issue of breastfeeding in relation to young mothers. Firstly, existing literature will be consulted in order to ascertain the extent to which research has established what teenagers know about breastfeeding, what influences young women to choose to breastfeed, how their situational and developmental position affects their breastfeeding experiences, and what kind of support might best enable them to breastfeed. Particular attention will be paid to the extent to which existing breastfeeding research has illuminated, considered or addressed the situational and developmental contexts of young mothers' lives.

Chapter four

Teenage perspectives on breastfeeding – a literature review

Introduction

This chapter presents the findings of a review of previous research on the knowledge and attitudes of both non-pregnant and pregnant teenagers towards breastfeeding. The review also covered the experiences of breastfeeding teenagers, the attitudes of health professionals towards teenagers and breastfeeding, and strategies that have been employed to support and encourage young mothers to breastfeed – these aspects are discussed in the following chapter. Although some qualitative researchers argue against conducting a literature review at the outset of a research project (McGhee et al 2007), it was considered that investigating current understanding of teenage perspectives on breastfeeding was a fundamental part of the realist evaluation framework, and would also expose gaps in knowledge which would then direct and focus the research question for the subsequent stages of this research. Furthermore, presenting the results of a literature search can be seen as a reflexive exercise exposing the researcher's presuppositions and thus helping the research to proceed in an open and transparent manner.

Search strategy

In order to gather together relevant research for the review, the search terms teenage/adolescent and breastfeeding and associated spellings and names were used to search the CINAHL, Medline, Maternity and Infant Care, British Nursing Index, Cochrane and IBSS databases. The original literature search was undertaken in 2010 and retrieved English language articles from 1990-2010. Top up searches were then carried out at regular intervals until the completion of the project in 2013. The search process is outlined in Appendix 4.1. Literature published before 1990 was not searched, both in order to limit the number of articles found to one that could be critiqued by a single reviewer and also because the publication of the WHO Innocenti Declaration in 1990, which advocated the benefits of breastfeeding for all mothers, marked a watershed in breastfeeding research (UNICEF 1990). Before this date, much of the research

into teenagers and breastfeeding was concerned with whether or not they were physically mature enough to produce sufficient milk (Bar Yam 1993). The references of retrieved articles were scanned to identify further articles, and relevant seminal papers outside the search dates were also identified and sourced. Studies were considered relevant to this review if they dealt exclusively with teenagers and breastfeeding, if they dealt with breastfeeding but included a distinct group or groups of teenagers in their sample, or if they dealt with teenagers' attitudes to pregnancy or parenting but included breastfeeding within that remit. Studies were not used if breastfeeding mothers were a control group for an unrelated intervention (Barlow et al 2006) or if breastfeeding was not an outcome measured in an intervention or evaluation study (Barnet et al 2002, Hall Moran et al 1999, Logsdon et al 2002, Navaie-Waliser et al 1996, Sadler et al 2007). 'Adolescent' or 'teenage' was taken to include the period from age 11 (when children in some communities commence secondary school) and 19. 20-year-olds were included in some studies, as young women could become pregnant aged 19 and give birth at 20 years of age.

Of the 79 relevant papers identified, approximately 50% were from the US and 18 were from the UK. Smaller numbers hailed from Canada (7), Australia (6) and Ireland (4), with Brazil and Korea contributing one paper each. Similar issues and themes were apparent across these different countries, perhaps reflecting a shared cultural heritage among some US, UK, Canadian, Australian and Irish citizens. The studies were divided into five categories: the breastfeeding knowledge and attitudes of non-pregnant teenagers (16 papers); breastfeeding knowledge, attitudes and intentions of pregnant teenagers (34 papers), breastfeeding experiences of teenage mothers (18 papers); health professionals' attitudes towards teenage mothers and breastfeeding (two papers), and interventions aiming to improve teenage breastfeeding rates (nine papers). The first two categories are discussed below. The following three form the basis of the next chapter.

The breastfeeding knowledge and attitudes of non-pregnant teenagers

The knowledge and attitudes of non-pregnant teenagers towards breastfeeding have been studied principally to ascertain how early in life attitudes towards breastfeeding are formed and decisions concerning infant feeding are made, in order to suggest ways in which these might be influenced through education. The findings of research in this area are relevant to the current study insofar as previous knowledge and attitudes will feed into and become the basis of those held by young people in pregnancy.

16 studies were identified in this category, 13 looking at the knowledge and attitudes of non-pregnant adolescents and three testing interventions to improve breastfeeding attitudes and beliefs among this population. The sample sizes, methods and results of these studies are summarised below in Table 4.1. The studies were conducted in the U.K, Ireland, USA, Canada and Australia. Most were undertaken in areas where breastfeeding initiation was particularly low, and the attitudes and knowledge of the respondents tends to reflect this. Sample sizes ranged from 40 to 2021, and the ages of the young participants from 11-19 (Forrester et al 1997 also used a group of college students, the oldest of whom was 43). Researchers generally used questionnaires with closed questions and LIKERT scales to gather information. Response rates were usually good as most questionnaires were given to the students in lesson time. However, closed question formats can limit the information gathered to responses to researcher identified themes and priorities (Brace 2005). There may have been other facets of the young peoples' knowledge and attitudes about which they were not asked. Three studies used focus groups to ascertain attitudes – giving the students more freedom to express their own views (Connolly et al 1998, Giles et al 2007, Allen 2008).

Table 4.1. Research into the breastfeeding knowledge and attitudes of non-pregnant teenagers

Study/ location	Sample	Method/ Focus	Results					
			Knowledge level/source	Attitude	Perceived benefits	Perceived barriers	Feeding intentions	Perceived influences
Purtell 1994 UK	40 female students aged 16-17	Questionnaire Open & closed questions Assessing knowledge and attitudes Asking whether adolescent girls had already decided on a feeding method			Best for baby (72%. 25% didn't know) More natural Full of nutrients Promotes bonding	Less convenient Time consuming Painful If you use formula, other people can feed the baby	40% intended to breastfeed 17% did not want to 42% unsure More likely to want to breastfeed if: - were breastfed - had witnessed breastfeeding - believed breastfeeding was better	29 thought family would have most influence on decision TV mentioned by 5
Yeo et al 1994 USA/ Japan	329 female students aged 16-17 at private schools	Questionnaire Closed questions Comparing attitudes in 2 cultures		Japanese students more positive US students low scores for natural (5%), cheaper (9%) and more convenient (8%)	US students believed: - healthy for baby (59%) - good and desirable (46%)	US students believed: -disturbs family life (98%) - weakens the mother (85%) - leads to obesity in the mother(56%)		
Forrester et al 1997 USA	346 high school students aged 13-19 244 college students aged 17-43 Both genders	Questionnaire Closed questions Assessing attitudes	Home School TV	Breastfeeding in public not acceptable	Healthier More convenient	Embarrassment		

Study/ location	Sample	Method/ Focus	Results					
			Knowledge level/source	Attitude	Perceived benefits	Perceived barriers	Feeding intentions	Perceived influences
Connolly et al 1998 Ireland	177 + 48 students age 16-19 - both genders	Questionnaire (n=177) + focus groups (n=48) Attitudes		Breastfeeding best and natural	Adequate nourishment Cheaper More hygienic	Embarrassment in public Inconvenient Excludes father Troublesome Time-consuming Tiring Painful Huge commitment	54% intended breastfeeding for own child 34% girls and 7% boys intended to bottle feed	
Kim 1998 Korea	412 female students age 16	Intervention – panel presentation and video		Students exposed to intervention significantly more likely to have more positive attitude to breastfeeding and intend to breastfeed				
Leffler 2000 USA	100 female students aged 14-19	Questionnaire Closed questions Attitudes and intentions		Breastfeeding in public problematic/ impolite	Healthier for baby	Formula feeding more convenient	52% planned to breastfeed 15% planned to formula feed	
Martens 2001 Canada	45 first nation students aged 13 – both genders	Intervention – classroom session		Attitude significantly more positive after intervention				

Study/ location	Sample	Method/ Focus	Results					
			Knowledge level/source	Attitude	Perceived benefits	Perceived barriers	Feeding intentions	Perceived influences
Gostling 2003 UK	217 students aged 11-15 - both genders	Online questionnaire	'Reasonably sound' 92% received no information in school 60.4 % wanted more education re breastfeeding		Natural (92%) Healthy (85%) Convenient (75%)	Embarrassing (26% - more girls than boys) Bottle feeding modern/convenient (96%) Babies should be breastfed at 'home alone' (92%)	69% intended own child should be bottle fed (79% of girls, 51% of boys) 16% intended breastfeeding for own child (14% of girls, 26% of boys) 15% intended own child should be mixed fed	
Goulet et al 2003 Canada	439 students – all grades, both genders	Questionnaire Focussing on attitudes and subjective norms using theory of Reasoned Action		Positive overall, especially if: - were breastfed - siblings were breastfed - had witnessed breastfeeding	Aware of benefits More convenient	Misconceptions were a major obstacle for boys - e.g.: - breastfed babies less self-sufficient in later life - breastfeeding is painful		Low motivation to comply with significant others, who mostly endorsed breastfeeding
Greene et al 2003 Ireland	419 students aged 14-16 Both genders	Questionnaire Attitudes		Breastfeeding should take place at home			Babies should be breastfed (45%) Babies should be formula fed (14%)	
Giles et al 2007 Ireland	48 + 121 students aged 13-14 - both genders	Focus groups (n=48)+ pilot questionnaire (n=121) Measuring attitudes	Limited exposure Some had no knowledge	Equally concerned about benefits and barriers	Promotes bonding Natural Convenient Cheap	Embarrassment in public Tiredness Time-consuming Excludes father Limits social activity Painful Not fashionable	More likely to intend to breastfeed if: - had witnessed breastfeeding - were breastfed - knew about benefits of breastfeeding	Mothers most important for girls, medical professionals for boys. View of partner important, but woman should have final say

Study/ location	Sample	Method/ Focus	Results					
			Knowledge level/source	Attitude	Perceived benefits	Perceived barriers	Feeding intentions	Perceived influences
Juliffe et al 2007 Australia	1845 year 9 & 12 students - both genders	Questionnaire Open + closed questions Compared knowledge and attitudes of rural and metropolitan students	'Less than ideal' More knowledgeable if: - metropolitan - were breastfed - saw siblings breastfeed -had witnessed breastfeeding - had read about breastfeeding - older	At least 50% responses neutral More positive if: -more knowledgeable -female		- not perceived as healthier for baby - less convenient	72.8% year 12 had considered breastfeeding own children	
Allen 2008 UK	Number not stated Students aged 15-16 - both genders	Focus group Attitudes to breastfeeding		Mixed Formula feeding viewed as 'normal'		Embarrassment Not fashionable		Media
Walsh et al 2008 Canada	121 students aged 15-19 Both genders	Educational intervention	Good knowledge overall				Significantly more students in intervention group stated would choose breastfeeding post intervention	

Study/ location	Sample	Method/ Focus	Results					
			Knowledge level/source	Attitude	Perceived benefits	Perceived barriers	Feeding intentions	Perceived influences
Giles et al 2010 Ireland	2021 students aged 14-15 - both genders	Questionnaire Attitudes to breastfeeding	< 50% knew: - formula fed babies have more illnesses - benefits for mothers - exclusive breastfeeding recommended for 1 st 6 months	More likely to intend to breastfeed if: - breastfed as child - seen someone breastfeed - attended class on breastfeeding	Bonding Helps prevent infections		65.5% girls extremely, quite or slightly likely to breastfeed	
Gale and Davies 2013 UK	81 students aged 13-15 Both genders	Questionnaire Attitudes		Generally positive	Natural Health benefits	Tiring for mother (41%) Formula feeding is convenient >40% thought formula feeding had health benefits for baby		

As can be seen from Table 4.1, non-pregnant teenagers' knowledge of breastfeeding, which was generally ascertained by closed question surveys, ranged from 'none' through 'less than ideal' to 'reasonably sound', or, in one Canadian study, 'good' (Gostling 2003, Giles et al 2007, Juliffe et al 2007, Walsh et al 2008). Knowledge levels increased with age. Students generally knew that breastfeeding is natural (Gostling 2003, Giles et al 2007), healthier/better than formula milk (Connolly et al 1998, Forrester et al 1997, Gostling 2003), and promotes mother/baby bonding (Purtell 1994, Leffler 2000, Giles et al 2007), but were less aware of benefits for the mother (Leffler 2000, Giles et al 2010). However, Australian students in one of the largest studies did not perceive that breastfeeding was healthier for the baby or more convenient (Juliffe et al 2007). Allen (2008) points out that even when adolescents are able to name some benefits of breastfeeding, this knowledge is often superficial, as they are unable to say why it is healthier, for example.

Although many teenagers considered breastfeeding to be more convenient (Connolly et al 1998, Forrester et al 1997, Giles et al 2007, Gostling 2003, Goulet et al 2003), and cheaper (Connolly et al 1998, Giles et al 2007 – both Irish studies), it was also regarded as embarrassing (Connolly et al 1998, Leffler 2000, Gostling 2003, Giles et al 2007, Allen 2008), time consuming and tiring (Purtell 1994, Connolly et al 1998, Giles et al 2007), painful (Connolly et al 1998, Goulet et al 2003, Giles et al 2007, Gale and Davies 2013), and to exclude the father (Connolly et al 1998, Giles et al 2007). Formula milk feeding, on the other hand, was regarded as 'normal', 'acceptable', and 'modern' (Gostling 2003, Allen 2008), and just over 30% of the participants in one recent UK study thought formula milk had health benefits for the baby (Gale and Davies 2013). Boys were generally more negative than girls about breastfeeding (Greene et al 2003, Juliffe et al 2007). However, one UK and one Irish study found that boys were more likely than girls to intend that their own children be breastfed (Connolly et al 1998, Gostling 2003).

Students tended to state that they gained most of their breastfeeding knowledge from home and from the media – particularly the television (Connolly et al 1998, Forrester et al 1997, Allen 2008). With the exception of the students in

Forrester et al's study, many of whom were enrolled on a parenting programme, the teenagers received little or no information about breastfeeding at school (Forrester et al 1997, Gostling 2003, Greene et al 2003). Young people were ambivalent about whether their teachers were in fact best placed to teach them about breastfeeding, preferring to see the subject promoted in healthcare settings or in magazines and on the television or radio (Greene et al 2003).

It would appear that attitudes towards and intentions about breastfeeding are influenced by the cultures in which young people live, again demonstrating the importance of environment on the initiation on breastfeeding. Indeed, the number of young people who intended that their own children would be breastfed usually roughly correlated with local rates of breastfeeding initiation in the study locations (Leffler 2000, Greene et al 2003, Juliffe et al 2007). Girls in particular felt that their mothers would be important role models when it came to making infant feeding decisions while boys were more influenced by medical professionals (Giles et al 2007). Teenagers of both genders were more likely to have positive attitudes towards breastfeeding and/or intend their own children to be breastfed if they were breastfed themselves, and/or had witnessed their siblings or other babies breastfeed (Purtell 1994, Leffler 2000, Goulet et al 2003, Green et al 2003, Giles et al 2007, Juliffe et al 2007, Giles et al 2010). Despite the protestations of the Canadian students in Goulet et al's 2003 study that they had a low motivation to comply with the views of their social referents, the evidence appears to suggest that subjective norms do influence young peoples' thinking about breastfeeding. Yeo et al (1994), for example, compared students in Japan, where the subjective norms are strongly in favour of breastfeeding and over 90% of mothers breastfeed for the first month, with students from an area in the U.S where only 58% of mothers breastfed their babies at least once. Only 17% of the American girls questioned perceived that their mothers talked positively about breastfeeding, compared to 54% of the Japanese teenagers. Students in Japan were overwhelmingly more positive about breastfeeding, with 96% agreeing that it was healthy for the baby and 99% agreeing that breastfeeding is natural, compared to only 59% and 5% of their American counterparts. Attitudes and intentions were also positively correlated with greater

knowledge, and with reading about breastfeeding or seeing someone breastfeed on the television (Giles et al 2007, Juliffe et al 2007).

Although teenagers' intention to breastfeed tended to mirror actual overall breastfeeding rates in a given community, many students had not yet decided how they would prefer their babies to be fed – only around 15% expressed a firm intention to bottle feed (Leffler 2000, Greene et al 2003). This indicates that, although important, subjective norms are not entirely predictive of behavioural intention, and given the right information and encouragement undecided students might decide to breastfeed their children. Indeed, participants in two studies stated that lack of knowledge about breastfeeding was a barrier to choosing to feed their babies this way (Connolly 1998, Giles et al 2007). The three studies that tested educational interventions all found that they lead to a more positive attitude to breastfeeding and a significantly higher proportion of students in the intervention group stating an intention to breastfeed (Kim 1998, Martens 2001, Walsh et al 2008). However, these studies are of limited value because the increase in knowledge and attitude is tested immediately after the session has taken place – although the results held true at ten days in one study (Martens 2001) and ten weeks in another (Walsh et al 2008). Additionally, Gale and Davies (2013) found that students in their UK study who had a positive attitude towards breastfeeding did not always intend to breastfeed, and an intention to breastfeed does not always translate into actual breastfeeding practice – a phenomenon that will be discussed further later.

Overall, studies of non-pregnant teenagers indicate that, as Gale and Davies (2013) point out, although breastfeeding is seen to be biologically more natural by this demographic, formula milk feeding is the socially more natural choice. Increased knowledge about breastfeeding is positively correlated to a more positive attitude, and young people are more likely to consider breastfeeding if it is the norm in their culture, they have witnessed someone breastfeed and/or were breastfed themselves. Breastfeeding knowledge is currently largely gained at home or through the media. Educational initiatives might address misconceptions, increase knowledge and persuade the large number of young people who have not decided on an infant feeding method of

the benefits of breastfeeding. It appears that young people would prefer any such initiatives to be delivered in a healthcare setting, or by a healthcare professional, rather than by a teacher. The importance of cultural environment and subjective norms on young peoples' attitudes towards breastfeeding indicates that health professionals should include significant others, such as mothers and partners, in any breastfeeding education with pregnant adolescents.

The breastfeeding knowledge, attitudes, and intentions of pregnant and postpartum teenagers

The knowledge, attitudes and intentions of pregnant and postpartum teenagers in regard to breastfeeding are well researched, as can be seen from the 31 studies listed in Table 4.2 below. Over two thirds of the studies on this topic originate in the US, with others being conducted in the UK, Australia, Canada and Brazil. Participants in 15 of the studies were young mothers. Ten studies included pregnant and postpartum teenagers, and six included only pregnant young women. The themes and issues that arise from this literature establish a context against which teenagers' experiences of breastfeeding can be better understood, and within which any interventions designed to support young women must be able to operate. Although the researchers use different methods and participants are at varying stages of pregnancy or early parenthood, there are a number of themes and trends that emerge. These are considered below under the sub categories of breastfeeding knowledge and attitudes, factors contributing to a decision not to breastfeed or to breastfeed, and factors increasing the likelihood of a teenage mother actually initiating breastfeeding.

Table 4.2. Studies assessing the breastfeeding knowledge, attitudes, and intentions of pregnant teenagers

Study	Location	Study population	Number in sample	Method	Focus	Support provided	Numbers breastfeeding
Joffe and Radius 1987	US	Teenagers, mixed parity, 2-9 months' pregnant	254	Questionnaire Closed questions	To identify factors influencing choice of infant feeding method		17% intended to breastfeed
Baisch et al 1988	US	Pregnant 13-20 year olds. No gestation or parity specified 68% African America	128	Questionnaire Closed questions	Attitudes of pregnant adolescents	Registered with multi-disciplinary care programme encouraging breastfeeding	32.4% initiated breastfeeding. 79% of those intending to breastfeed actually did so
Radius and Joffe 1988	US	As Joffe and Radius above			Assesses perceived benefits of and barriers to breastfeeding among teens		
Lizarraga et al 1992	US	Primiparous 14-18 year old newly delivered mothers Mainly Hispanic	64	Interviewed within 48 hours of delivery. Closed questions	To identify factors influencing choice of infant feeding method		72% intended to breastfeed
Peterson and Da Vanzo 1992	US	Retrospective data from National Longitudinal Surveys of Youth 1979-85 Primiparous women up to age 29	2,960	Retrospective data analysis	Investigates reasons for low breastfeeding rates among teens		42.3% breastfed
Bar Yam 1993	US	Literature review 15 studies – 14 pre 1990		Literature review	Factors influencing adolescent feeding decisions		

Study	Location	Study population	Number in sample	Method	Focus	Support provided	Numbers breastfeeding
Maehr et al 1993	US	Primiparous newly delivered teens and matched adults	40 teens, 40 adults	Interviewed within 48 hours of delivery Open and closed questions	Compares adolescents and older mothers' reasons for choosing breastfeeding and feeding behaviour		Not recorded
Robinson et al 1993	US	Postnatal women under 20 Low socio-economic group	84	Questionnaire Closed questions	Evaluates attitudes and other influences on teen infant feeding decisions		8/84 attempted to breastfeed
Ineichen et al 1997	UK	19 pregnant and 35 young mothers responding to survey in newsletter	55	Questionnaire Closed questions	Explores attitudes and behaviour		58% young mothers had breastfed
Wiemann et al 1998	US	Newly delivered teen mothers, mixed parity and ethnicity	696	Interviewed within 48 hours of delivery Closed questions	Explores racial and ethnic variations in breastfeeding levels among teens		35% initiated breastfeeding
Wiemann et al 1998a	US	As Wiemann et al above			As above, plus factors influencing feeding decision		42% of bottle feeders had considered breastfeeding
Pierre et al 1999	US	14-22 year old pregnant, primiparous women	78	Questionnaire Closed questions	Asks whether ego development associated with breastfeeding intention and behaviour	Enrolled in adolescent pregnancy programme or 'teen and tot' clinic	85% breastfed at birth
Rubin and East 1999	US	Pregnant teens followed through to 24 months after giving birth	154	Questionnaires	Explores relationship between pregnancy intentions and postpartum behaviours		Teens who planned pregnancy more likely to breastfeed

Study	Location	Study population	Number in sample	Method	Focus	Support provided	Numbers breastfeeding
Hannon et al 2000	US	Primiparous women aged 12-19, pregnant or delivered within past 3 months	35	Semi-structured ethnographic interviews and focus groups	Explores perceptions and influences	School for pregnant and postpartum teens or community based support programme	Not recorded
Misra and James 2000	US	Women from low socio-economic group attending public health clinic 31.5% adolescents	29,589	Retrospective record analysis	Examines initiation and duration of breastfeeding among adolescent and older women		¾ teens and 2/3 adults never breastfed or breastfed < week 19% teens and 68% adults breastfeeding at time of study
Brownell et al 2002	US	African-American Mothers aged 15-21	25	Interviews Multiple choice and open questions	Defines barriers to breastfeeding		52% initiated breastfeeding 16% breastfeeding at 5 days and 8% > 2 weeks
Dewan et al 2002	UK	Teenage and older primiparous women attending booking clinic	40 teenagers and 40 older women	Questionnaires Closed questions	Knowledge and attitudes		22.5% teens intended to breastfeed (67.5% of older women)
Greenwood and Littlejohn 2002	Australia	Adolescents/young mothers up to age 25	42	Longitudinal study Questionnaires Open and closed questions	Explores intentions and outcomes	All attending antenatal classes in community-based programme	97.6% intended to breastfeed 82.8% breastfeeding on discharge from hospital
Park et al 2003	US	Teenage Mothers enrolled on WIC programme	3534	Retrospective enrolment records analysis	Explores predictors of breastfeeding initiation among teens		35.1% initiated breastfeeding

Study	Location	Study population	Number in sample	Method	Focus	Support provided	Numbers breastfeeding
Shaw et al 2003	UK	Primiparous teenage mothers, 16-21 years old Health professionals	11 teens, 15 health professionals	Semi –structured interviews with teens – antenatally and postnatally Focus groups with health professionals	Investigates factors influencing teens' feeding decisions		Not recorded
Gaff-Smith 2004	Australia	Teenage mothers, 6-52 weeks postnatally	113	Semi-structured interviews	Effects of self-esteem and social support on breastfeeding		86% breastfed on discharge from hospital. 13% breastfed at 6 weeks
Harner and McCater-Spaulding 2004	US	Teenage mothers during postnatal hospital stay. Mostly African-American	86	Semi-structured interviews	Explores impact of paternal age on teens' feeding decision		24% breastfed during hospital stay
Wambach and Koehn 2004	US	Teenagers, 18-39 weeks pregnant Mostly primiparous and African-American	14	Pilot study Focus group interviews	Explores factors influencing decisions about infant feeding using Theory of Planned Behaviour		Not recorded
McFaddon and Toole 2006	UK	Low income women, adolescent women and women from minority ethnic groups - Pregnant or with children under 4	35	Focus groups	Explores women's views on barriers to breastfeeding, influences on feeding decision and strategies to increase breastfeeding rates	Access to Sure Start services	Not recorded
Arthur et al 2007	UK	Teenage mothers	8	Semi-structured phenomenological interviews	Teenagers' perceptions of local maternity services		Not recorded

Study	Location	Study population	Number in sample	Method	Focus	Support provided	Numbers breastfeeding
Cordova do Espirito Santo et al 2007	Brazil	Mothers and babies, 0-6 months (1/4 < 20 years old)	220 mother/baby pairs	Longitudinal study Face to face and telephone interviews	Identifies factors associated with early cessation of breastfeeding		All
Feldman-Winter and Shaikh 2007	US	Literature review		Literature review	Reviews adolescent decision making process and breastfeeding interventions		N/A
Bailey et al 2008	UK	Ante and postnatal teenagers and older women	57: 16-24 years – 16 25 –40 years - 41	Questionnaires – self-esteem and self-efficacy scales	Psychosocial factors influencing breastfeeding duration		All
Mossman et al 2008	Canada	Pregnant teenagers contemplating breastfeeding	100	Questionnaire. Closed questions	Examines influence of attitudes and confidence on adolescent breastfeeding initiation and duration	Adolescent clinic providing pre and postnatal care, plus lactation consultants available during hospital stay.	84% initiated breastfeeding
Nelson 2009	US	Pregnant and postpartum adolescents	16	Focus groups	Attitudes, beliefs and concerns of pregnant and postpartum teens re breastfeeding	Attending outreach programme	Not recorded
Dyson et al 2010	UK	Socioeconomically deprived pregnant teenagers	71	Questionnaire (n=71) Focus groups (n=17)	Factors influencing feeding decisions		Not recorded

Breastfeeding knowledge and attitudes

Most of the studies looking at the breastfeeding knowledge and attitudes of pregnant and postpartum teenagers used closed questions or provided a list of statements with which the young women were invited to agree or disagree. The most commonly cited sources of the adolescents' breastfeeding knowledge were doctors or other health professionals, mothers or other family members, and TV, magazines or books (Baisch et al 1988, Bar Yam 1993, Brownell et al 2002, Wambach and Koehn 2004). Nelson (2009) noted that teenagers appear to attach more credence to the experiences of breastfeeding mothers than to information given by professionals. In particular, reports that other women found breastfeeding painful had a great deal of impact.

Like non-pregnant teenagers, pregnant teenagers who had been breastfed themselves, had witnessed other people breastfeeding, whose boyfriends had been breastfed or who had heard about breastfeeding from their own family, were more likely to have positive attitudes towards breastfeeding (Baisch et al 1988, Bar Yam 1993, Robinson et al 1993). Positive attitudes among teenagers were not generally found to differ by race, age, or level of maturity (Baisch 1988, Pierre et al 1999), although young women have less positive attitudes than women aged 25-40 (Bailey et al 2008). Adolescents are more likely to have negative attitudes towards breastfeeding if they are parous or if they have been discouraged from breastfeeding by a medical professional (Baisch 1988, Robinson et al 1993).

Pregnant teenagers have been found to know less about breastfeeding than older women (mean age 26 years five months) (Dewan et al 2002). The most frequently endorsed advantage of breastfeeding among pregnant and mothering teenagers was that it was best for baby's health (Baisch 1988, Brownell et al 2002, Hannon et al 2000, Robinson et al 1993, Shaw et al 2003, Wambach and Koehn 2004). Even so, this advantage was endorsed more strongly by the adults in Dewan et al's study (Dewan et al 2002). Although the young women were generally less aware of the advantages of breastfeeding for the mother, they were aware that breastfeeding would help a mother shed pregnancy weight gain (Nelson 2009, Wambach and Koehn 2004). The teenagers were also likely to agree that breastfeeding promotes mother/baby

bonding (endorsed by 22/25 young mothers in Brownell et al's study), but were ambivalent as to whether this was a good thing, as the mother might not then be able to leave her baby with anyone else (Baisch et al 1988, Brownell et al 2000, Hannon et al 2000, Wambach and Koehn 2004).

Pregnant and mothering teenagers talked about advantages of breastfeeding over bottle feeding, such as not having to warm up bottles at night, but overall appeared to view bottle feeding as more convenient (Shaw et al 2003, Wambach and Koehn 2004). They differed in this from their non-pregnant counterparts, many of whom agreed that breastfeeding was more convenient. Shaw et al (2003) point out that the perceived convenience of bottle feeding is the result of several decades of media campaigns by formula milk companies, and note that the young women in their study who bottle fed were disappointed that bottle feeding took so much time.

Recent focus group research has ascertained that adolescents' infant feeding attitudes are influenced by moral norms, with those intending to or actually formula milk feeding regarding breastfeeding as a morally inappropriate behaviour (Dyson et al 2010). Similarly, ideas of appropriate behaviour have been used to defend breastfeeding in other focus groups and interviews with young mothers - specifically, Nelson (2009) found that pregnant and mothering teenagers believed that mothers should put their babies first. This was used as an argument to persist with breastfeeding if difficulties were encountered, and also as a reason to stop breastfeeding if it was not meeting the baby's needs or s/he appeared not to like it (Wambach and Koehn 2004, Nelson 2009). The young women also believed that a healthy baby gains weight, and a mother should provide plenty of food for her offspring. This led to concerns that breastfeeding would not provide enough milk, and a belief that some formula milks might be better for the baby, especially if the mother's diet was wanting (Shaw et al 2003, Wambach and Koehn 2004).

Factors contributing to a decision not to breastfeed

By far the most frequently cited reason given for not wanting to breastfeed was that it was inconvenient and would affect the adolescents' social life or ability

to return to school or work (Radius and Joffe 1988, Ineichen et al 1997, Wiemann et al 1998, Hannon et al 2000, Brownell et al 2002, Dewan et al 2002, Greenwood and Littlejohn 2002, Wambach and Koehn 2004, McFadden and Toole 2006). Peer interaction is an important aspect of identity formation during teenage years (Wambach and Koehn 2004), and many pregnant or recently delivered adolescents perceived that breastfeeding would place too onerous a burden on them and would stop them drinking, smoking or being able to see their friends. This view is summed up by one of the participants in Greenwood and Littlejohn's study, who commented 'I only want to breastfeed up until New Year's Eve. I want to drink' (Greenwood and Littlejohn 2002, p21). Others believed that a baby who had been breastfed might refuse to take a bottle, or be difficult to wean (Nelson 2009). Bottle feeding, in contrast, allowed the young mother to leave her baby in the care of others (Wiemann et al 1998, Shaw et al 2003, Wambach and Koehn 2004). 'Others' were apparently keen to feed the young women's babies - Wiemann et al (1998) found that adolescents living in the same house as an older female are less likely to breastfeed than those living alone or just with their partners.

Embarrassment or public exposure was the next most frequently cited reason for not wanting to breastfeed (Radius and Joffe 1988, Hannon et al 2000, Brownell et al 2002, McFaddon and Toole 2006, Shaw et al 2003, Dyson et al 2010). Embarrassment was not just about feeding in public – adolescents were embarrassed about feeding at home if family members disapproved of breastfeeding (McFaddon and Toole 2006). Wiemann et al's large study, however, did not find embarrassment to be a factor in deciding whether or not to breastfeed (Wiemann et al 1998). A perception that breastfeeding was painful was also a major consideration (Brownell et al 2002, Hannon et al 2000, Ineichen et al 1997, Shaw et al 2003, Wambach and Koehn 2004). Some pregnant adolescents simply found the idea of breastfeeding distasteful (Hannon et al 2000, Ineichen et al 1997), or were put off by stories of leaking or enlarged breasts (Brownell et al 2002). Others were not interested, or thought breastfeeding would make them feel run down as well as making it difficult to lose weight, that their milk would be affected by their emotions or their poor diets, that the choice of different preparations of formula milk made it a better option, or that

breastfeeding would make their breasts ugly (Brownell et al 2002, Hannon et al 2000, Joffe and Radius 1987, Wambach and Koehn 2004). Some were also concerned about sexual feelings associated with breastfeeding, and there was a belief that the baby's 'reaction' to the breast or bottle would confirm which method was best (Wambach and Koehn 2004).

One author studied the literature to ascertain whether a history of childhood sexual abuse was related to the feeding decisions of adolescent mothers (Bowman 2007). Her hypothesis was that breastfeeding might trigger abuse-related defensive emotions that either prompt the young mother to stop breastfeeding or prevent her starting in the first place. There is, however, currently no specific research to support this (Bowman 2007). On a more positive note, Radius and Joffe (1987,1988) noted that the barriers identified in their study were not as influential as the benefits: adolescents could cite many barriers to breastfeeding, but would still intend to breastfeed if they were sufficiently convinced of its benefits. Indeed, the young women themselves stated that they would breastfeed if they knew more about it (Baisch 1989, Joffe and Radius 1987). This indicates that, despite the fact that breastfeeding was considered a difficult and embarrassing behaviour to undertake, adolescents are still drawn towards it and would like to be able to feed their babies this way.

Factors contributing to an intention to breastfeed

Many teenagers do not decide how they are going to feed their babies until late in pregnancy or after giving birth (Maehr et al 1993, Ineichen et al 1997). Pregnant adolescents are more likely to express an intention to breastfeed if they have a positive attitude towards breastfeeding, high levels of self-efficacy and/or feel that their partner and peers support their decision (Joffe and Radius 1987, Baisch et al 1988, Lizarraga et al 1992, Bar Yam 1993, Pierre et al 1999, Hannon et al 2000, Bailey et al 2008). Intention to breastfeed was higher among young women who had talked about breastfeeding, particularly with a family member or the baby's father, were informed, encouraged, understood the benefits and had discussed ways of overcoming perceived barriers (Joffe and Radius 1987, Hannon et al 2000).

Young women intending to breastfeed also tend to be married and to have left school before becoming pregnant (Lizarraga et al 1992). Teenagers of Hispanic origin are more likely to intend to breastfeed, while those of black African origin are particularly likely not to intend to breastfeed (Lizarraga et al 1992, Wieman et al 1998, Misra and James 2000), even though some authors found no correlation by race in their particular samples (Joffe and Radius 1987, Baisch et al 1988,). Although Lizarraga et al found that adolescents intending to breastfeed tend to be older, other authors found no correlation between breastfeeding intention and age (Joffe and Radius 1987, Baisch et al 1988, Wiemann et al 1998a), and one study that particularly looked at breastfeeding intention and practice and the adolescent's stage of ego-development found that the two were not connected (Pierre et al 1999).

When asked, young women stated that the decision to breastfeed was their own (Hannon et al 2000, Spear 2006, Wambach and Koehn 2004). However, as Wambach and Koehn (2004) point out, social and family influences are evident. Health professionals and the teenagers' mother emerge as the strongest sources of influence (Robinson et al 1993, Wiemann et al 1998, Wambach and Koehn 2004). Wiemann et al (1998) found that breastfeeding was advised or encouraged significantly less often by health professionals caring for African American teenagers. Young women also consider their partners' views, and have been found to be less likely to initiate breastfeeding if their partner is four or more years older than they are (Harner and McCarter-Spaulding 2004). Some were influenced by TV programmes and teaching videos (Wambach and Koehn 2004).

Teenagers who decide to breastfeed state that they intend to do so because breastfeeding is better for their baby's health (Joffe and Radius 1987, Maehr et al 1993, Ineichen et al 1997, Wiemann et al 1998, Brownell et al 2002, Greenwood and Littlejohn 2002, Spear 2006). Although teenagers in one study mentioned benefits to the mother, such as weight loss and uterine involution (Brownell et al 2002), pregnant adolescents were generally unaware of the benefits to themselves or did not mention them as impacting on their decision (Maehr et al 1993, Greenwood and Littlejohn 2002).

Ease and convenience is the second most frequently cited reason for deciding to breastfeed (Ineichen et al 1997, Wiemann et al 1998, Brownell et al 2002, Greenwood and Littlejohn 2002), followed by promoting bonding with their baby (Ineichen et al 1997, Wiemann et al 1998, Greenwood and Littlejohn 2002). Teenagers intending to breastfeed also stated that it was natural and free (Joffe and Radius 1987, Greenwood and Littlejohn 2002), and agreed that breastfeeding would enable them to feel important as it was something only they could do for their baby (Radius and Joffe 1988, Wiemann et al 1998).

Factors making it more likely that a teenage mother will initiate breastfeeding

Studies and audits have found that an adolescent's statement of intent to breastfeed, or that breastfeeding is being contemplated, does not always lead to breastfeeding initiation (Wiemann et al 1998a, Lavender et al 2005, Hunter 2008, Mossman et al 2008). 42% of bottle feeding young mothers in one study had considered breastfeeding (Weimann et al 1998b).

Teenage mothers who actually initiated breastfeeding differed from their contemporaries in that they tended to have more positive attitudes towards breastfeeding, be older, employed, to have stayed in the education system for longer (this was the greatest predictor of breastfeeding in a large study by Park et al (2003), to live with their partners and/or in smaller households and receive fewer benefits (Peterson and Da Vanzo 1992, Robinson et al 1993, Wiemann et al 1998b, Misra et al 2000, Park et al 2003). Teenagers initiating breastfeeding are less likely to live with their mothers or mothers-in-law, although a close female family member with a positive experience of breastfeeding can be a motivating factor (Peterson and Da Vanzo 1992, Nesbitt et al 2012). They also tend to be primiparous women who do not smoke or had stopped smoking during pregnancy, are not considered to be anaemic, had planned their pregnancies, enrolled for antenatal care in the first trimester, decided to breastfeed before pregnancy or during the first trimester, state an intention to breastfeed for longer than those who intended to breastfeed but bottle fed, and have supportive partners or significant others and higher self esteem (Rubin and East 1999, Wieman et al 1998a, Misra et al 2000, Park et al 2003, Gaff-Smith 2004,

Mossman et al 2008, Brown et al 2011, Nesbitt et al 2012). Actual breastfeeders were also significantly more likely to have received feeding advice from a health care provider, as well as to have discussed barriers to breastfeeding and ways of overcoming them (Ineichen et al 1997, Weimann et al 1998, Hannon et al 2000).

Teenagers who contemplated breastfeeding but bottle fed had generally been exposed to fewer role models, had been encouraged to bottle feed by at least two significant others, and were more aware of, or had experienced greater stigmatization as a result of being a pregnant teenager. They were more influenced by perceived barriers than a lack of information (Wiemann et al 1998a), and were sometimes dissuaded from putting their babies to the breast by negative experiences on the postnatal ward, such as witnessing other women experiencing difficulties with breastfeeding (Shaw et al 2003).

Implications for practice

The evidence discussed above suggests that, if young women are offered information and support, many of the barriers to them initiating breastfeeding can be overcome. In particular, young women appear to benefit from exposure to positive breastfeeding role models, and attach credence to the experiences of other breastfeeding mothers (Joffe and Radius 1987, Peterson and Da Vanzo 1992, Maehr et al 1993, Weimann et al 1998b, Feldman-Winter and Shaikh 2007, Nelson 2009). A decision not to breastfeed appears to be predicated mainly on the difficulty of incorporating breastfeeding into the young mothers' everyday lives – they are concerned about being able to leave their babies in the care of others and spend time with their peers, and breastfeeding in public. Young mothers also expressed a concern that their milk supply may not be adequate to meet their baby's needs. Addressing these concerns and discussing ways of dealing with them may enable more young women to breastfeed (Wiemann et al 1998, Mossman et al 2008, Nelson 2009). The belief that bottle feeding is convenient and better able to satisfy a baby's needs appears deeply ingrained among pregnant adolescents – they perhaps need more information about the superiority of breastmilk and the realities of bottle feeding (Shaw et al 2003). Pregnant teenagers may also benefit from more education about the specific benefits of

breastfeeding to baby as well as the benefits to themselves (Ineichen et al 1997, Peterson and Da Vanzo 2002, Shaw et al 2003, Wambach and Koehn 2004, Nelson 2009).

Conclusion

This chapter has outlined the process undertaken to conduct a literature review on teenagers and breastfeeding, and presented the results in relation to non-pregnant and pregnant teenagers' knowledge and attitudes to infant feeding. Research has established that teenagers are more likely to have a positive attitude towards breastfeeding and intend to breastfeed themselves if they were breastfed or had witnessed breastfeeding. Although many young people are aware that breastfeeding is 'best for baby' and can enhance the mother/baby bond, they are less aware of the benefits of breastfeeding for the mother and tend to regard breastfeeding as embarrassing, tiring and painful. Formula feeding, on the other hand, is seen as 'normal', convenient and modern.

Adolescents' views on breastfeeding tend to reflect the cultural norms of their families and communities. Although there is some evidence that where these views are challenged by health professionals or through education in school attitudes and intentions can be changed, young mothers need high levels of family, professional and peer support and self-efficacy in order to be able to initiate and establish breastfeeding. Perhaps for this reason teenage mothers who continue to breastfeed beyond the first few days tend to be older and more highly educated.

The following chapter looks at the actual experiences of breastfeeding teenage mothers, the attitudes of health professionals looking after them and strategies that have been trialled to improve breastfeeding rates among young mothers.

Chapter five

The experiences of, and support offered to, teenage mothers – a literature review

Introduction

Having explored the knowledge, attitudes and intentions of young women with respect to breastfeeding in the previous chapter, this chapter presents the findings of literature investigating the breastfeeding experiences of teenage mothers, the attitudes of health professionals looking after them, and strategies that have been employed to increase breastfeeding rates among young mothers. These topics conclude the theoretical component of stage one of the realist evaluation framework – an investigation into ‘what is happening now and why’. The attitudes of health professionals were considered integral to this process, as the consideration of practitioner views is central to the realist approach. Eliciting the views of maternity professionals therefore formed a component of the primary research undertaken for this study.

The breastfeeding experiences and support needs of teenage mothers

The initial literature research for this review, conducted in 2010, found only seven studies exploring the breastfeeding experiences of teenage mothers (Benson 1996, Dykes et al 2003, Nelson and Sethi 2005, Spear 2006, Hunter 2008, Ingram et al 2008 and Wambach and Cohen 2009). However, the years 2010-2013 saw a proliferation of research publications on this subject, and a further nine papers were added after subsequent searches. Details of each of the 16 studies discussed in this section can be found in Table 5.1 below. Relevant data from studies included in chapter four, and from Lavender et al’s 2005 intervention (see Table 5.3) is also discussed here.

Table 5.1. Studies looking at the breastfeeding experiences of teenage mothers

Study/ location	Sample	Focus	Method	Main findings
Benson 1996 Australia	47 teenage mothers Predominantly breastfeeding	Experiences of parenting and breastfeeding	Brief interview with set questions within 2 days of delivery 18 followed up with open interview at 4-6 months	Importance of supportive environment, particularly in early postnatal period Importance of sleep Significant influence of home environment
Dykes et al 2003 UK	20 teenage mothers Breastfed 4 days – 5 months	Experiences and support needs of adolescent mothers who initiate breastfeeding	Focus groups (7 girls – babies 2 weeks - 6 months old) In-depth semi-structured interviews (13 girls – babies 6-10 weeks old)	Young breastfeeding mothers feel watched and judged, lack confidence, feel tied down and experience tiredness and discomfort Importance of 5 domains of support
Nelson and Sethi 2005 Canada	8 teenage mothers with baby 6-27months old Breastfed 2-17 months	Breastfeeding experiences	Interviews using grounded theory	Teenage mothers need to continuously commit to breastfeeding Need for additional support
Spear 2006 USA	53 teenage mothers with baby 5 months – 2 years old Breastfeeding at hospital discharge	Breastfeeding experiences of teens after hospital discharge	Interviewed by phone	Inadequate breastfeeding knowledge Need for more support
Hunter 2008 UK	29 teenage mothers Breastfeeding & not breastfeeding	Experiences of postnatal care and breastfeeding	Postal questionnaire Mainly closed questions	Need for more proactive breastfeeding help and support in hospital
Ingram et al 2008 UK	22 mothers from black and minority ethnic groups, including distinct group of 5 young mothers aged 16-23 Breastfed 5 weeks – 5 months	Barriers to exclusive breastfeeding	Focus groups	Health professionals giving different advice to family members Attitudes and support from partners and family important influence Difficult to feed outside home More guidance needed
Wambach and Cohen 2009 USA	23 teenage mothers Breastfed for at least 2 weeks	Breastfeeding experiences	Focus groups or individual interviews	Support of significant others important factor in continuing to breastfeed More proactive guidance needed Importance of informational, instrumental and emotional support
Grassley 2010 USA		Adolescent support needs in early postpartum	Literature review	Importance of health professionals providing 5 domains of support in early postpartum

Study/ location	Sample	Focus	Method	Main findings
Brown et al 2011 UK	138 young mothers aged 17-24, with baby aged 6-24 months Breastfeeding and not breastfeeding	Experience of breast or formula milk feeding	Questionnaire (n=138) Interviews with 10 mothers who breastfed for at least 6 months	Importance of being part of a supportive breastfeeding community
Karp and Lutenbacher 2011 USA	67 predominantly African American mothers aged 15-22, with baby aged 6-12 months Breastfeeding and not breastfeeding	Infant feeding practices	Semi-structured interviews	Lack of knowledge re appropriate infant feeding: 82% added cereal to formula milk feeds 64% started solid food before 6 months
Dennis et al 2011 USA	100 young women aged 15-19, at 34 weeks gestation and 4 weeks postnatally Breastfeeding and not breastfeeding	Testing the breastfeeding self-efficacy scale – short form	Questionnaire	Antenatal classes and professional support may be particularly important for increasing adolescent breastfeeding self-efficacy
Condon et al 2012 UK	6 pregnant teenagers and 23 young mothers aged 13-20 Breastfed at least once	Experiences of breastfeeding promotion and support	Focus groups (n=12) and interviews (n=17)	Social barriers to continuing breastfeeding are considerable and insufficiently recognised by health professionals Conflicting breastfeeding norms of teenagers and health professionals Challenges of breastfeeding outside home
Grassley et al 2012 USA	100 young mothers aged 13-20 Breastfeeding and not breastfeeding	Testing the supportive needs of adolescents scale	Questionnaire	Instrumental and informational support are crucial in early postpartum period – both need to be embedded in emotional and appraisal support
Hall Smith et al 2012 USA	5 pregnant and mothering teenagers Breastfed 9 days – 5 months	Early breastfeeding experiences	Followed adolescents from pregnancy until 2 weeks after cessation of all breast milk feeding Interviews and phone calls	Breastfeeding practices closely related to experiences as new mother. Poor breastfeeding knowledge and inadequate support
Nesbitt et al 2012 Canada	16 young mothers aged 17-19 with babies aged 12 months or less Breastfed for at least 2 days	Breastfeeding experiences	Semi-structured interviews	Attitude and support of partner and family influential Lack of breastfeeding knowledge Negative impact on social life Early postnatal support vital
Noble-Carr and Bell 2012 Australia	24 young mothers aged 17-28 Over 50% were teenagers when 1 st child born Predominantly breastfeeding	Breastfeeding experiences	Focus groups	Experiences characterised by negative judgement. Strongly influenced by partners, mothers and peers Negative experiences of support in hospital Challenges of feeding outside home

Studies included in this section were conducted in the US, UK, Canada and Australia. Study participants were aged between 13 and 23, and most had at least some experience of breastfeeding. All the studies use qualitative interview techniques, ranging from a mix of open and closed questions, through a semi-structured approach to an open, unstructured encounter. This led to varying degrees of success in eliciting the views of young women. The 53 young mothers interviewed by Spear (2006), who had given birth up to two years previously, took part in a brief telephone interview which was conducted by a stranger and of which they had no prior warning – adolescent mothers often talk of how unwilling they are to open up to health care professionals they do not know (Price and Mitchell 2004, Hunter 2008), and the lack of warning gave them no time to prepare their thoughts. This is likely to have impacted on the data gathered. The eight Canadian mothers in Nelson and Sethi's 2005 study did have prior warning of their interviews, but the unstructured nature of the encounters has perhaps tended towards more superficial data – the authors' main conclusion is that young mothers have to continuously commit to breastfeeding, in that they decide to breastfeed, learn to breastfeed, adjust to breastfeeding and, at some point, stop breastfeeding (Nelson and Sethi 2005). Qualitative research has been criticised for research that states the obvious and lacks depth (Alvesson and Skoldberg 2000). The semi-structured approach adopted by Dykes et al (2003) appears to have yielded the richest responses. The authors used focus groups to elicit the experiences of young mothers who breastfed, and then used the data from the focus groups to create prompts and topics for semi-structured interviews, taking care to ensure that participants in the interviews were still able to introduce new topics (Dykes et al 2003). In this way participants were given talking points that came from their peers, rather than reflecting the mindset and priorities of the researcher (DePoy and Gitlin 2005).

Young mothers' breastfeeding experiences

Across the studies, the teenagers' descriptions of their experiences illustrate ways in which their unique developmental situation impacts on breastfeeding success. For example, while they were in hospital, many of the young mothers felt watched and disapproved of by older women, including health professionals (Benson 1996, Dykes et al 2003). Benson has suggested that this

feeling of being watched results from adolescents' belief that they are the centre of everyone's universe, rather than just of their own (Benson 1996). This sense of disapproval was accompanied by a lack of confidence that they were breastfeeding properly or producing enough milk to satisfy their babies (Dykes et al 2003, Spear 2006). Again, this can be seen as a typical reaction of someone who is new to adulthood, as well as to mothering. A sense of being watched and judged negatively is also cited by adolescents in recent Canadian and Australian studies as a reason for not wanting to breastfeed in public (Nesbitt et al 2012, Noble-Carr and Bell 2012). Young mothers felt they were already stigmatized due to their age, and by breastfeeding in public they would simply attract more attention to themselves and invite further negative comment.

An unwillingness to feed in public, or even in front of family members, meant that breastfeeding was socially isolating for some young mothers, who were torn between wanting to breastfeed and wanting to spend time in their peer groups (Nesbitt et al 2012, Condon et al 2012). Access to peer and support groups who accepted and supported breastfeeding enabled young mothers to feel comfortable breastfeeding outside the home and continue breastfeeding for longer (Brown et al 2011, Nesbitt et al 2012).

The physical demands of breastfeeding, which were more onerous than many of the young mothers had expected, their anxiety and the painful and sore nipples that many of them experienced, were exacerbated by tiredness and lack of sleep (Benson 1996, Dykes et al 2003, Hall Smith et al 2012, Nesbitt et al 2012). In fact sleep emerged as a major theme in Benson's study, and a routine of sleeping through the night was the source of considerable pride (Benson 1996). Many of the young women introduced mixed feeding so that their partner's could share the burden of night feeds, or so that they did not have to feed in public (Dykes et al 2003, Spear 2006).

The young mothers linked their breastfeeding success or failure to the amount of support they received from their families, particularly their mothers and partners, and from health professionals (Benson 1996, Dykes et al 2003, Nelson and Sethi 2005, Spear 2006, Ingram et al 2008, Noble-Carr and Bell 2012).

Emotional support, particularly from partners and female family members, helped young mothers feel encouraged and cared for (Nesbitt et al 2012). However, there was evidence to suggest that family members lacked the knowledge and skill to offer practical advice or help the young women overcome problems (Hall Smith et al 2012). Perhaps because of this, seeking help and advice from breastfeeding specialists was associated with longer breastfeeding duration (Brown et al 2011).

Support from health professionals was particularly important in the early postnatal period, when the teenagers were still in hospital and felt lonely and isolated (Dykes et al 2003, Hunter 2008, Grassley et al 2012). Friendly, proactive support at this time could have a significant impact on whether or not the young mother chose to continue to breastfeed, especially since teenagers were reluctant to use the buzzer system or ask for help from health professionals they did not know (Benson 1996, Dykes et al 2003, Price and Mitchell 2004, Peterson et al 2007, Grassley 2010). This suggests that, in addition to the mothers' wider cultural environment, the microenvironment of the postnatal ward also plays a significant role in determining breastfeeding behaviour. Overall, health professionals were seen to be pro-breastfeeding, but this made some young women feel under pressure to breastfeed when this was not the accepted norm in their communities (Condon et al 2012). However, there was a tendency among some health professionals to assume that young mothers would formula feed (Brown et al 2011, Condon et al 2012), and some young mothers who started breastfeeding were advised by health professionals to give their babies formula milk (Hall Smith et al 2012).

Teenagers who persisted with breastfeeding tended to feel that it made them closer to their babies (Lavender et al 2005, Nelson and Sethi, 2005, Wambach and Cohen 2009). They also found breastfeeding to be a positive experience overall, and expressed pride and increased self-esteem, especially when breastfeeding marked them out for special consideration and met with the approval of their peers (Lavender 2005, Nelson and Sethi 2005, Spear 2006). The young women believed that breastfeeding benefited their babies' health as

well as being convenient – particularly at night - and economical (Lavender et al 2005, Nelson and Sethi 2005, Spear 2006, Wambach and Cohen 2009).

Young mothers' breastfeeding support needs

It has become customary to divide the breastfeeding support needs of young breastfeeding mothers into five different domains: emotional, esteem, informational, instrumental, and network (Dykes et al 2003, Grassley 2010). These align with the three key elements of social support identified as being important for young people in the chapter three – the emotional support discussed there encompasses both emotional and esteem support, and instrumental support has likewise been subdivided here into instrumental and network support. In the specific area of breastfeeding support, young mothers described emotional support as being cared for by familiar faces who were non judgemental, patient and made the young mothers feel at ease – continuity of carer was especially valued in this respect (Benson 1996, Dykes et al 2003, Hunter 2008, Lavender 2005, Nelson and Sethi 2005). Esteem support involves plenty of praise and encouragement. This includes the encouragement of a satisfied baby – many young mothers were discouraged and stopped breastfeeding if their baby appeared not to like it or was unsettled (Dykes et al 2003). Esteem support aims to build confidence and self-efficacy, which is crucial to breastfeeding duration – teenagers who were still breastfeeding at four weeks postpartum were more confident about breastfeeding than those who stopped before this time (Mossman et al 2008). Emotional and esteem support have been identified as particularly important for young mothers, and to form a bedrock without which other aspects of support are unacceptable (Dykes et al 2003, Lavender 2005, Nelson and Sethi 2005, Brown et al 2011, Grassley 2010, Grassley et al 2012). This is perhaps because teenagers' levels of confidence and self-efficacy have been found to drop more markedly postnatally than those of older mothers, as they have not yet developed the internal resources to learn a new skill or adapt to a new situation without external affirmation, praise and encouragement (Bailey et al 2004, Nesbitt et al 2012, Noble-Carr and Bell 2012).

Informational support from health professionals has been identified as essential for young mothers in the early postnatal period, as their knowledge

base is generally very low (Hall Smith et al 2012). Young mothers themselves have identified a need for more guidance about managing breastfeeding in the early days, particularly in respect of knowing what to expect, how to tell if a baby is getting enough milk, anticipating and overcoming challenges and receiving reassurance that breastfeeding will get easier with time (Hunter 2008, Ingram et al 2008, Wambach and Cohen 2009, Grassley 2010, Condon et al 2012, Hall Smith et al 2012, Nesbitt et al 2012). Evidence also suggests that some young mothers who initiate breastfeeding hold erroneous beliefs such as that the benefits of breastfeeding are gained in the first few days and weeks, and go on to introduce supplements and solid food before the recommended age (Karp and Lutenbacher 2011, Condon et al 2012). Since many of these beliefs and practices emanate from the young mothers' families, it is suggested that including them in informational support is advisable (Grassley 2010).

Instrumental support involves practical help – the young women wanted health professionals to show them how to latch their babies onto the breast (not just do it for them), and to stay with them through the feed (Dykes et al 2003, Nelson and Sethi 2005, Spear 2006, Grassley 2010). Such support was highly valued in the early postnatal period and increased young mothers' knowledge, skills and confidence (Nesbitt et al 2012). Some young mothers, however, perceived that health professionals 'grabbed' their breasts, or gave instructions in a pushy, authoritarian manner which discouraged the young women from seeking further assistance (Dykes 2003, Noble-Carr and Bell 2012). Instrumental support also includes facilitating skin to skin contact and engaging the young mothers' significant others – Grassley et al (2012) found that although adolescents wanted both of these things, they were among the least experienced aspects of care.

Although studies found that help from a supportive significant other did not influence breastfeeding initiation, network support, as indicated above, has been found to influence breastfeeding duration among young mothers (Gaff-Smith 2004, Feldman-Winter and Shaikh 2007). Only women who came from supportive families with a strong tradition of breastfeeding appear to be able to breastfeed for any length of time (Benson 1996, Wambach and Cohen 2009).

Reasons given by young mothers for not continuing to breastfeed

Like their older counterparts, young women cited pain caused by sore or cracked nipples, and concern about perceived inadequate milk supply, as the principal reasons for early breastfeeding cessation (Benson 1996, Ineichen et al 1997, Hannon et al 2000, Greenwood and Littlejohn 2002, Shaw et al 2003, Lavender et al 2005, Spear 2006, Hunter 2008, Nelson 2009, The NHS Information Centre 2012). Young mothers were also worried about going back to school, did not like using a breast pump or found pumping too difficult once they had returned to school or work (Ineichen et al 1997, Hannon et al 2000, Spear 2006, Nelson 2009). However, one small American study found pump use was associated with significantly longer provision of breast milk (Hall Smith et al 2012). Young mothers who did not breastfeed for long were often unprepared for and unable to cope with physical changes, such as their milk coming in, did not receive enough support on the postnatal ward and found breastfeeding draining and tiring (Arthur et al 2007, Greenwood and Littlejohn 2002, Hannon et al 2000, Quinlivan et al 2003, Shaw et al 2003, Spear 2006). Some were given inaccurate or confusing advice by health workers (Benson 1996, Hunter 2008, Wambach and Cohen 2009).

Young women also gave their partner not liking breastfeeding as a reason for stopping (Quinlivan et al 2003), and there is some evidence that a dislike of being tied to their baby and a consequent lack of freedom to socialize (also cited as reasons for not starting to breastfeed) sometimes contributed to the decision to switch to formula milk (Quinlivan et al 2003, Lavender et al 2005).

Implications for practice

Current knowledge of young mothers' breastfeeding experiences and support needs underlines the importance of the wider culture and context of young mothers' lives and also the microenvironment of the postnatal ward in determining infant feeding behaviour. In particular, the literature suggests that appropriate professional support in the early postnatal period is vital, but the environment of the postnatal ward, where many feel watched and judged, is not conducive to breastfeeding success (Benson 1996, Dykes et al 2003, Denis et al 2011, Hall Smith et al 2012). Young mothers can feel under-confident and

unsupported, and need proactive, practical help while they are learning how to breastfeed – many stop breastfeeding due to an inability to latch their babies correctly, the subsequent pain and discomfort this causes, and a perception that their baby is not getting sufficient milk (Dykes et al 2003). This review highlights the need for breastfeeding support for young mothers to be embedded within a relational approach to care that incorporates emotional and esteem support. This includes an ability on the part of carers to initiate supportive relationships with young mothers that build confidence and self-efficacy with regard to breastfeeding (Joffe and Radius 1987, Pierre et al 1999, Bailey et al 2008, Mossman et al 2008, Grassley 2010). Moreover, the literature also suggests a need for carers to acknowledge that teenagers' mothers, partners, families and friends are important sources of breastfeeding support (Benson 1996, Nelson and Sethi 2005, Spear 2006). A relational approach should therefore include providing these significant others with enough knowledge to enable them to play a supportive role, and facilitating young mothers' access to social groups where they can breastfeed without feeling watched and judged.

Health Professionals' views of teenage mothers and breastfeeding

Only two studies were found specifically investigating health professionals' views of teenage mothers and breastfeeding (see Table 5.2 below), and yet the widespread societal condemnation of young mothers described in chapter three could, if shared by health professionals, impact on the breastfeeding support young mothers receive. The study by Shaw et al (2003) is included here as well as in the discussion on teenage mothers' breastfeeding experiences because it contains data from health professionals as well as from young mothers. A further two studies were found that addressed health professionals' attitudes to teenage mothers in general, but did not mention breastfeeding (Shakespeare 2004 – phenomenological interviews with six UK community midwives – and Breheny and Stephens 2007 – interviews with 17 New Zealand health professionals). These studies are included in the discussion because they illuminate attitudes that could potentially impact on breastfeeding support.

Table 5.2. Studies addressing health professionals' views of teenage mothers and breastfeeding

Study/ Location	Study population	Number in sample	Method	Focus
Shaw et al 2003 UK	Primiparous teenage mothers, 16-21 years old Health professionals	11 teens, 15 health professionals	Semi –structured interviews with teens – antenatally at 34-36 weeks, and at 6 and 17 weeks postnatally. Focus groups with health professionals	Investigates factors influencing teenagers' feeding decisions
Spear 2004 US	Maternal Child Nurses	151	Questionnaires	The promotion of breastfeeding among teenage mothers

Health professionals in both of the studies specifically addressing breastfeeding believed that teenage mothers were uncomfortable with their bodies and were not necessarily mature enough to commit to breastfeeding. Similarly, the participants in Breheny and Stephens' study also believed that the developmental characteristics of adolescence could preclude young women acquiring the skills to become 'good' mothers. In Shaw et al's UK study, which included midwives, health visitors and a community nurse, this belief takes on a pejorative tone, particularly in towards low-income, white teenage mothers:

'They don't even put the effort in to wash the dishes never mind breastfeed'

(Shaw et al 2003 p 301).

This judgemental attitude is challenged in Shakespeare's 2004 interviews with UK community midwives, who were more sympathetic towards teenage mothers and believed they could be very successful given the right support. Spear's 2004 study also describes a strong belief that young mothers are capable of breastfeeding and should be encouraged to do so.

In addition to maturity levels, the breastfeeding studies revealed a belief on the part of health professionals that breastfeeding could be challenging or unattractive to young mothers because they generally hailed from communities where formula milk feeding was regarded as the normal, acceptable way to feed

a baby. This was felt to result in teenage mothers not knowing a great deal about breastfeeding. Furthermore, almost half of the American nurses in Spear's study were either uncertain, or believed that the breastmilk produced by teenage mothers was quantitatively different from that produced by adult mothers, and a quarter of the sample revealed that they themselves were uncomfortable observing breastfeeding in public (Spear 2004). All these beliefs are likely to make health professionals reticent about giving breastfeeding support to young (or sometimes indeed any) mothers.

Overall, the limited literature on health professionals' views of teenage mothers appears to expose two conflicting discourses: the view largely disseminated by the media, particularly here in the UK, that portrays young mothers as feckless adolescents and frames teenage pregnancy in negative terms; and an alternative view, perhaps more often (but by no means always) held by people with more experience of working with young mothers, that teenage parents are potentially vulnerable people who can be successful parents given the right support (Shakespeare 2004). Interestingly, developmental arguments are used to justify both points of view. However, the limited data available indicates that further research into health professionals' attitudes is warranted.

Interventions to improve teenage breastfeeding rates or duration

Nine studies were found evaluating interventions designed to increase teenage breastfeeding initiation and duration rates. These are summarised in Table 5.3 below. Only one of the studies was conducted in the UK (Lavender et al 2005). Two studies trial antenatal interventions, one targets the intrapartum period, four use comprehensive packages of ante and postnatal support and two look at the effects of a postnatal intervention. The sample sizes, methods, interventions and outcomes of each trial are described in Table 5.3.

Table 5.3. Studies looking at interventions aimed at improving teenage breastfeeding rates

Study/ location	Sample	Intervention	Design	Findings	Methodological limitations
Hartley and O'Connor 1996 USA	90 pre-test and 90 post-test mother/infant pairs	Educational programme: at each antenatal visit, mother asked 'What do you know about breastfeeding?' Acknowledgment and targeted education of concerns Checklist in notes to ensure relevant topics covered	Pre and post intervention evaluation No user involvement	Tripling of breastfeeding rate at hospital discharge among teenagers (2/18 – 10/27) Rate doubled for population overall	Groups not concurrent
Pobocik et al 2000 US territory of Guam	244 intervention and 163 comparison pregnant teenagers	Education and support programme: 8 nutrition-based classes (3 on breastfeeding) using visual images, learning activities, peer role models, and held monthly or bimonthly Home visits or phone calls after birth if desired	Teenagers assigned to intervention/usual care (non-random) Teen focus groups commented on proposed intervention	Teenagers receiving intervention Significantly more likely to initiate breastfeeding (77.9% vs 66.3%) and significantly more likely to breastfeed at 2 months	Not all intervention group received all lessons No information on uptake of postnatal support Control group received different levels of breastfeeding education Demographic differences between groups
Volpe and Bear 2000 USA	91 pregnant teenagers	Education and support programme: 3 bf classes delivered by lactation consultant plus ongoing peer counsellor support including visit in hospital after birth, postnatal phone calls and 1-to-1 support Family members encouraged to attend class and included in educational sessions in hospital	Teenagers received intervention in a specific school year (previous year group used for comparison)	Teenagers receiving intervention more likely to initiate breastfeeding (65.1% v 14.6%) – no information on breastfeeding duration	Uses same teacher and classroom for both groups, but neither random nor concurrent Aim to evaluate education provided by lactation consultant, but addition of peer counsellor makes it impossible to determine how much of result attributable to which aspect of care
Quinlivan et al 2003 Australia	139 pregnant teenagers	5 structured postnatal visits by nurse midwives	Randomised controlled trial	No significant increase in breastfeeding knowledge or initiation	Aims to measure effect on breastfeeding knowledge and initiation, but intervention does not start until 2 weeks postnatally
Grady and Bloom 2004 USA	124 teenage mothers	Group education and support programme with peer supporter Family members involved	Retrospective evaluation	Breastfeeding initiation rates rose from 28% to 46%	Retrospective evaluation of non-concurrent groups

Study/ location	Sample	Intervention	Design	Findings	Methodological limitations
Lavender et al 2005 UK	60 teenagers intending to breastfeed or uncertain about feeding choice	Breastfeeding guardian provided comprehensive package of education and support, introducing teenagers to other young breastfeeding mothers involving family members, visiting teenagers within a couple of hours of birth, and providing ongoing postnatal contact	Pre and post intervention evaluation Teens asked to complete questionnaire and diary detailing breastfeeding experiences	Pre intervention, 43% of those planning to bf initiated bf, and 57% of those initiating bf were still bf on discharge from hospital Post intervention, 63% of those intending to bf or uncertain initiated bf. 79% still bf on hospital discharge	No information on how many eligible women were contacted Only ½ completed questionnaire and 1/3 completed diary Comparison group from local audit in 1997 – time lag between this and intervention unknown
Di Meglio et al 2010 Canada	46 teenage mothers	Postnatal telephone support at specified intervals from trained peer supporters for 5 weeks	Randomised controlled trial	No significant increase in overall breastfeeding duration Increase in exclusive breastfeeding duration	Small sample size Inconsistent application of intervention Difficulties encountered retaining peer supporters
Grassley and Sauls 2012 USA	106 intrapartum and postnatal teenagers	Age-appropriate intrapartum care given by specially trained nursing staff - included resourcefulness, skin to skin contact and initiating breastfeeding within an hour of giving birth	Quasi-experimental post– test of separate, non-concurrent samples	Intervention group more satisfied with childbirth experience and more likely to initiate breastfeeding within 1 hour Non-significant increase in breastfeeding rates at discharge from hospital, 6 weeks and 3 months	Demographic differences between groups Non-concurrent groups (although care given by same nurses) No information on fidelity to support protocol 23% attrition rate
Wambach et al 2011 USA	289 pregnant, predominantly African-American teenagers.	2 antenatal breastfeeding classes facilitated by peer counsellor and lactation consultant Phone call from peer counsellor before and after class 1, and after class 2 In-hospital visit from peer counsellor In-hospital visit from lactation consultant if considering or actually breastfeeding Phone call from lactation consultant or peer counsellor at 4, 7, 11, 18 days and 4 weeks postnatally	Randomised controlled trial with 2 control groups: - usual care - attention group receiving equivalent amount and timing of content, but not breastfeeding-specific	Positively influenced breastfeeding duration No significant increase in breastfeeding initiation or exclusive breastfeeding	Age of peer supporter not stated (although she had been a teenage mother) Cannot isolate successful component(s) of package

Antenatal interventions

Two American studies (Hartley and O'Connor 1996, Grady and Bloom 2004) specifically target the antenatal period, using one-to-one breastfeeding education at antenatal appointments or a programme of group education. Both use retrospective analysis of records from periods immediately before and after the intervention to calculate its effect. Although there are some problems with this approach, as we do not know what other factors may have altered between the pre and post test periods that may have affected the results, both studies report an impressive rise in breastfeeding initiation rates, which may lead to the conclusion that postnatal support is not necessary (Grady and Bloom 2004, Hartley and O'Connor 1996). However, it is interesting to note that in Hartley and O'Connor's study a package of postnatal breastfeeding support was already available in the study location before the antenatal intervention was introduced: lactation specialists were on hand in the hospital and phoned all breastfeeding mothers at home after discharge to answer their questions. All low-income breastfeeding mothers (the study population) received a home visit within 72 hours of discharge (Hartley and O'Connor 1996). Without the antenatal input, however, this postnatal support had little impact – perhaps because before the intervention women were unaware of the support available.

Intrapartum interventions

Only one study, from America (Grassley and Sauls 2012), was identified in this category. The authors developed a training package for intrapartum nurses in America, which included age-specific caring strategies and a checklist of behaviours supportive of initiating breastfeeding, such as skin to skin contact and breastfeeding within an hour of birth. Their aim was to teach nurses research-based strategies to enable young mothers to draw upon their own coping resources during birth and while initiating breastfeeding. The nurses cared for a group of adolescents before they received the training, and another group once they had been trained. Adolescents cared for by a nurse who had received the training were moderately more satisfied with their childbirth experience and more likely to initiate breastfeeding within an hour of birth (Grassley and Sauls 2012). However, although breastfeeding rates in the post-training group were higher at hospital discharge, six weeks and six months postnatally, these increases did not

reach statistical significance. Additionally, the use of non-concurrent groups means that the increase may not be directly attributable to the training. Although the nurses were asked to complete a checklist of the strategies they used, we are not told how completely the package was implemented, or which support behaviours were used most widely.

Combined ante- and postnatal interventions

Four studies - Pobocik et al (2000), Volpe and Bear (2000), Lavender et al (2005), and Wambach et al (2011) - trialled comprehensive packages of antenatal education and postnatal support. Apart from the British trial by Lavender et al (2005), they were all conducted in the US. As well as delivering an education package, three of the studies provided a support person over the ante and postnatal periods who got to know the young women, and their families in two of the trials, and provided both with information and support (Volpe and Bear 2000, Lavender et al 2005, Wambach et al 2011). Although Wambach et al (2011) did not specifically target families, the participants were encouraged to bring a support person along to the antenatal classes. In these three trials, the support person either provided one to one help in hospital and could be contacted by phone at any time (Volpe and Bear 2000, Lavender et al 2005), or initiated phone contact at specific time points (Wambach et al 2011). This intense personal support was well-evaluated by the young mothers, but impacted on the personal lives of the providers (Lavender et al 2005). It is not known whether the postnatal support in the remaining trial was delivered by a known supporter (Pobocik et al 2000). Three of the studies report a substantial increase in breastfeeding initiation (Pobocik et al 2000, Volpe and Bear 2000, Lavender et al 2005). Wambach et al (2011) report a non-significant rise in breastfeeding initiation in the intervention group, but a statistically significant increase in breastfeeding duration. However, the comprehensive nature of the interventions makes it impossible to determine which aspects of the support were successful (Hall Moran et al 2007). Lavender et al and Volpe and Bear both used non-concurrent comparison groups, so once again it is impossible to rule out other changes in the time between the control and intervention groups that could have influenced the results. Although the intervention and comparison groups in Pobocik et al's trial were concurrent, there are other methodological limitations

with this trial – particularly the different demographic characteristics of the two groups and the inconsistent application of the intervention – that may bias the results. Nevertheless, it would appear that teenagers are receptive to education and support across the ante- and postnatal periods, particularly when it is provided by a known carer.

Postnatal interventions

The two studies focussing on the postnatal period tested interventions in randomised controlled trials, widely acknowledged as the gold standard for proving the effectiveness of an intervention (Donnan 2000). Quinlivan et al (2003) trialled an intervention comprising five structured postnatal visits by nurse midwives which aimed to reduce the occurrence of adverse neonatal outcomes and improve knowledge of breastfeeding, contraception and infant vaccination schedules. They also included breastfeeding initiation and continuation rates in their outcome measures. None of breastfeeding outcomes increased in the intervention group, probably because the trial was not designed specifically to improve breastfeeding rates, and did not in fact start until one week postnatally. Much of the nurses' time was spent teaching young mothers how to formula milk feed (Quinlivan et al 2003).

Di Meglio et al (2010) measured the effect of telephone peer support at specified intervals for five weeks postnatally on any and exclusive breastfeeding duration. 15 young mothers who had breastfed went on a peer support training programme, and 22 new mothers were randomised to receive telephone peer support from them following discharge from hospital. There were 24 controls (Di Meglio et al 2010). No effect was found on the primary outcome of any breastfeeding duration, but exclusive breastfeeding duration (the secondary outcome) was found to increase in the intervention group. There are some methodological problems with this trial. Only five of the 15 peer supporters completed their training, and only one remained involved for the duration of the project. This was despite significant time and effort on the part of the Principal Investigator, who provided intensive support to the trainees throughout the study. The authors conclude that

‘unless better methods are developed for retaining peers, this is likely to be a labour-intensive approach to extending exclusive breastfeeding among adolescent mothers’

(Di Meglio et al 2010, p 41).

Furthermore, some of the supporters did not make all the necessary calls, and many disliked cold calling (Di Meglio et al 2010). The researchers acknowledge that telephone peer support for breastfeeding women was found to be ineffective in a Cochrane meta-analysis (Britton et al 2007 – this report has since been updated (Renfrew et al 2012), but the same conclusion is reached), but chose this method as the costs and logistics of transporting supporters to young mothers’ homes and hospital beds were prohibitive. They reflect that a social networking site such as Facebook may have been a more appropriate medium through which to deliver support (Di Meglio et al 2010). Perhaps because this trial focuses on breastfeeding duration, rather than initiation, the intervention does not start until after the young women leave hospital, even though it is known that many young women will stop breastfeeding before hospital discharge (Hunter 2008, Mossman et al 2008).

Implications for practice

The interventions trialled to date to improve teenage breastfeeding initiation rates suggest that education and support targeted at this vulnerable group can yield results. However, although the intervention studies use reasonable sample sizes, many use non-concurrent comparison groups and there are problems with compliance rates and responses. Additionally, the complex nature of the interventions makes these studies very difficult to replicate.

Future research into interventions that support breastfeeding teenagers could pick out aspects of the support that were perceived to be particularly successful in the trials discussed above. For example, the inclusion of a peer supporter, particularly if they offered continuity of carer over the ante and postnatal periods, was well received by the teenagers (Grady and Bloom 2004, Volpe and Bear 2000). Interventions using peer support need to be mindful of the

challenges of working with young mothers, however (Di Meglio et al 2010). There is evidence that a known supporter of any age is acceptable and effective (Lavender et al 2005). There is also evidence that the 'significant others' around the teen (usually her partner and mother) can have an impact on the length of time she continues to breastfeed and, if they are supportive of her feeding choice, are often a major source of support (Grady and Bloom 2004, Lavender et al 2005, Volpe and Bear 2000). However, significant others often lack knowledge about breastfeeding and value education and support (Lavender 2005, Volpe and Bear 2000), which suggests that either they need to receive training or that their support needs to be supplemented with advice and guidance from breastfeeding experts. Additionally, Volpe and Bear (2000), Lavender et al (2005) and Wambach et al (2011) all offer proactive breastfeeding support in hospital in the early postnatal period in their packages. Support in the early postnatal period also emerged as an important theme in the studies of adolescent breastfeeding experiences discussed above. Moreover, the failure of the Quinlivan trial, offering targeted support a week after birth, to impact on breastfeeding rates, indicates that implementing support sooner than this may be a crucial factor in improving breastfeeding initiation rates among teenagers (Quinlivan et al 2003).

Conclusion and implications for future research

Studies of teenagers' experiences of breastfeeding indicate that these reflect the interplay between their environment and their unique developmental situation as adolescents. While in hospital they feel watched and judged, and indeed the limited evidence available does suggest that not all health professionals have positive views about teenage mothers and breastfeeding. Furthermore, many young mothers are unwilling to breastfeed in public, or even in front of family members, for fear of drawing attention to themselves. This heightened sense of visibility while breastfeeding in communities where this is not the norm makes it difficult for breastfeeding mothers to spend time with their peers – hence the importance of breastfeeding peer and support groups.

This review has highlighted the importance of a relational approach to breastfeeding support for young mothers in the early postnatal period. To date,

trials of interventions to support young mothers to breastfeed have not looked specifically at this time. Additionally, while the evidence suggests that support interventions can improve breastfeeding rates and duration among young mothers, the complex support needs of this demographic make it very difficult to quantify which components of a given intervention are having a positive impact. This suggests that alternative evaluation methods to the traditional pre/post test and randomised controlled trial need to be explored.

The importance of early support to young mothers, and the fact that many young women who intend to breastfeed either stop before they are discharged from hospital or never put their babies to the breast, constitute a strong argument for further research in this area. In particular, there is a need to discover more about the provision of relational support on the postnatal ward, both from the point of view of young mothers and the health workers looking after them. The primary research undertaken in phase one of this study therefore set out to elicit the views and experiences of health professionals and young mothers with respect to breastfeeding support for young women on the postnatal ward. Identifying the barriers to young women breastfeeding in hospital and gaining a clearer picture of the proactive support young mothers appreciate enabled a targeted breastfeeding support intervention to be developed. The next chapter outlines the aims and objectives of this research in more detail, and discusses the philosophical underpinnings and methodology employed to undertake this investigation.

Chapter six

Research Design – Phase One

Introduction

An enquiry into the early infant feeding experiences of young mothers, the barriers to their initiating breastfeeding, and support measures that may have helped them overcome these forms the primary research element of phase one of this study. The research was designed to help answer stage one of the realist evaluation framework - 'what is happening now and why' - by generating reflection and discussion among maternity professionals, through an e-questionnaire, and young mothers, via focus groups and interviews. The participants' views on support measures that might have led to more young mothers breastfeeding were sought in order to inform phase two of the study: the development and implementation of a support intervention package. The aims and objectives of this investigation are outlined below. The philosophical framework underpinning this section of the project is then discussed, and the research methods are presented and justified.

Phase One Aims and Objectives

Aims

- To understand how teenage mothers' experiences in hospital prevent many of them from initiating breastfeeding successfully.
- To ascertain support measures that might enable more young women to breastfeed.

Objectives

- To seek out the opinions of health professionals involved in the care of young women regarding current barriers to breastfeeding and how young mothers could best be supported to initiate breastfeeding.
- To ask young mothers to describe and reflect on their experiences in hospital after giving birth, particularly in relation to feeding their babies.

- To ascertain the views of a group of teenage mothers about support measures that either helped or would have helped them to breastfeed successfully in hospital.

Philosophical framework

As this investigation seeks to understand the lived experiences of a specific population (newly-delivered teenage mothers), a qualitative approach is clearly appropriate (Bowling 2002). Using texts, observations or interviews, a qualitative researcher

‘constructs a picture that draws from, reassembles and renders’
subjects lives’

(Charmaz 2000, p 521).

In the current study, this is placed within a constructivist perspective that acknowledges the pluralistic and changing nature of reality and the confining/defining power of language (Miles and Huberman 1994, Charmaz 2000, Schwandt 2000). Essentially, constructivists view reality as something that is constructed by humans, who use language to put forward concepts, models and schemes to make sense of experience, and modify these constructions or meanings in the light of new experience (Schwandt 2000). An individual’s understanding is therefore limited by the words and concepts available to them within their particular culture, and may develop and change as new words and concepts become available through intercultural and intracultural exchanges. The constructivist outlook is highly compatible with a realist approach that seeks to understand how interventions operate in the contexts in which they are placed, as different individuals’ understandings of the actions performed in a particular environment are central to this process. The qualitative approach and constructivist perspective employed in this primary investigation influenced the choice of research participants, the extent to which the findings were seen as a ‘true’ rendition of the research subjects’ lives, and the steps taken to reduce or expose the influence of the researcher on the findings. These issues are discussed below.

Choice of research participants

The current project presupposed that knowledge about teenage mothers' experiences would best be gained by speaking to teenage mothers themselves. Seeking the views of teenage mothers is consistent with a philosophy aiming to shape the health and social care system around the needs of patients, where those needs are expressed by the patients themselves and not by a distant 'expert' (Maslin-Prothero 2003, Beresford 2007, Lindenmeyer et al 2007). Such user involvement has many advantages, including an increased likelihood that the project will address the needs and priorities of the intended beneficiaries of the research, use methods that are acceptable to the participants, take into account potential barriers to communication and participation and understand and connect with the 'real world' in which the research will be applied (Beresford 2007, Lindenmeyer et al 2007, Smith et al 2008, BIG Lottery Fund 2009). However, in the current project the views of the maternity professionals who would be implementing the intervention were also investigated. Incorporating practitioner views is considered an important aspect of realist investigations (Pawson and Tilley 1997), and maternity professionals were considered uniquely suited to identifying any structural and cultural aspects of the health service that might prevent young mothers receiving adequate support, as well as being able to contribute support ideas that would be appropriate to the clinical context (Pearson et al 2005). Additionally, eliciting the views of both users and providers enabled a more complete picture of current barriers to providing effective support, and possible solutions to them, to be formed. It was not anticipated that the views of the health workers would 'prove' the authenticity of the young mothers' accounts, or vice versa, but that having the two perspectives would aid interpretation and add breadth and richness to the enquiry (Bloor et al 2001, Silverman 2006).

Truth and constructivism

Within qualitative thought, there are different views of the extent to which research results reflect the actual experiences being studied. This reflects different views of the nature of reality, understanding or truth. Some qualitative

researchers subscribe to the positivist view of objective, external, unchanging truth (Silverman 2006), while others accept a postmodernist fragmentation of truth into local, historically bound narratives (Alvesson and Skoldberg 2000). From a constructivist standpoint, meaning and understanding (or one's perception of reality) are not stable, but changing, and there can be multiple equally correct and valid interpretations of an event or experience, depending on the constructs within which it is explored and described (Schwandt 2000, Porter 2007). Research participants' interpretations of their experiences could evolve and develop as they discuss these experiences with others during the course of the research, especially when, as during the current project, interactive methods such as focus groups are used. Whether or not one wishes to claim that the results represent a fixed and immutable truth is, in the end, irrelevant – the truth that matters is the one that is rendered by the subjects of the research. The aim of qualitative research is to try and understand what research participants define as real and where their definitions of reality take them (Charmaz 2000). The findings that are presented in the current study are those offered by the participants at the time the study took place. They may since have developed or modified their ideas, just as other participants at different times or in different places may have had other ideas to contribute. That does not render the results invalid. They are a contribution to a debate, and as such may modify understandings that have gone before and will be modified by what follows.

Reflexivity and the influence of the researcher on findings

Constructivism acknowledges that, just as research participants' accounts are constrained by the language available to them and rooted in their previous experience and cultural norms, the researcher in receipt of these accounts must use their own linguistic heritage, formed from their own culture and experience, in order to understand and interpret them. Charmaz (2000) notes that in the interaction between researcher and researched, categories and concepts are created as differing inherited narratives collide. Meanings are inevitably interpreted both by the researcher and the participant, and data is generated as a result of interaction between the two (Charmaz 2000, Miles and Huberman 2004).

If one accepts that a researcher inevitably imposes their own meaning on participants' stories and experiences, and that the aim of qualitative research is to render aspects of other peoples' lives, then it is important to ensure the results presented are as close as possible to the participants' reality, and not merely the researchers' understanding imposed upon the data. In a constructivist context, this will involve the researcher allowing the participants' accounts to challenge and change their own pre-existing ideas, and using strategies to ensure that the participants' voices always have centre stage and are presented as completely and accurately as possible. Rather than attempting, as a positivist researcher might, to put one's personal views and experiences to one side, constructivist researchers argue that it is through engaging with research data that one comes to understand it, but that in the process one is inevitably changed – Schwandt (2000) describes this as a growth in inner awareness. Constructivism recognizes that, far from being a neutral observer, the researcher is part of the dialogue and the means through which the results of the dialogue are presented to the reader (Charmaz 2000, McGhee et al 2007). The researcher is not, however, a neutral conduit but a being conditioned by his or her own heritage and experiences – a conditioned self.

The concept of reflexivity has been proposed to expose the interface between researcher and researched, and encourage researchers to be open and honest about the influence they have on their data (Alvesson and Skoldberg 2000). A reflexive researcher uses self awareness to limit the extent to which their particular world view and preconceptions dominate or distort the research (Patton 2002, McGhee et al 2007). Reflexivity requires both researcher exposure, in respect of their preconceptions and worldview being made as explicit as possible, and that steps are taken to ensure that the respondents' views are fully considered. The current study has attempted to achieve the former requirement by presenting a brief biography of the researcher (presented in the foreword to this thesis), and by undertaking a detailed literature review outlining relevant prior work which will influence the perspective and direction of the project (McGhee et al 2007). This discussion of the philosophical background to the project is a further exposition of the researcher's perspective.

Reflexivity was further enhanced in the current project by the use of concurrent and retrospective member checking during data collection. This ensured that the researcher had captured participants' meanings as accurately as possible. Additionally, in the presentation of the findings verbatim quotations are widely used so that the participants' voices are heard. The researcher's voice is included in some quotations so that her participation in the meaning-making process is visible. Data analysis was undertaken inductively using content analysis (discussed further below), to ensure that the themes identified reflected the concepts and ideas expressed by those taking part.

Research Methods

A questionnaire was developed to ascertain the views of health workers about barriers to teenage mothers breastfeeding successfully in hospital and support measures that might enable them to breastfeed successfully. Questionnaires were chosen in order to enable as many maternity professionals as possible to respond both from the Trust in which phase two of the research was carried out and nationally. It was felt that a national perspective would increase the validity of the findings. In order to capture a broad range of views and experiences, and in the hope of overcoming the low response rates often associated with postal surveys (Hicks 1996), the questionnaire was distributed electronically. E-questionnaires can be easy to access, convenient to respond to and anonymous (Brindle et al 2005, Douglas et al 2005, Jones et al 2008a, Katz et al 2008, Sue and Ritter 2007). For the researcher, electronic responses also have the advantages of speed and accuracy (data received electronically does not need to be entered onto a spreadsheet or analysed manually) (Jones et al 2008, Sue and Ritter 2007).

The views of the teenage mothers themselves were sought via focus groups. A focus group consists of a group of individuals specifically convened to explore a clearly defined topic through a discussion facilitated by a moderator using open-ended questions and prompts (Kitzinger 1994, Leung and Savithiri 2009). The defining characteristic of a focus group is considered to be the promotion and use of group interaction to both create and expose meaning

(Kitzinger 1994, Webb 2002, Gray 2009). Focus groups have been identified as an invaluable method of eliciting the views and experiences of patients and caregivers on aspects of healthcare provision and identifying gaps in services (Owen 2001). They can also be used to generate suggestions for improving services and to involve users in the process of reform (Bloor et al 2001, Owen 2001, Curtis and Redmond 2009). As such they are ideally suited to the current project. Furthermore, they can be particularly suited to eliciting the voices and opinions of marginalised groups, such as teenage mothers (Kitzinger 1994, Bloor et al 2001). This is partly due to the fact that group discussion can enable participants to become aware of and articulate the reasoning behind their beliefs and opinions (or group or cultural norms) – a process that Bloor et al (2001, p6) describe as 'retrospective introspection'. Additionally, the group format allows individuals to explore and clarify their views without feeling exposed and 'put on the spot' as they might in an individual interview (Madriz 2000). Ultimately, focus groups enable participants to formulate and contribute their own ideas in their own language – thereby facilitating communication and understanding between the researcher and the researched, making them an ideal tool for constructivist investigations (Kitzinger 1994, Serrant-Green 2007).

Sampling

Purposive sampling was used to invite relevant experts to participate in the research. It was considered that health professionals involved in the care of pregnant teenagers and young mothers, and teenage mothers who had given birth in the last 6 months and who had considered breastfeeding, would be best placed to comment on aspects of postnatal hospital care that either helped or hindered the initiation of breastfeeding.

There are no recommended sample sizes for qualitative research (Punch 2006). It was considered that, as the responses to the e-questionnaire were likely to contain less depth than data gathered during a focus group or interview, a larger number of responses would be needed for the former. Patton (2002) notes that less depth from a larger number of people can be especially helpful in exploring a phenomenon. Quantifying a 'larger number' in advance was little more than a guess, but, based on received knowledge from quantitative surveys

that 30 responses are needed for even the most elementary analysis (Walliman 2005), the target sample size for health professionals was put at 50. It was estimated that this would both produce a large enough body of credible information and be contained enough for a lone researcher to analyse. As the data from the focus groups would be more detailed and complex, a target of three groups of five-eight participants each was set for this stage of the project. Six-ten participants is often quoted as the optimal number for a focus group (Mansell et al 2004, Howatson-Jones 2007, Curtis and Redmond 2009), although many studies use fewer participants (Dykes et al 2003 and Forster et al 2008 for example). It is argued that it may be difficult to get participants to interact in groups that are too small, whereas large groups can disintegrate into sub sets or leave participants feeling frustrated that they have not been able to be heard (Bloor et al 2001, Marlowe 2008). Many projects seem to struggle to recruit sufficient members to focus groups, and many researchers therefore over-recruit to compensate for the fact that not everyone is likely to turn up (Owen 2001, Mansell et al 2004). The current project aimed to invite up to 12 young mothers to each group in the sure and certain knowledge that not everyone would attend.

The e-questionnaire was sent via e-mail to two groups: 159 NHS staff (134 midwives and 25 maternity support workers (MSWs)) working for a Trust in Oxfordshire, England, and the 91 members of the national Teenage Pregnancy Midwives' Online Forum. This is a national forum for health professionals (principally midwives but also including MSWs and health visitors) involved in the care of pregnant and parenting teenagers in the UK. It is run by the National Teenage Pregnancy Midwifery Network, which is funded by the Teenage Pregnancy Unit (part of the Department for Education).

Teenage mothers attending young parent groups in five locations in Oxfordshire were approached and invited to participate in focus groups. Although generally considered to be a prosperous area, Oxfordshire has significant pockets of social deprivation, with its city ranked 131/354 in the English Index of Multiple Deprivation 2010, placing it in the top half most deprived local authority areas in England (Oxford City Council n.d). The young parent groups from which the participants were drawn were all based in deprived areas. A mix of rural and

city groups were targeted to ensure that a variety of experiences and opinions were canvassed. Geographic location was limited to Oxfordshire as the final intervention would be trialled in an Oxfordshire hospital, and so that the researcher could reach the groups. The focus groups were arranged at a time and venue convenient to potential participants (generally the usual young parent group venue and time).

Ethical Considerations

Ethical approval for the project was obtained from the University of West London and from the NHS National Research Ethics Service (Oxfordshire Research Ethics Committee C).

A covering letter was distributed with the link to the e-questionnaire, clearly outlining the purpose of the project and inviting potential respondents to contact the researcher with any questions or concerns (see Appendix 6.1). This has been identified as good practice when mailing e-surveys (Sue and Ritter 2007). The letter also gave details of research sponsorship and ethical approval. Potential respondents were assured that their contributions would be anonymous and that they would not be asked for their name or contact details. They were offered the opportunity to request a copy of the results under separate cover. Informed consent was then presumed if people chose to complete and return the questionnaire. The first page of the questionnaire reiterated the purpose of the survey, gave a further assurance of anonymity and clearly stated that there were four demographic and four survey questions to complete. Access to completed questionnaires was password protected.

Target respondents to the questionnaire were professionals used to accessing and using computers and communicating via e-mail in their working lives. It was therefore considered very unlikely that distributing the questionnaires electronically would exclude anyone who was eligible from taking part. However, as it has been suggested that some potential respondents to e-questionnaires may find using the technology challenging (Jones et al 2008), the covering letter gave the researcher's contact details and invited potential respondents to contact

her with any questions or problems accessing the survey, or if they would prefer to complete the survey by phone. In order not to exclude potential participants in Oxfordshire without access to the staff intranet, posters were displayed in maternity staff rooms in the largest hospital in the participating NHS Trust, inviting people to take part in the research either online or by phone. An article was also placed in a local newsletter for maternity staff. It was not anticipated that respondents would suffer any harm as a result of taking part in the survey, or that reading and writing English would be a problem for the target respondents.

When recruiting for and organising the focus groups, consideration was given to the fact that a marginalised and vulnerable group was being targeted, and potential participants may find it difficult to vocalise their questions and concerns. Principles of ethical and effective user involvement developed by Telford et al (2004) and Beresford (2007) for use with marginalised groups, such as an inclusive approach and the building of confidence and self-esteem, were followed. These are outlined in Appendix 6.2. Facilitators of young parent groups around Oxfordshire were contacted by phone and given information about the research. Further information was sent by e-mail. The facilitators then took the proposal to their groups, giving the group the opportunity to question someone they knew and decline to meet the researcher. If the group was happy to consider taking part, a date was arranged for the researcher to visit in order to give more verbal and written information, answer questions, and invite people to participate. The written information consisted of a booklet with an easily digestible 'at a glance' summary of the research project, followed by more detailed explanations (see Appendix 6.3). Madriz (2000) writes of the need to recruit women from marginalised groups face to face, and it was hoped that meeting the researcher would help potential participants feel more at ease with her and thereby encourage attendance (Owen 2001, Howatson-Jones 2007). It was made clear to potential participants that they had the right not to take part or to withdraw at any time, and this decision would not compromise their future care (Jackson and Furnham 2000, Matthews 2006). At the end of this meeting, a date convenient for the potential participants was set for the researcher to return and conduct the focus group. The researcher's contact details were provided in case individuals had any questions or concerns following the meeting. The focus group was

always held at least a week after the initial meeting with the researcher, and written consent was not asked for until participants arrived for the focus group, to give people the opportunity to read and discuss the proposal. Participants were individually offered help reading consent forms, to ensure that low literacy levels or poor eyesight were not barriers to taking part. The consent forms are included in Appendix 6.4.

Rather than using reminder letters or phone calls, a decision was taken to contact potential participants by text on the day before the focus group to confirm the arrangements. In the researcher's experience, teenagers respond well to this method of communication, and it gives them the opportunity to text back if they have any last minute questions or concerns. Potential participants who expressed an interest in attending were asked for their mobile numbers at the initial meeting with the researcher. Dyas et al (2009) suggest that participants may be more likely to attend the focus group if a topic-related non-financial incentive is incorporated into the session, such as a consultation of some kind. The group facilitators were therefore asked whether there were any activities they believed would complement the focus group that could be offered after the session, but no suggestions were received. Reimbursement of travel costs and lunch were also offered.

It was considered very unlikely that any harm would come from participating in a focus group, but potential participants were warned that taking part might trigger memories of unhappy experiences of their maternity care. The NHS National Research Ethics Service committee who reviewed the proposal stated that it was not necessary to inform GPs or health visitors of participants' involvement. Participants were invited to contact their community midwife, the researcher or her supervisor by phone or e-mail if they had any concerns over the course of the project. Group facilitators were aware of participants' involvement and consulted if there were any concerns about an individuals' mental health, learning capabilities or other factors that might make taking part upsetting or stressful. Every attempt was made to conduct the focus groups in a comfortable and supportive environment. Group discussions were structured to enable and encourage all participants to contribute and be heard. At the end of each focus

group, participants were thanked for their time and each given a certificate of attendance, which is included in Appendix 6.5. It was hoped that this would both recognise their efforts and increase self-esteem.

Focus group participants' anonymity and confidentiality were protected by keeping contact details and demographic information separately from focus group transcripts and completed questionnaires in a locked cabinet. Participants were not identified by name in any report of the research.

Ethical considerations in the current proposal were further complicated by the young age of those taking part. A lower age limit of 16 was set to prevent very young pregnant girls being approached to take part. Historically, adolescents have been excluded from research, but more recently research has come to be viewed less as a dangerous activity from which people should be protected and more as an established method of potentially improving care (Riesch et al 1999). Additionally, it has been found that teenagers are as skilled as adults in assessing the implications involved in agreeing to participate in a project (Riesch et al 1999), and 16-19 year olds are now presumed to be competent to give consent (MRC 2004). Riesch et al (1999) suggest that adolescents are used as consultants in studies targeted at their peers, and their advice is sought regarding presenting and advertising the study and wording the consent document so that younger participants will understand what is being asked of them. A young parents' group was approached and agreed to provide this advice for the current project. This group was not recruited as a focus group. They were visited three times over the course of the project and their advice and feedback were sought on focus group questions and activities as well as on the format and wording of information and consent documents. Potential study participants were also encouraged to talk to their parents or guardians about the project and offered a second copy of the information pack to give to them. They were only recruited to the project if the researcher and their group facilitator were satisfied that they had fully understood what was involved. Many group facilitators chose to be present during the focus groups, offering an extra dimension of safety and support to the young mothers taking part. As recommended by the MRC, consent was viewed

as a continuing process, with participants invited to re-confirm their consent at each stage of the project (MRC 2004).

Inclusion criteria

The following inclusion criteria were set for the focus groups:

- Aged 16-19 at time of baby's birth.
- Recently delivered mother with healthy, live infant less than 6 months old.
- Intended to breastfeed or attempted to breastfeed at least once.
- Speaks and understands English.
- No mental health or learning difficulties that might make taking part difficult, upsetting or stressful.

It was considered that young mothers would have the clearest re-call of their experiences during the first 6 months after delivery. However, in actual fact some of the young women who wanted to take part had older babies, and had very clear memories of the first days after giving birth. Because these young women presented themselves at the focus groups, and felt very strongly that they wanted to be heard, the researcher was unable to think of any reasonable basis on which they should be turned away. Some young women also asked to take part when they were still pregnant. They then attended an additional focus group after they had given birth.

E-questionnaire design

The e-questionnaire comprised four demographic and four open questions. These are outlined in Table 6.1 below. Open questions were chosen so that key issues in a relatively un-researched area might be identified without responses being defined by the researcher's outlook and preconceptions (Brace 2004, Douglas et al 2005). The final question in the survey was an invitation to participants to add any further comments or information they considered relevant. This was designed to prevent respondents becoming frustrated that the questionnaire had not allowed them to express all their views on the survey topic (Walliman 2005).

The questionnaire was piloted in paper form with midwives and MSWs attending an NHS Trust study day at the participating Trust. Following this, the questions were re-worded to make it clear that responses should focus on support in hospital.

Table 6.1 – E- questionnaire questions

Question	Response Options
What is your job title?	Open question
In your role, about how many pregnant teenagers or teenage mothers do you look after each year?	<5 5-10 11-20 >20
What sort of care do you provide? (Select all that apply)	Antenatal Intrapartum Postnatal
Where do you work?	Oxfordshire London Scotland Wales Ireland England (North) England (South) England (Midlands) Non-UK
What, in your view, are the obstacles to pregnant teenagers who state an intention to breastfeed being able to initiate breastfeeding in hospital in the early days after giving birth?	Open question
Please tell us about any initiatives you have come across that you think might enable more teenage mothers to breastfeed in hospital	Open question
Can you suggest any additional ways in which in-patient care might be changed so that more young women who wanted to breastfeed could successfully initiate breastfeeding in hospital?	Open question
Is there anything else you would like to add?	Open question

The format of the questionnaire was kept clear and simple in order to minimise confusion, distraction or stress to the respondents (Douglas et al 2005, Jones et al 2008). The demographic questions were all on one page at the beginning of the survey. Respondents were able to see all the possible answers to each

question before selecting an answer. It was not possible to proceed to the open questions unless all the demographic questions were answered. The four survey questions were also grouped together on a page, allowing respondents to see all the questions before answering any. A separate text box was provided with each question. Respondents were able to review and change their answers either within a page or by using a 'back' button. It was possible to leave open questions unanswered. The final page of the survey thanked respondents for taking part and reminded them that they could request a copy of the results.

There is some evidence to suggest that people responding to surveys electronically are more likely to skip questions and give shorter answers (Velez et al 2004). Questions were therefore kept to a minimum in order to encourage complete responses. A lack of direct interaction with respondents can also create problems for the researcher, for example if the survey is forwarded to other people, or if respondents reply more than once (Whitehead 2007). Respondents were asked to state where they worked, so that if the survey was forwarded, responses from outside the UK could be eliminated. Although it is possible that those invited to take part in the research could forget whether they had already responded and complete the questionnaire a second time, it was considered that the open question format would make it unlikely that respondents would want to complete the survey twice.

E-questionnaire distribution

The questionnaire was uploaded onto a web-survey host site (SurveyMonkey.com), which generated a link that respondents could click to access the questions. The link was e-mailed directly to potential participants along with a covering letter. This strategy is more straightforward, and has been found to deliver a better response rate, than sending information and details of how to access online questionnaires by post (Aitken et al 2008, Hunter 2012a).

The letter and questionnaire link were sent to midwives and MSWs at the participating NHS Trust with an intranet address via a list held by the Head of Midwifery. This comprised 46 addresses, 11 of which were group e-mails (generic

department or community group addresses). The maximum number of individual recipients was 159. Survey distribution within the hospital Trust is summarised in Table 6.2. A reminder e-mail was sent after two weeks, with the letter and link, thanking those who had already responded and asking more people to do so.

Table 6.2. E-questionnaire distribution to NHS Trust

Total number of e-mail addresses	46
E-mail addresses belonging to individuals	35
E-mail addresses belonging to groups	11
Combined maximum number of individuals in groups	124
Maximum total number of recipients	159

The letter and questionnaire link were also sent to the 91 members of the Teenage Pregnancy Midwives' online forum by the site moderator. There were 95 addresses on the moderator's list, but three people had provided two addresses each, and one address was void, leaving 91 potential respondents in all. A high and prompt response rate from this group meant that it was not necessary to send any reminders. This part of the survey distribution is summarised in Table 6.3. A maximum total number of 250 individuals were contacted across both groups. The survey link was distributed in February 2010 and closed after three months.

Table 6.3. E-questionnaire distribution to National Teenage Pregnancy Forum

Total number of e-mail addresses	95
Individuals with 2 e-mail addresses	3
Void addresses	1
Maximum total number of recipients	91

Response rates to e-questionnaire

There were 17 responses from the NHS Trust and 87 from the online forum. One Trust respondent and 18 forum respondents had answered the demographic but not the open questions. Two responses were received via the online forum from overseas and were discounted. The final usable response rate was n=16 (10%) for the Trust and n=67 (74%) from the forum, making a total of 83. The response rates are summarised below in tables 6.4 and 6.5.

Table 6.4 – Response rates from NHS Trust

<u>Time span</u>	<u>Number of responses</u> <u>(cumulative)</u>
3 weeks	13
5 weeks	16
Total responses	17 (= 11%)
Non usable responses	1
Final usable responses	16 (= 10%)

Table 6.5 – Response rates from e-forum

<u>Time span</u>	<u>Number of responses</u> <u>(cumulative)</u>
3 days	38
1 week	55
3 weeks	83
Total responses	87 (= 96%)
Non usable responses	20
Final usable responses	67 (=74%)

The response to the e-questionnaire from the national online forum was not only much higher, but also more immediate and required a great deal less follow up effort on the part of the researcher. Possible reasons for the disparity in the response rates between the two sample groups might be:

- That group e-mails are less likely to elicit a response than e-mails sent to individuals. Many groups share a computer terminal, and not everyone in the group necessarily accesses group e-mails on a regular basis.
- That one individual may respond on behalf of the entire group.
- That the Trust e-mails could only be accessed at work, and people are perhaps less likely to reply during busy shifts (although many of the e-forum members also used work e-mail addresses).
- That the recipients of the Trust e-mail included health workers who did not work with teenagers, whereas the recipients of the web-forum mailing had expressed an interest in caring for young women by joining the group in the first place.
- That the members of the e-forum may feel more comfortable responding to a questionnaire online.
- The initial approaches to the two groups were assigned different subject headings by the PA and site moderator who sent them out. The Trust mailing was headed 'Teenage Breastfeeding Research' whereas the forum mailing was headed 'Survey on teenagers and breastfeeding – please help!' It may be that this direct appeal for assistance helped boost the response rate.

The number of partial responses is also worthy of comment. 19 respondents (18 from the online forum) answered the demographic but none of the open questions. This could be a result of placing the demographic questions at the beginning of the survey. Oppenheim (1992) argues that demographic questions should always be put at the end of questionnaires as respondents, who are keen to engage with the questionnaire topic, find them frustrating and off-putting. It could also be a consequence of using an online format -Velez et al (2004) found that partial non response rates were higher in the e-response group when they compared electronic and paper/pencil responses to a survey of college students. However, Hanscom et al (2002) argue that the missing value rate for a computer survey is about half that for a paper survey.

A far greater number of responses were received from midwives than MSWs. This was to be expected from the online forum, whose membership consists principally of midwives. MSWs may have been discouraged from responding to the Trust questionnaire as they were less likely to have a personal intranet address or to access or assume ownership of a group address.

E-questionnaire analysis

Data from the e-questionnaires was analysed using a form of inductive content analysis, as described by Elo and Kyngas (2007). Generally in content analysis, a predetermined set of categories are applied to the data, but in this case the categories arose from the responses themselves, in order to ensure that the respondents' words and priorities were captured. A process of open coding was used to identify themes within each question (Ryan and Bernard 2000). Statements were then cut and sorted into piles under each theme (Miles and Huberman 1994). This process continued until all the data had been sorted, ensuring that nothing was overlooked. It was then possible to count the number of responses in each theme, giving an idea of the strength of feeling behind each one. Miles and Huberman (1994) point out that counting can help researchers remain analytically honest and protect against bias, as people otherwise tend to overweight information they agree with and ignore or forget data that contradicts their reasoning. In order to further protect against bias, the Lead Midwife for Teenage Pregnancy in the participating Trust was invited to read the responses and comment on the identified themes.

Once the sorting process was complete, similar themes were organised into sub categories, which were then grouped into categories. Categories were grouped together under the two topics of 'health professionals' views of the obstacles to teenage mothers initiating breastfeeding', and 'support interventions to enable more teenage mothers to breastfeed'. An example of a sub category is given in Table 6.6. It can be seen from the table that a number of themes expressing health professionals' views of the reasons preventing some teenage mothers from continuing to breastfeed have been grouped together under a sub category of 'any difficulty encountered is met with them reaching for the formula

feeds'. The most frequently cited theme within this sub category was 'lack of confidence'. This sub category then formed part of a category of 'personal barriers to breastfeeding'. This was linked with other categories addressing barriers to breastfeeding which together gave rise to the metaphor 'fish out of water'. This became the central motif for the topic 'health professionals' views of the obstacles to teenage mothers initiating breastfeeding'. A conceptual map was produced for each topic (see Figures 7.1 and 7.2 in following chapter), showing how the different elements within it related to one another and interlinked (Ryan and Bernard 2000).

Table 6.6 – Example of a sub-category

Sub-category	Number of times raised in responses	Themes	Number of times raised in responses
'Any difficulty encountered is met with them reaching for the formula feeds' (R58, community midwife, Midlands)	32	Lack of confidence	8
		Unrealistic expectations	6
		Do not persevere	6
		Lack of motivation to devote time to overcome difficulties	4
		Lack of maturity	3
		Lack of patience	2
		Didn't really want to	1
		Didn't like it	1
		Perceived lack of milk	1

Focus Group Design

A number of open questions and prompts were developed for use in the focus groups, as outlined in Appendix 6.6. They were intended to promote discussion and were not all used in every group. Additional questions and topics were introduced by the participants or the researcher as each group progressed. Easy, non-threatening questions were followed by more challenging topics (Curtis and Redmond 2007, Leung and Savithiri 2009). The first three questions were designed to help break the ice and focus the group's attention (Kitzinger 1994, Bloor et al 2001, Mansell et al 2004). After the topics covered in the questions and prompts had been discussed, the group were shown a series of cards outlining support interventions that either formed part of the UNICEF Ten Steps to

Successful Breastfeeding (UNICEF n.d), were suggested or used as interventions in the literature reviewed in chapters four and five, were put forward by respondents to the e-questionnaire undertaken for this study, or arose from reflection and informal discussion with colleagues undertaken by the researcher. The content of the cards and background to each intervention is outlined in Appendix 6.7. Participants were asked to rank the interventions as 'essential', 'very helpful' 'quite helpful', 'wouldn't make much difference', or 'not acceptable/unhelpful'. If the intervention on the card had already been raised and discussed by the group, it could be skipped. The cards were an attempt to distance the researcher from the ideas being presented, so that participants did not feel obliged to agree with them. It was considered that gathering young mothers' views of proposed and trialled interventions was an important aspect of ascertaining the sort of support they would find acceptable. The use of cards also enabled comparisons to be made across groups (Kitzinger 1994).

The focus group questions and cards were piloted with the young parent group members acting as consultants to the project to expose potential pitfalls, make sure they included all relevant information and to assess how long they took to complete (Bloor et al 2001, Webb 2002, Howatson-Jones 2007). This was assessed by holding, and then seeking verbal feedback on, a 'dummy' focus group at one of their weekly meetings. Following this exercise, some of the cards were amalgamated as they were thought to be too similar. This 'dummy' group was not included in the study findings.

At the beginning of each focus group, the researcher introduced herself, explained the exact purpose and structure of the meeting and the estimated running time (Marlowe 2008). Participants were also reassured that there were no right or wrong answers or opinions, and reminded that they were free to leave at any time. Ground rules such as confidentiality and mutual respect were established (Beyea 2000, Marlowe 2008). Consent was sought to record the session (although this was also included on the consent form), and each participant was asked to introduce themselves at the beginning of the tape, both to reduce their anxiety about speaking in a group and to provide a point of reference during transcription (Mansell et al 2004). The researcher also

attempted to facilitate the transcription process by using the participants' names as much as possible during the session (Bloor et al 2001). Each session was drawn to a close after a maximum of two hours. At the end of the session, the main discussion points were summarised by the researcher, and participants were asked whether they agreed with the summary or whether they felt anything had been overlooked (Curtis and Redmond 2009). The researcher then explained the next steps of the research process – transcribing and analysing the tapes – and offered to return to the group at a later date to share and seek validation of the findings (Bloor et al 2001). The participants were thanked for their time and each given a certificate of attendance.

In the current project, focus group meetings were held at pre-existing young parent groups. It was considered that young people, who are notoriously difficult to engage, would be more likely to turn up to a focus group on a day and at a venue that they are used to attending. They are also more likely to feel comfortable with their friends, and able to discuss the issues at hand without reference to the moderator – something that would be harder to do in a group of strangers. Participants who know one another might also jog one another's memories and challenge each other over any contradictions between what people say and what they have actually been seen to do (Kitzinger 1994). On the other hand, it has been suggested that pre-existing groups may have taken for granted norms and experiences that they no longer feel the need to discuss, there may be power politics at play and certain views and opinions may be censored (Bloor et al 2001, Curtis and Redmond 2007). Mindful of these potential disadvantages, probing questions and prompts were used to encourage the group to articulate shared experiences and norms, and to try and ensure all opinions were heard.

The focus group meetings were held over lunch, to promote an informal, relaxed and friendly atmosphere that would encourage discussion (Kitzinger 1994, Bloor et al 2001). Chairs were arranged so that all participants were able to establish eye contact with each other and with the moderator (Beyea 2000, Gray 2009). A participant information sheet containing demographic questions and asking for information about early infant feeding practice (see Appendix 6.8) was

completed as people arrived, along with the consent forms. This allowed the researcher to double check peoples' eligibility, offer help as required and answer any questions. It also providing a convenient time-filler while the group assembled (Bloor et al 2001).

The researcher acted as moderator in each focus group. Some authors caution against this approach, on the basis that the researcher may be seen as an outsider or authority figure, and the moderator should be similar in age, dress and appearance to the group (Curtis and Redmond 2009, Gray 2009). It is, however, an important feature of qualitative (and particularly constructivist) research that the researcher is also the instrument of data collection and analysis (Parahoo 2007). It is often only by being a part of the research process that researchers are able to analyse and make sense of the data collected (Mansell et al 2004). By facilitating the groups, the researcher remained close to the data and was able to ensure that all relevant avenues were explored. Fortunately, as Howatson-Jones (2007) points out, many of the characteristics of a good moderator are second-nature to health care professionals (the researcher is a midwife), who are used to interacting with and extracting answers from people from all walks of life.

Initially, it was anticipated that an assistant moderator would also attend the focus groups. This is considered good practice in order to ensure the smooth running of the focus group, and to help limit any bias in the initial analysis. Although an assistant moderator was identified and agreed to attend the focus groups, she was not available on the dates on which they were held. This did not in fact disrupt or hinder the smooth running of the groups, as group facilitators generally chose to attend the session (so took on aspects of the assistant moderator role), and the numbers attending were easily managed by one person. In fact the introduction of another 'outsider' may have made participants feel uncomfortable and less inclined to discuss personal issues.

Focus group numbers

Six focus groups were set up in all. A total of 15 participants attended the groups (numbers at each group ranged from one to five). One group met twice, as two of the participants were still pregnant at the time of the first meeting. The remaining five groups met once each. On two occasions, only one young mother attended the group. When this happened, interviews were conducted in order to ensure that no perspectives were ignored.

Analysis of focus group data

Focus group analysis has been identified as complex and problematic, and researchers have been criticised for using inappropriate methods or not giving detailed accounts of the processes they used (Webb and Kevern 2001, Mansell et al 2004). The fundamental difficulty seems to be that focus groups yield data through interaction, and yet in organising the data into themes the conversations, disagreements and debates that gave rise to those themes are lost. Many researchers ignore the group context in the analysis and only cite quotes from individual participants (Forster et al 2008 and Wambach and Cohen 2009, for example). The challenge is to maintain a sense of the whole while at the same time drilling down into the detail.

In order to ensure that the analysis in the current project reflected the interactive nature of the data collected, a modified version of content analysis was used (Elo and Kyngas 2007). In the first instance each focus group recording was transcribed verbatim by the researcher, including interruptions, laughter and hesitations (Kitzinger 1994, Bloor et al 2001, Webb and Kevern 2001). Although time-consuming and arduous, transcription is recognised as the most rigorous method of capturing focus group data – the alternative of listening to the tapes and summarising their content risks becoming selective and superficial (Bloor et al 2001, Curtis and Redmond 2007).

Content analysis considers completed episodes or texts. Therefore, unlike grounded theory, all the data was collected and transcribed before the analysis began. Grounded theory advocates concurrent data collection and analysis –

purposive sampling is undertaken to confirm the validity of previous analysis or seek more depth and detail about particular ideas (McGhee et al 2007, Roberts 2008). This approach was rejected in the current study, on the grounds that it requires the researcher to highlight and prioritise some ideas over others at a very early stage. This can lead to bias in later data collection, as the researcher may only be looking for confirming or disconfirming instances of emerging theories and can ignore other concepts (Charmaz 2000). It is, of course, inevitable that a researcher will take elements of conversation from one group into another, and that understanding will be modified and deepened along the way, but the semi-structured format of the sessions should have prevented the researcher steering the conversation too determinedly in any particular direction.

Once transcribed, the data from each group was coded to identify basic themes. The codes emerged inductively as the text was considered line by line. As codes were identified they were entered into a codebook (Ryan and Bernard 2000). Material could be assigned to more than one code, and, as new codes were identified, earlier data was assigned extra or different indices as the transcripts were re-read (Bloor et al 2001, Mansell et al 2004). Further re-readings were undertaken to develop and refine codes. Selected transcripts were independently coded by a third party (the project supervisor) to check the validity of the codes and emerging concepts. Codes were then validated or amended accordingly.

Memo-writing was used as coding was undertaken in order to help refine codes and make sense of the data. As ideas, connections and concepts occurred to the researcher, they were recorded in the code book. Memo-writing has been identified as an intermediate step between coding and the development of conceptual analysis, as it helps the researcher identify and record perceived relationships in and between codes (Charmaz 2000, Ryan and Bernard 2000). It can also aid the process of reflexivity, encouraging the researcher to question their initial interpretations as analysis develops into a discussion between the data, the memos, the emerging concepts and the researcher (McGhee et al 2007).

The transcripts were then colour coded so that excerpts could always be attributed to a particular group, and cut into separate segments or 'units of analysis', each of which illustrated a particular code. Segments illustrating the same code were put together. If a segment was relevant to more than one theme it was copied and catalogued in more than one area. This exercise again enabled entries under each code to be counted – even though the themes in the focus group discussions were to some extent dictated by the questions asked, counting was still considered an important way of measuring different points of view and confirming concepts and interpretations (Ryan and Bernard 2000, Silverman 2006). Grouping all the data relevant to a particular code together also enabled trends to be identified and connections to be formed.

Whereas the units of analysis in the e-questionnaire analysis tended to be short, concise points, the segments in the focus group analysis were often longer and could extend to a page or more of transcribed dialogue. This was to ensure that the analysis incorporated dialogue, rather than simply isolating contributions from individuals, so that the interactive nature of the focus group was not lost. In this way it was hoped to show how consensus evolved as opinions were developed and modified through discussion (Webb and Kevern 2001). However, the argument of Joseph et al (2000) that, as the aim of the focus group is to produce data through interaction between the participants it is only that interaction that should be included in the analysis, was rejected. It was considered that the researcher's interaction with the group is an important part of the process of forming his or her understanding and should therefore be included. By directing and participating in the group, and also by analysing the data, the researcher is inextricably linked to the focus group process, and it might even appear dishonest to eradicate their contribution to the debate. Equally, individual narratives, both within the focus groups and during the one to one interviews, also yielded rich data which it would not have been appropriate to overlook.

Once identified, the codes were brought together under concepts that were thought to explain the data and illustrate emergent themes (Miles and Huberman 1994). The concepts were then taken back to the original manuscripts to ensure that they made sense of these (Miles and Huberman 1994). This iterative process

continued until a conceptual framework was developed that made sense of, and was grounded in, the data produced during the focus groups. Once again, the messy, qualitative nature of focus group data can pose a problem at this stage of the analysis. Many researchers strive to tidy the data into an over-riding message – indeed Bloor et al (2001) suggest that ambiguous data should be removed – but contradictions and dissenting voices are part and parcel of the group process and need to be evident in the final report. There is also a dilemma over wanting to include all points of view but it not being appropriate in a qualitative project to measure strength of opinion using statistics such as ‘25% of participants felt that...’ (Parahoo 2007, Marlowe 2008). As one of the aims of the current focus groups was to reach a consensus on the most appropriate way of supporting young mothers to breastfeed in hospital, it would not be inappropriate to report any views and ideas put forward by the majority of the participants in a group, while at the same time giving space to contradictory and different views.

Finally, the concepts were taken back to one of the participating groups to make sure that they recognised the concepts used and considered that they made sense of their views (Patton 2002). Such member checking can be problematic in the sense that it can be difficult to reconvene the exact groups and people may have changed their minds, not accept conclusions that are incompatible with their self-image or remember what they wish they had said rather than what they actually said (Bloor et al 2001, Mansell et al 2004, Silverman 2006). However, it does enable the findings to be checked against the groups’ understandings and give the participants an opportunity to comment on the proposed intervention (Bloor et al 2001, Mansell et al 2004, Porter 2007). Although not all the original participants, and some new members, were present to discuss the results of the analysis, the conversations that took place at this meeting indicated that participants recognised and identified with the concepts presented.

Credibility (Rigour) of e-questionnaire and focus groups

Credibility is the term adopted by many qualitative researchers to indicate the extent to which a piece of research can be judged to be an accurate portrayal

of the respondents' experiences, given the constrictions of language and communication discussed above (Bradbury-Jones 2007). There is much debate about how credibility should be assessed, with views ranging from the rigorous application of method to the postmodernist assertion that each individual must form their own judgement using insight and experience (Miles and Huberman 1994, Porter 2007). In the current project, the following framework was applied, based on the TAPUPAS criteria developed by Pawson et al (2003):

Transparency – the process of knowledge generation and the philosophy underpinning the project are described in detail, in order to be open to outside scrutiny. Tensions and differences are presented (Olesen 2000, Silverman 2006, Bradbury-Jones 2007).

Accuracy/Persuasiveness – Data was considered as fully and completely as possible. Evidence from the data is presented to support the claims made (Silverman 2006). Counting was used to establish the dominance of themes within the respondents' accounts (Miles and Huberman 1994, Silverman 2006). A reflexive approach was adopted in order to limit the extent to which the researcher dominated the data and allow respondents' voices to be heard. Member checking and independent coding of sample data were used.

Purposivity – the methods used were specifically adapted to suit the research situation. Silverman (2006) argues that work becomes scientific by adopting methods of study appropriate to its subject matter.

Triangulation – this is not part of Pawson et al's framework, but is included here as it is recognised that different stakeholders will all have a different 'take' on the factors that promote or inhibit the effectiveness of an intervention (Porter 2007). Credibility is therefore enhanced when different perspectives are taken into account, as is the case in the current project. Triangulation is not used in the positivist sense of different perspectives illuminating a central truth or providing a 'double check' on findings (Miles and Huberman 1994).

Utility – this represents the extent to which the knowledge claims are appropriate to the needs of the practitioner (Porter 2007). Practitioners' views were actively sought in the current project, and a resulting intervention was judged on its practicability in a clinical setting.

Propriety – Ethical approval was sought and granted for the project, and the ethical considerations of the research are outlined.

Accessibility – this represents the extent to which the research is presented in a style that is accessible to the practitioner. Output from this research has been published both in academic journals (Hunter 2012a), and in journals widely read by practitioners (Hunter 2012, 2013, 2013a).

Specificity – this is an emerging indicator in Pawson et al (2003)'s construct, testing the extent to which the knowledge generated by a study reaches source-specific standards. Pawson et al point out that knowledge standards within social care are poorly defined. However, by meeting the standards outlined above, this project sought to produce credible results.

The current project used a constructivist approach acknowledging the possibility of multiple true interpretations of an experience. The concept of reliability, which asserts that results are 'proved' if another researcher adopting the same methods came to the same conclusions (Silverman 2006), was not therefore felt to be relevant. The research represents a unique meeting of a particular researcher with a particular set of participants in a particular setting at a particular time. Future researchers meeting different participants in a different place (or the same place at a different time) may well reach different, but equally valid, conclusions (Porter 2007). That is not to say that constructivist research is not at all generalisable - having assessed the credibility of a project, practitioners can judge whether it resonates closely enough with their own particular situation to be applicable there (Mantzoukas 2007).

Conclusion

This chapter has described and justified the philosophical framework and methods used to gather data from health professionals and young mothers. The constructivist approach adopted in this research aimed to understand the lived experiences of teenage mothers on the postnatal ward and the way in which both they, and the maternity professionals caring for them, conceptualise and interpret those experiences. This information helped build a picture of the context within which interventions aiming to improve the support provided to young mothers in

the early postnatal period need to operate. The use of inductive content analysis to analyse the data enabled the participants to determine the key themes identified, thus helping to ensure that the picture built reflected their reality as far as possible.

The findings of the e-questionnaire and focus groups and interviews are presented in the following three chapters. Chapter seven outlines maternity professionals' views of the breastfeeding experiences and support needs of young mothers, and chapters eight and nine present and analyse the responses of the young mothers themselves.

Chapter seven

Maternity professionals' perceptions of obstacles faced by, and support available to, teenage mothers initiating breastfeeding

Introduction

This chapter presents and discusses the results of an e-questionnaire survey of UK maternity professionals, canvassing their views of the obstacles to young mothers initiating breastfeeding in hospital and of support measures that might improve breastfeeding rates among this group. Soliciting the views of health professionals, in addition to those of young mothers, enabled a more complete picture of the obstacles currently faced by young mothers wanting to breastfeed to be ascertained, particularly in respect of the culture within which care is provided. The health professionals' responses also provided evidence of the sorts of support interventions that would receive the support of staff working with young mothers. Their breastfeeding support suggestions were later put to young mothers during focus groups in order to build a consensus of appropriate and acceptable breastfeeding support measures.

Demographic Information

The survey distribution, and a breakdown of response rates, was presented in the previous chapter. The geographical location of the respondents from the Trust and national forum is outlined in Table 7.1 below. The 83 respondents were reasonably evenly distributed across England, with only two responses received from Scotland and one from Wales. This, together with the low number of responses from London, reflects the membership of the national Teenage Pregnancy Forum e-group.

Table 7.1. Location of e-questionnaire respondents

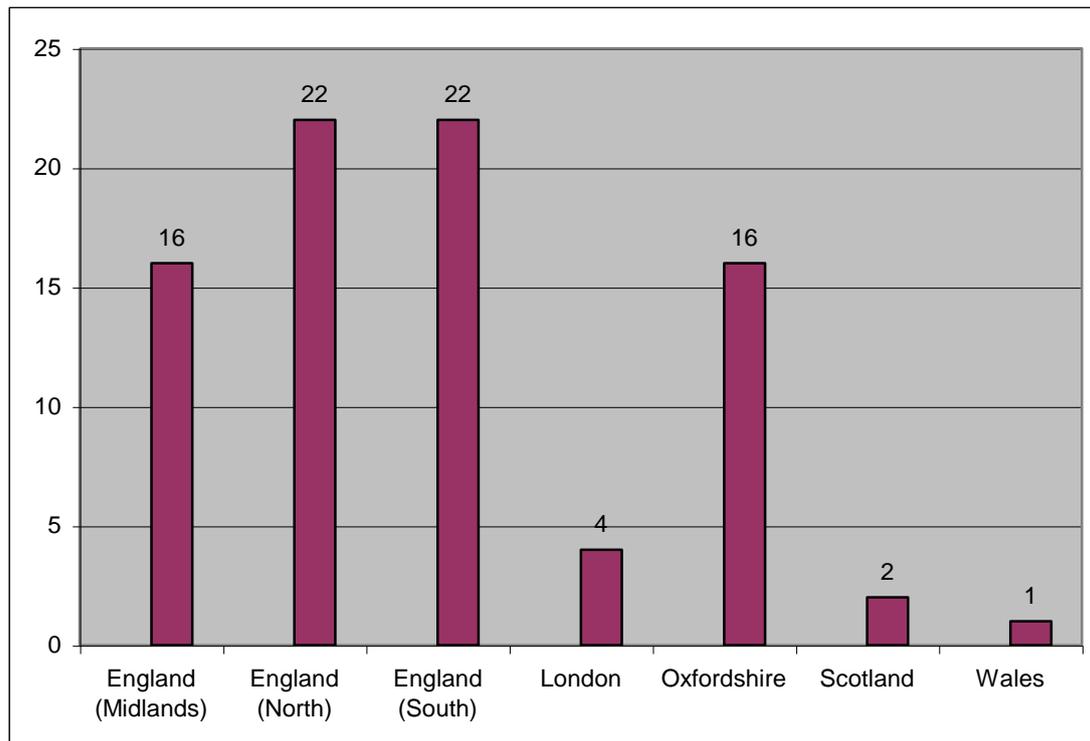
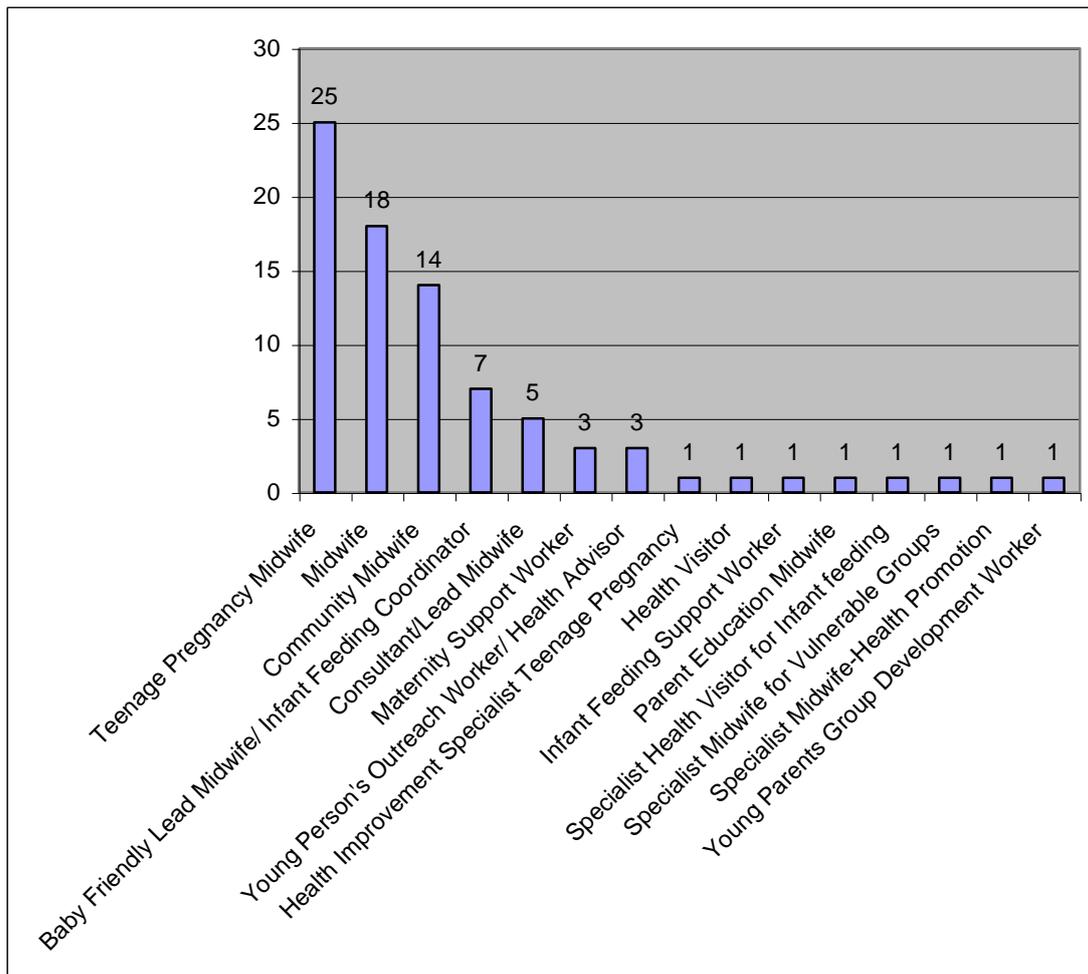


Table 7.2 below lists the respondents' job descriptions. Almost 87% (n= 73) were midwives, with 30% (n= 25) describing themselves specifically as teenage pregnancy midwives. Four MSWs (including one infant feeding support worker) and two health visitors took part. Participants represented a mix of different special interests, including infant feeding specialists as well as practitioners with a particular focus on young mothers or vulnerable groups and general ward and community staff.

Table 7.2 Job titles of survey respondents



Most of the participants cared for over 20 young mothers per year, and provided a mix of ante and postnatal care, as illustrated below in Tables 7.3 and 7.4 .

Table 7.3. Number of pregnant teenagers cared for by survey respondents each year

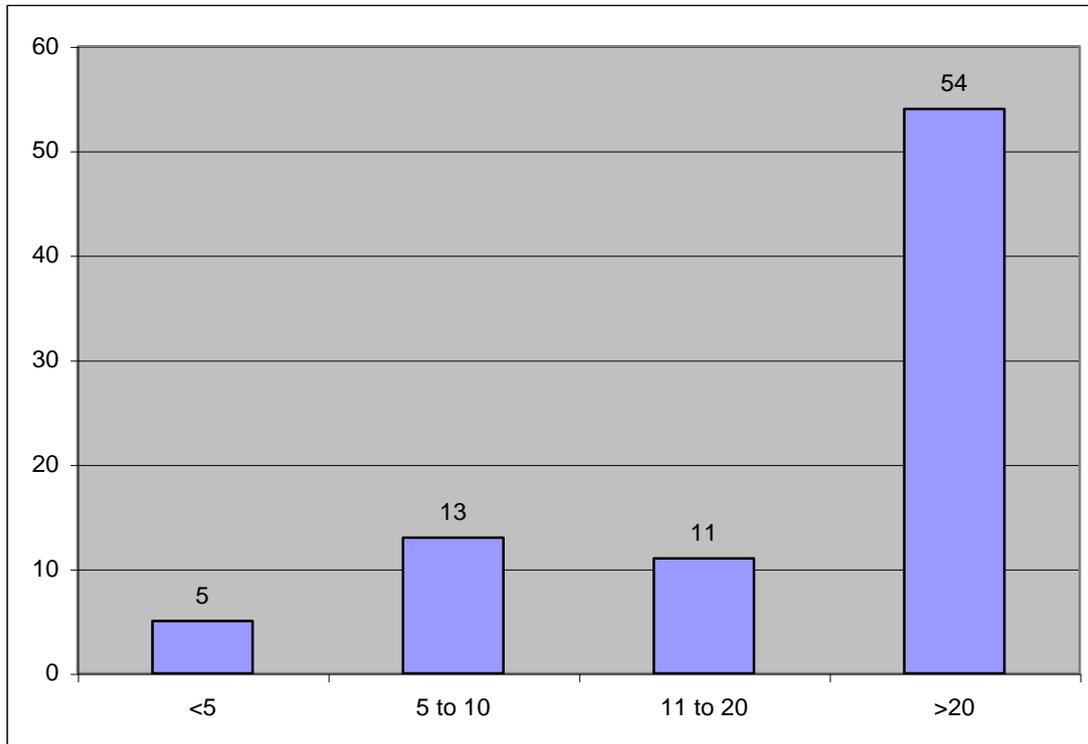
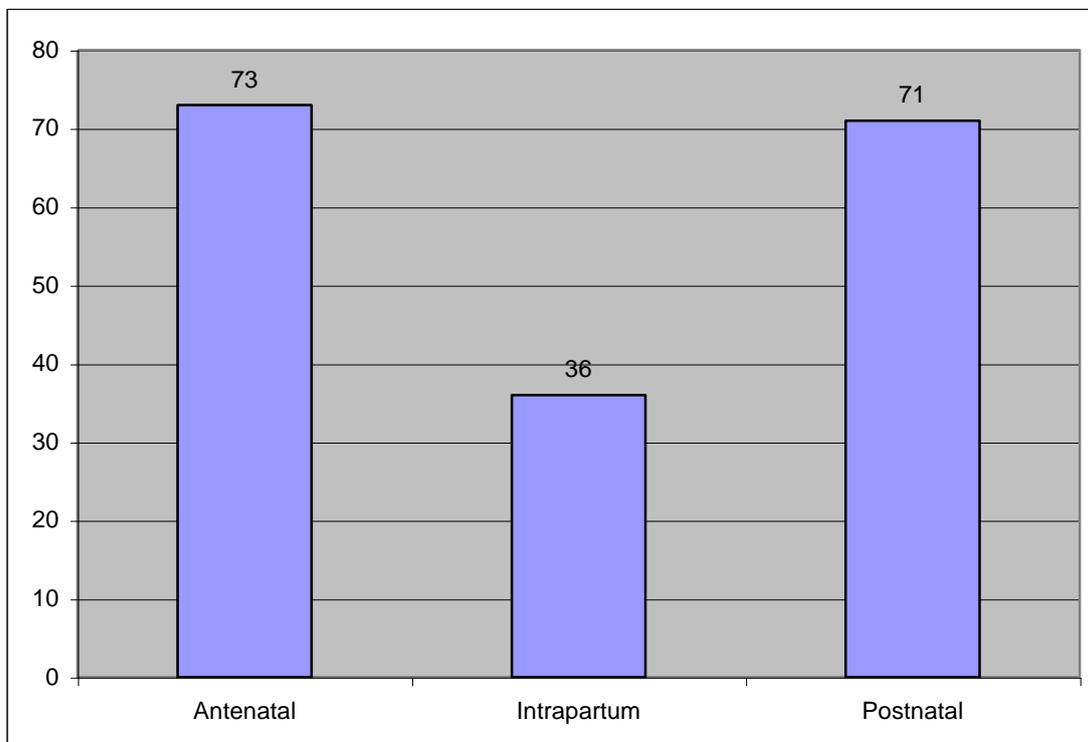


Table 7.4 Types of care provided by survey respondents



Presentation of results

A form of inductive content analysis, as described by Elo and Kyngas (2007) was used to sort and analyse the responses to the e-questionnaire. This process is described in the previous chapter. The responses were analysed as two distinct topics: health workers' views of the obstacles to teenage mothers initiating breastfeeding, and of appropriate support interventions to enable more teenage mothers to breastfeed. These topics correlated with the survey questions, as outlined in Table 7.5 below. However, some points raised in answers to questions about interventions related to obstacles and vice versa. When this happened, the points were moved and categorised under the appropriate topic. Table 7.5 shows the number of responses to each of the four survey questions, and the number of additional comments imported from answers to other questions. Responses to question four (Is there anything else you would like to add?) that did not relate directly to obstacles or support interventions were used to inform the analysis.

Table 7.5. Responses by survey question

Topic 1: Health workers perceptions of obstacles to teenage mothers initiating breastfeeding in hospital					
	Total number of responses received	Number of usable responses (excludes those exported to other sections)	Total number of points raised in usable responses (excludes those exported to other sections)	Additional points imported from other answers	Total number of points
Question 1: What, in your view, are the obstacles to pregnant teenagers who state an intention to breastfeed being able to initiate breastfeeding in hospital in the early days after giving birth?	83	83	226	21	247
Topic 2: Health workers' views of appropriate support interventions for breastfeeding teenage mothers					
Question 2: Please tell us about any initiatives you have come across that you think might enable more teenage mothers to breastfeed in hospital.	73	63	123	11	134
Question 3. Can you suggest any additional ways in which in-patient care might be changed so that more young women who wanted to breastfeed could successfully initiate breastfeeding in hospital?	80	77	170	16	186
Additional information					
Question 4. Is there anything else you would like to add?	46	6	6	0	6

In order to make the analytic process as transparent as possible, the results are presented in a series of tables, tabulating the number of times each identified sub-category, and each individual theme within that sub-category, was mentioned in the responses. A central underlying (core) concept was identified for each topic, which was considered to unite and give depth and meaning to the issues raised. The core concept for topic one: 'health professionals' views of the obstacles to teenage mothers initiating breastfeeding' was 'teenage mothers on the postnatal ward: fish out of water'. The core concept for topic two: 'support interventions to enable more teenage mothers to breastfeed' was 'normalising breastfeeding'.

Responses from local and national respondents were analysed together. Also, responses from different groups of professionals (for example, community and hospital midwives) are not analysed separately. Although different viewpoints and philosophies were apparent in the results, they were not easily attributable to health workers in a particular location or holding a particular role. So that the reader can see the range of respondents' views used in direct quotations, each respondent has been numbered (R1 – R103), and quotations are followed by the respondent number, job title and location.

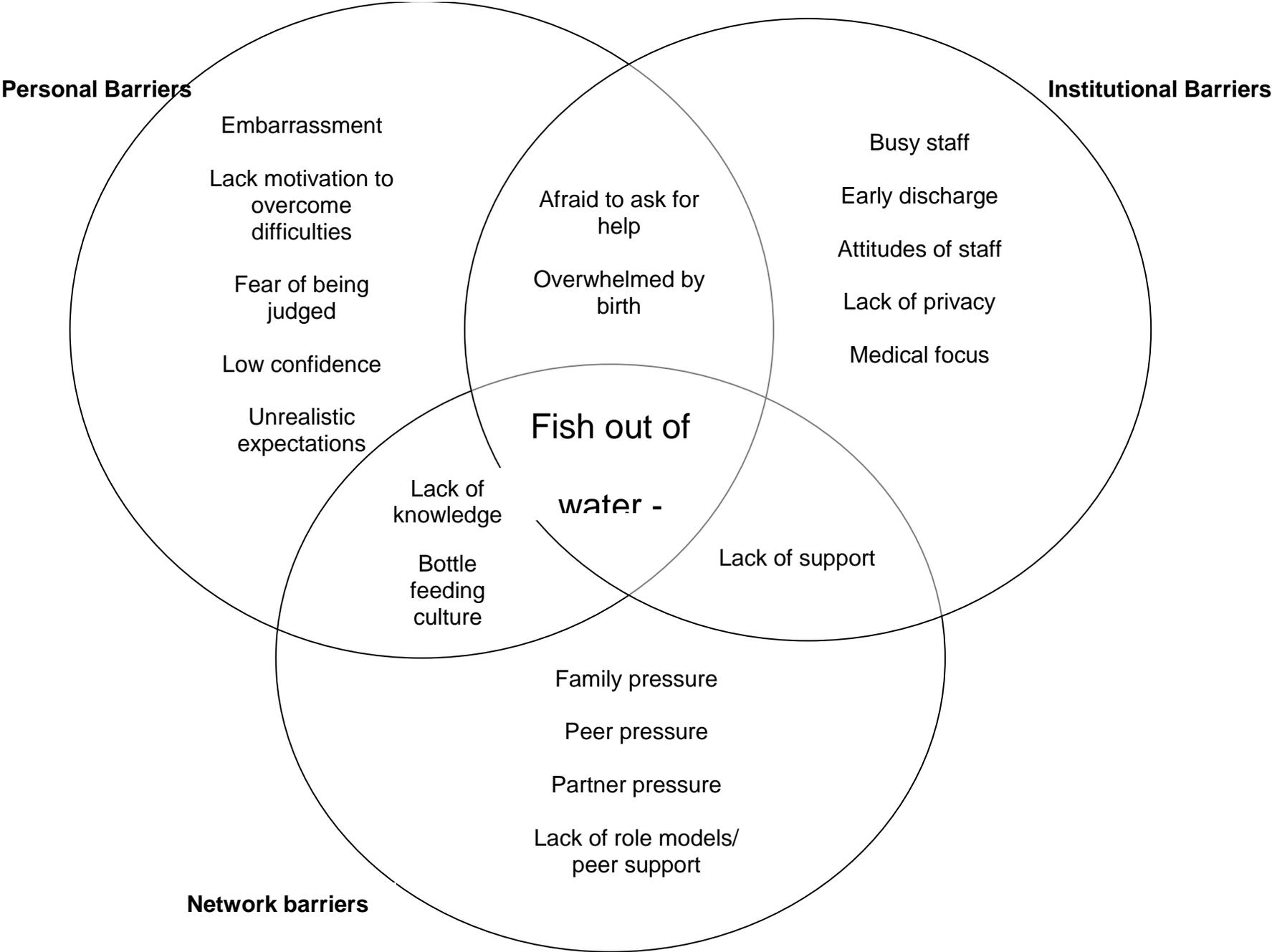
Topic one: maternity professionals' perceptions of obstacles to young mothers initiating breastfeeding in hospital

Maternity professionals portrayed young women attempting to breastfeed as 'fish out of water' – a metaphor that encapsulates the perceived alienation and helplessness experienced by breastfeeding teenage mothers in hospital. This was seen to lead to a lack of perseverance with breastfeeding, especially when difficulties were encountered.

The obstacles to breastfeeding which gave rise to the fish out of water metaphor have been grouped into three organising categories: personal obstacles, emanating from the young women themselves; institutional obstacles, produced by the hospital staff and environment; and network obstacles, resulting from the women's families and social circle. Figure 7.1 illustrates how the

personal, institutional and network categories interlink and create a situation in which many young mothers feel exposed, out of place, unsupported and afraid or unwilling to ask for help while they are attempting to learn to breastfeed. The three categories, and the themes within them, are discussed below.

Figure 7.1: Breastfeeding teenage mothers: fish out of water



Personal obstacles to teenage mothers initiating breastfeeding

The teenagers' personal barriers to breastfeeding, as identified by the health professionals, are listed below in Table 7.6. They include a lack of motivation to overcome difficulties, embarrassment, fear of being judged, lack of knowledge about breastfeeding and recovering from giving birth.

Table 7.6 – Personal obstacles to teenage mothers initiating breastfeeding

Sub-category	Number of times raised in responses	Themes	Number of times raised in responses
'Any difficulty encountered is met with them reaching for the formula feeds' (R58, community midwife, Midlands)	32	Lack of confidence	8
		Unrealistic expectations	6
		Do not persevere	6
		Lack of motivation to devote time to overcome difficulties	4
		Lack of maturity	3
		Lack of patience	2
		Didn't really want to	1
		Didn't like it	1
'Not being comfortable with their bodies, and feeling embarrassed' (R99, Teenage Pregnancy Midwife, South England)	19	Perceived lack of milk	1
		Embarrassed	8
		Shy	3
		Poor body image	3
		Breasts = sexual objects	3
Fear of being judged: 'scared to ask for support thinking they are being judged by needing help' (R19, Teenage pregnancy midwife, South England)	19	Self – conscious	2
		Scared/embarrassed/ not confident to ask for help	11
		Feel highly visible, watched and judged by staff and older mothers	5
Lack of knowledge: 'lack of information antenatally on the benefits and management of breastfeeding' (R24, Breastfeeding Lead Midwife, North England)	21	Intimidated by staff	3
		Not given enough information antenatally	11
		Perceive bottle feeding easier	4
		Lack of/incorrect knowledge/education	5
		Reduced antenatal care	1

Birth Experience: 'feeling overwhelmed by the birth' (R28, Infant Feeding Health Visitor, North England)	8	Birth interventions	3
		Feeling overwhelmed	3
		Fatigue	1
		Not having skin to skin contact	1

Lack of motivation to overcome breastfeeding difficulties was the most frequently mentioned personal barrier, and is encapsulated in the comment that

'any difficulty encountered is met with them [teenage mothers] reaching for the formula feeds'

(R58, Community Midwife, Midlands).

The two most frequently cited reasons for this perceived lack of patience and determination were low confidence levels and unrealistic expectations. Teenage mothers were reported to say

'I will try to breastfeed but I don't know if I will be able to'

(R74, MSW, Oxford),

revealing a questioning of their ability that was seen to persist even when they had successfully initiated breastfeeding:

'many do initiate it but...decide that the baby is not feeding'

(R6, Consultant Midwife, North England).

Other teenagers were reported to expect that 'breastfeeding is easy' (R58, Community Midwife, Midlands) – this lack of awareness of 'how hard it can be in the early days' (R60, Midwife, South England) meant they soon switched to formula milk if a baby was not 'taking to the breast easily' (R77 Midwife, Oxford). Some health professionals linked this low tolerance of initial difficulties to the young women's age –

'you have to persevere, which maybe a young person is less likely to do'

(R9, Parent Education Midwife, North England) -

as well as to not really liking breastfeeding or not really wanting to do it.

An unwillingness to persevere in the face of difficulties can also be understood as a consequence of young mothers feeling self-conscious and not wanting to draw attention to themselves on the ward. 'Not being comfortable with their bodies, and feeling embarrassed' (R99, Teenage Pregnancy Midwife, South England) was another recurrent theme. Teenage mothers were perceived to have 'poor body image' (R3, Community Midwife, Oxford) and to view their breasts as 'sexual objects – not for feeding' (R70, Teenage Pregnancy Midwife, Scotland).

It was not only the possibility of exposing their breasts that was perceived to cause discomfort, however - young mothers appeared to think that both the staff and the other mothers were watching and judging them, and to feel uncomfortable 'just by being on the ward' (R29, Teenage Pregnancy Midwife, South England). In particular, young mothers appeared to have difficulty working out how the ward was organised, and were therefore unsure 'who or when to ask for help' (R4, Community Midwife, Oxford) and felt out of place. They were also intimidated by staff and scared that asking for assistance would result in their being judged as not coping (R8 and R19, Teenage Pregnancy Midwives, South England). Such concerns made it

'easier to say bottle than ask for help to get started breastfeeding, even though they had intended to give breastfeeding a try'

(R46, Teenage Pregnancy Advisor, South England).

Unsuccessful breastfeeding initiation among teenage mothers was also linked to

‘lack of information antenatally on the benefits and management of breastfeeding’

(R24, Breastfeeding Lead Midwife, North England).

Health professionals felt that young mothers were ill prepared for their attempts to breastfeed and unsure what to expect. This can be seen further to reinforce their sense of floundering and alienation on the postnatal ward. Some health professionals also reported that teenage mothers generally viewed formula milk feeding as easier and more convenient (R41, Teenage Pregnancy/Community Midwife, North England; and R60, Midwife, South England). Some young mothers were further judged to hold incorrect beliefs about the frequency of feeds, or to think that it was not possible to breastfeed following a caesarean section (R43, Midwife, North England; and R54, Health Visitor, Midlands). The teenagers’ lack of knowledge was attributed to reduced antenatal care and lower educational attainment among this group (R64, Health Promotion Midwife, South England; and R81, Midwife, Oxford).

A final personal obstacle to the initiation and establishment of breastfeeding identified in the current study was the experience of giving birth. Young mothers were perceived to be overwhelmed and exhausted postnatally (R94, Teenage Health Advisor, South England; and R97, MSW, Oxford), and to have received care that militated against breastfeeding, such as being given opiates, having assisted deliveries or not being offered skin to skin contact (R9, Parent Education midwife, North England; R38, Midwife, South England; and R67, Infant Feeding Coordinator, Midlands).

Institutional obstacles to teenage mothers initiating breastfeeding

The sense of alienation observed in young mothers on the postnatal ward was perceived by maternity professionals to be compounded by staff who were

too busy to offer support and sometimes did not believe young mothers would breastfeed, and a medical culture focusing on processing women through the ward as quickly as possible (early discharge), and carrying out observations and tests. These are the institutional obstacles to breastfeeding identified by survey respondents, and are listed in Table 7.7 below.

Table 7.7. Institutional obstacles to teenage mothers initiating breastfeeding

Sub-category	Number of times raised in responses	Themes	Number of times raised in responses
'Lack of support and encouragement in hospital' (R35. Midwife, North England)	61	Lack of staff, and time	23
		Lack of support/encouragement	17
		Attitudes of staff	11
		Need one to one care	3
		Lack of information	2
		Inconsistent advice	2
		Ignored when ask for help	2
		Pressure from staff	1
Hospital culture	30	Early discharge	15
		Lack of privacy	9
		Medical focus	5
		Lack of money to fund initiatives	1

'Lack of support and encouragement in hospital' (R35, Midwife, North England) was the most commonly cited institutional obstacle to teenage mothers being able to breastfeed. Health professionals paint a picture of care on the postnatal ward that is seriously compromised by lack of staff and time. This resulted in the young mothers who did ask for support often having to wait, or being ignored. One respondent expressed frustration that

'nearly all of my young women want to breastfeed but when it gets difficult in the hospital...they feel as if they have no one who can help immediately'

(R69, Teenage Pregnancy Midwife, North England).

Another felt that midwives actively pressurised new mothers to formula milk feed (R20, Teenage Pregnancy/Community Midwife, North England). Some respondents bemoaned a lack of one to one care or consistency of advice when help was given on the postnatal ward, although this was not a major theme.

Ward staff holding negative attitudes towards teenage mothers and believing that they either could not or would not breastfeed was also a common theme. Respondents thought that some of their colleagues believed that teenagers either lacked the maturity to persevere with breastfeeding or to put in sufficient effort to succeed. These beliefs were felt to impact on the level of support young mothers were offered:

‘People assume that because of their age they are not committed to breastfeeding so they don’t bother trying [to] help’
(R96, Teenage Pregnancy Midwife, North England).

‘...the attitudes of health professionals to teenage mothers that they ‘can’t be bothered’ with breastfeeding is a terrible attitude...’
(R45, Young Parents’ Group Worker, North England).

It was observed that the teenagers’ feelings of embarrassment and of being watched and judged were exacerbated by a lack of privacy on the postnatal ward. One respondent mentioned a policy of having the curtains around beds open at all times (R22, Teenage Pregnancy Midwife, Midlands), and it was also observed that a designated breastfeeding room was ‘just used for expressing’, and that there was no ‘comfy space’ available for mothers to use (R50, Midwife, Oxford). New mothers didn’t even have much time with their babies in the delivery room, which was a private environment, as staff were under pressure to move them onto the postnatal ward as quickly as possible to make way for the next labouring woman (R36, Teenage Pregnancy Midwife, South England).

‘Busy wards full of higher risk women needing medical care’ (R25, Infant Feeding Coordinator, South England) were also thought to generate a medical focus within which there was ‘constant worrying about blood sugar levels’

(R8, Teenage Pregnancy Midwife, South England), and formula top-up feeds were regularly prescribed (R81, Midwife, Oxford). Both these practices are likely to have undermined the confidence of any breastfeeding mother. Furthermore, for those whose babies were in the Special Care Unit, availability of free pumps was limited (R29, Teenage Pregnancy Midwife, South England).

Despite believing that the environment on the postnatal ward did not support or enable young mothers to breastfeed, many health professionals stated that young women being discharged home from hospital after only 24 hours or less presented a further obstacle to establishing breastfeeding successfully on the ward. There was a perception that, if only the young mothers had stayed in hospital a little longer, they would have received the help they required. Early discharges were sometimes initiated by the hospital, and sometimes a result of teenage mothers' desperation to get home:

'not being able to stay in hospital long enough and in some cases not wanting to be in hospital at all'

(R74, MSW, Oxford).

Some young mothers were even reported to switch to formula milk feeding in order to get away:

'some tell me they want to get home – ward staff want them to stay a bit longer to ensure baby is feeding satisfactorily so then they will change to formula to get home'

(R29, Teenage Pregnancy Midwife, South England).

This quotation vividly illustrates how the young women's experience of the ward environment is seen to shape their infant feeding behaviour. The next section gives further examples of the role of context and environment in infant feeding behaviour, as the influence of the young women's friends and families is explored.

Network obstacles to teenage mothers initiating breastfeeding

Teenagers' attempts to breastfeed were also perceived to be frustrated by 'friends and families where bottle feeding is the norm' (R20, Teenage Pregnancy/Community Midwife, North England). The individual themes that make up this network obstacle to the successful initiation of breastfeeding are listed in Table 7.8.

Table 7.8. Network obstacles to teenage mothers initiating breastfeeding

Sub-category	Number of times raised in responses	Themes	Number of times raised in responses
'Support from friends and families where bottle feeding is the norm' (R20. Teenage pregnancy/ community midwife, North England)	57	Inadequate/inappropriate support from families, especially mothers	30
		Peer pressure	7
		Lack of role models/ peer supporters	7
		Pressure from partners	7
		Bottle feeding culture	6

It appears that as well as feeling out of place on the ward, in attempting to breastfeed teenagers were perceived to have marked themselves out as different from their family, partners and friends, who lacked the knowledge and motivation to support them. Teenage mothers are perceived to live in a 'massive bottle feeding culture' (R54, Health Visitor, Midlands) where breastfeeding is relatively unknown, resulting in a dearth of family or peer supporters and role models. The teenagers' mothers were thought to be particularly unsupportive if they had not breastfed themselves (mothers who breastfed are seen to be supportive). Families are reported to advise the young mothers that

'they [the parents] bottle fed and they [the new mothers] are OK'
(R21, Teenage Pregnancy Midwife, North England),

and to be

‘opposed to breastfeeding and often help by buying some milk to give the girls a rest’

(R96, Teenage Pregnancy Midwife, North England).

This could make visiting times somewhat problematic. Partners, families and peers were all seen to be complicit in encouraging young mothers to conform to cultural expectations of bottle feeding, resulting in them either giving up breastfeeding or not wanting to feed in front of family or friends, or in public.

Discussion of topic one findings

The maternity professionals’ views of the obstacles to young mothers initiating breastfeeding have suggested that personal, institutional and network obstacles combine to create a situation in which young mothers feel like fish out of water on the postnatal ward and are unlikely to initiate or continue breastfeeding. Personal characteristics of young mothers were perceived to include a lack of maturity, adolescent discomfort with body issues, fear of negative judgement and a lack of knowledge about breastfeeding. Institutional challenges included a lack of staff, negative judgements of staff and a focus on medical care; and network obstacles centred on families and friends who were unfamiliar with and unsupportive of breastfeeding.

The current findings concur with the four other studies looking at health professionals’ attitudes to teenage mothers generally or specifically in respect of breastfeeding, which were discussed in chapter four/five, particularly in respect of the issues of maturity and body image (Shaw et al 2003, Shakespeare 2004, Spear 2004, Breheny and Stevens 2007). Some of the comments in the current study, for example ‘any difficulty encountered is met with them reaching for the formula feeds’, can be seen to reveal a rather judgemental attitude towards young mothers. Respondents also claimed that not all of their colleagues were supportive of young breastfeeding mothers. Although Spear (2004) found that, when questioned directly, health professionals will declare themselves supportive of young breastfeeding mothers, the current study, together with anecdotal evidence from the US (Podgurski 1995, Berg and Jaramillo 2000), and the

pejorative comments cited by Shaw et al (2003), suggests that there is a significant corpus of negative beliefs and attitudes towards teenage mothers and breastfeeding among maternity professionals. The current findings further indicate that this negativity has a detrimental impact on the breastfeeding support that young mothers are offered. It is important to note, however, that other respondents, both community and hospital based, were supportive of young mothers wanting to breastfeed.

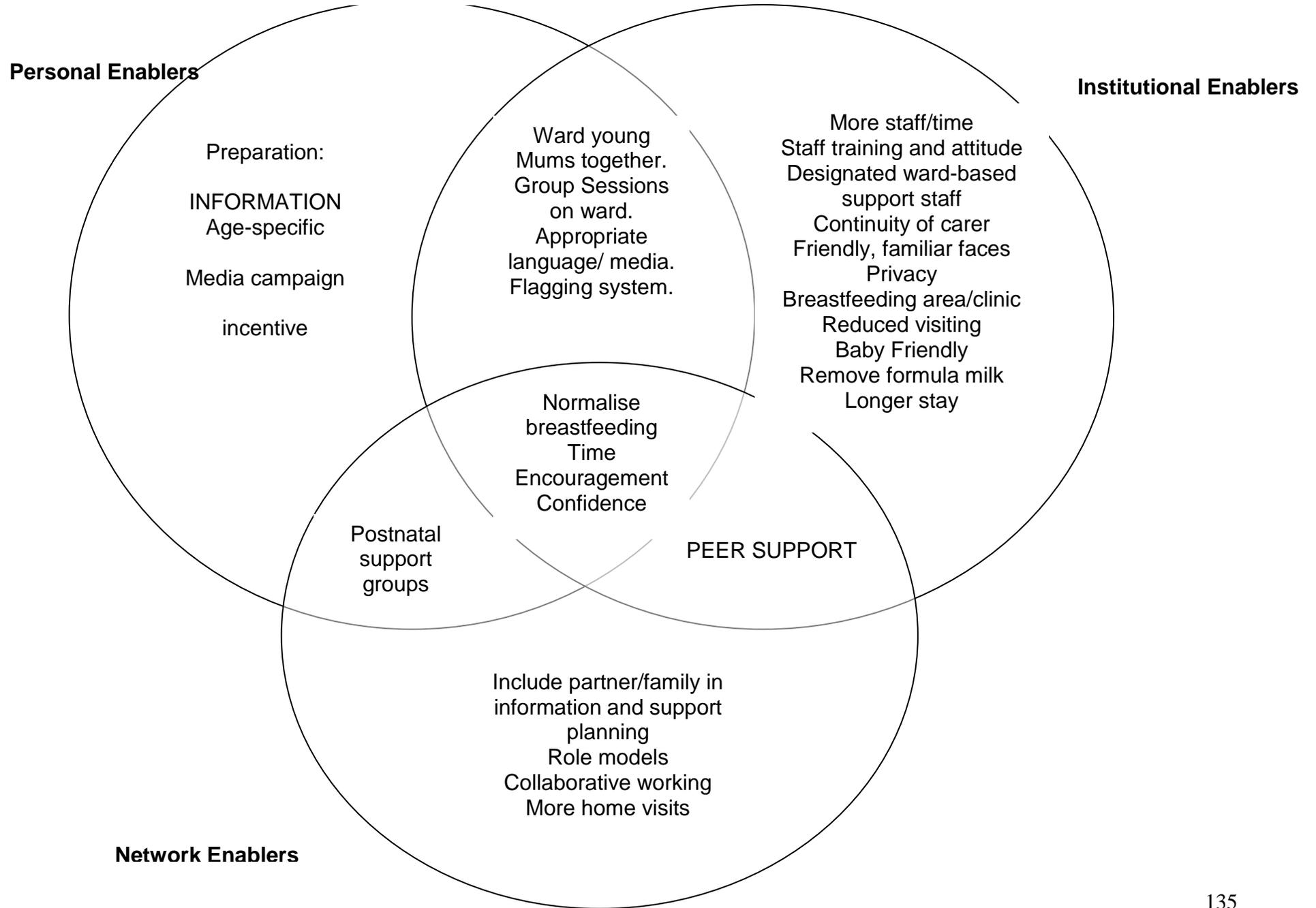
The current findings indicate that the environment on the postnatal ward had a direct impact on young mothers' infant feeding behaviour. The lack of confidence, embarrassment, feeling of exposure, quickness to be defeated and yearning to escape attributed to young mothers in the current study are all behaviours typical of rookies in an unfamiliar, and apparently unwelcoming and hostile, environment (Frydenberg 1997, Coleman and Hagell 2007). Here it is seen to lead to an inability to secure help, being embarrassed to breastfeed in a public space, a lack of perseverance with breastfeeding, and even switching to formula milk purely in order to get home.

Finally, the findings add to literature attributing low levels of breastfeeding among young mothers to the cultural norm of formula milk feeding (Mahon-Daly and Andrews 2002, Dyson et al 2006, Henderson et al 2010) by revealing some of the ways in which an entrenched bottle feeding culture militates against breastfeeding. An example of this is the purchase of formula milk by young mothers' families in order to give the new mother a rest. Thus young mothers wanting to breastfeed can be seen to be thwarted at every turn on the postnatal ward – they are in an environment which makes them feel uncomfortable and exposed, they lack the knowledge and confidence to initiate breastfeeding on their own, health professionals are often too busy or unwilling to offer assistance, and families' and friends' attempts to help are not supportive of breastfeeding.

Topic two: maternity professionals' views of appropriate support for young breastfeeding mothers

Strategies that were identified to support young mothers attempting to breastfeed centred around the core concept of 'mak[ing] breastfeeding the norm, rather than the 'weird' option' (R93, Community Midwife, North England). Maternity professionals cited support initiatives, or put forward suggestions, that they believed answered the barriers identified in topic one above. Thus time, encouragement and confidence emerge as central breastfeeding support requirements, as illustrated in figure 7.2 below.

Figure 7.2. Making breastfeeding normal



For the purposes of analysis, answers to the questions ‘please tell us about any initiatives you have come across that you think might enable more teenage mothers to breastfeed in hospital’ and ‘can you suggest any additional ways in which in-patient care might be changed so that more young women who wanted to breastfeed could successfully initiate breastfeeding in hospital’ were grouped together. Both of these questions aimed to encourage respondents to share and suggest ways of improving breastfeeding uptake among young mothers. The responses have been divided into personal enablers, institutional enablers and network enablers, as indicated in Figure 7.2 above.

Personal enablers

Health professionals suggested that antenatal initiatives such as classes, teaching and advice dispensed by their midwife during routine appointments, and health campaigns would give young women knowledge and confidence, making them more likely to breastfeed postnatally. The specific details of these initiatives are outlined in Table 7.9 below.

Table 7.9 Antenatal initiatives to enable more young women to breastfeed in hospital

Sub-category	Number of times raised in responses	Themes	Number of times raised in responses
Antenatal class/workshop	33	Specifically for teenagers	15
		Incorporating peer support	4
		Invite breastfeeding young mother	4
		Show DVD	4
		Interactive/fun	2
		Incorporate into hospital tour/ baby resuscitation session	2
		Run in Children's Centres	1
Information giving at antenatal midwife appointments	21	Explain advantages	4
		Inform/explain and explore principles	4
		Discuss with family and partner	4
		Explain what will happen in hospital	2
		Normalise breastfeeding	1
		Problem solve	1
		Incorporate into other discussions	1
		Supportive chat	1
		Dispel myths	1
		Advise against taking formula milk in to hospital	1
		Reinforce easiness of breastfeeding	1
Health Campaign	18	Written information/posters/media campaign	15
		Provide incentive/reward for breastfeeding	3
Alternative formats	3	Teenage antenatal clinics - include breastfeeding specialist midwife	2
		Designated midwife providing one to one tuition	1

Almost half (15/33) of the respondents who gave details about the antenatal classes or workshops stated they should be specifically for teenagers, as young people were perceived to 'talk more freely around people their own age' (R76, Community Midwife, Oxford). There was also a suggestion that dedicated antenatal clinics for teenagers should be provided.

Suggestions involving peer support, introducing pregnant young women to young breastfeeding mothers and weaving breastfeeding into other discussions and activities all represent attempts to normalise breastfeeding:

'I do a tour of the maternity unit for the young people and find another Mum who has breastfed to give positive images'

(R5, Teenage Pregnancy Midwife, North England).

'When discussing the healthy start vouchers it is a good time to discuss breastfeeding as it is free!'

(R70, Teenage Pregnancy Midwife, Scotland).

It was suggested that a health campaign incorporating written information and celebrity-endorsed media advertising would support and reinforce these activities:

'lots more...media coverage, publicity that breastfeeding is normal and best'

(R89, Community Midwife, Oxford).

Respondents also spoke of tailoring information giving to young people, by using DVDs such as the Department of Health (DH)'s 'From Bump to Breastfeeding', interactive teaching methods, and written material produced by other young people such as a

'Bump to Baby' guide for young parents to be developed by young people'

(R67, Infant Feeding Coordinator, Midlands).

It was felt that young people needed to hear about the advantages of breastfeeding, particularly ones that might appeal to a younger demographic such as

'explaining how breastfeeding aids calorie burn e.g. back into jeans plus healthy baby'

(R3, Community Midwife, Oxford).

One respondent suggested that the ease of breastfeeding should be emphasised, but others questioned the wisdom of this approach, advocating

instead that young mothers should be given a realistic account of what to expect in hospital and taught to problem solve:

‘sometimes talking about it before they go in helps...explaining what will happen, to try and make them less self conscious’

(R78, Midwife, Oxford).

Overall, these suggestions indicate an acknowledgement by maternity professionals that young mothers require dedicated and age-specific information and support if they are to be enabled to breastfeed. In particular, adequate antenatal information sharing and preparation was believed to make a crucial contribution to postnatal breastfeeding success.

Institutional enablers

The focus of many of the responses in topic two was on the care given on the postnatal ward. This was probably due to the way the questionnaire was phrased, as well as the possibility that the health workers perceived that many antenatal initiatives were already in place. The institutional enablers put forward by the maternity professionals included ideas about who should provide breastfeeding support, the attributes of these providers and the nature of the support provided (outlined in Table 7.10 below); and improvements to the ward environment (outlined in Table 7.11). The resulting categories of postnatal support and the postnatal environment are discussed separately below.

Table 7.10. Characteristics of breastfeeding support for young women on the postnatal ward

Sub-category	Number of times raised in responses	Themes	Number of times raised in responses
Support providers	84	Breastfeeding peer supporters/ volunteers	49
		Breastfeeding support workers	12
		Specialist midwife	6
		Specialist teenage support worker	5
		Shift midwife allocated to care for teenagers/breastfeeding women	4
		Specialist teenage midwife	4
		Maternity outreach workers	2
		Specialist teenage Health Visitor	1
Attributes of support providers	61	Teenager's mother	1
		Available on postnatal ward	30
		Familiar faces	8
		Be young mothers themselves	7
		Provide care ante- and postnatally	4
		Continuity of carer	4
		Provide breastfeeding support	3
		Patient, kind, sympathetic	2
Nature of support	38	Available 24/7	2
		Friendly, approachable	1
		More relational/proactive/intensive	12
		Given in accessible/appropriate ways	9
		Group sessions on the ward	5
		Implementing BFI 10 steps	4
		Information giving	2
		Skin to skin contact	2
One-to-one care	2		
Encourage new mothers to support each other	1		
Good discharge information	1		

Characteristics of postnatal breastfeeding support

There were 75 suggestions of people additional to the ward midwives who could provide breastfeeding support on the ward. This indicates a strong belief that the ward midwives are either too busy, or not the appropriate people to undertake this role. Breastfeeding peer supporters were by far the most frequently cited providers of support (although only seven respondents stipulated that they should be a similar age to the young mothers). Peer supporters were considered by health workers to be able to spend more time with individual women, and to be better able to build positive relationships with young mothers,

who did not view them as authority figures. Specialist teenage or breastfeeding midwives or support workers were also cited as appropriate providers of breastfeeding support. There was a strong belief that

‘a dedicated midwifery/support person can make a difference’

(R32, Teenage Pregnancy Midwife, North England),

and figures were provided to show that such an approach increased breastfeeding rates:

‘we had breastfeeding support workers trained to work with teenage mums antenatally intrapartum and postnatally up to 6 weeks, our breastfeeding rates increased dramatically and we had over 80% initiation rate’

(R84, Infant Feeding Coordinator, Midlands).

Continuity of carer was an important underlying theme – it appeared that familiar faces on the postnatal ward, follow up care at home or the opportunity to get to know postnatal supporters antenatally were deemed to be an important part of care, as illustrated in the following comments:

‘I try and visit on the wards when available’

(R29, Teenage Pregnancy Midwife, South England).

‘Antenatal and postnatal input from dedicated breastfeeding support workers, including daily support in hospital’

(R35, Midwife, North England).

The findings indicate that, whoever was providing breastfeeding support, a relational, proactive approach was necessary in order to give young mothers

‘time, support and encouragement with their feeding needs’

(R96, Teenage Pregnancy Midwife, North England).

Like the antenatal initiatives discussed above, it was considered important that postnatal breastfeeding support was delivered in an accessible way. Texts and DVDs were cited as media particularly suited to young people. Respondents expressed disappointment that, despite evidence for its effectiveness, the UNICEF ten steps to successful breastfeeding (UNICEF n.d.)

‘does not seem to be being delivered’

(R96, Teenage Pregnancy Midwife, North England),

or that it was followed on Labour Ward but not elsewhere.

The postnatal ward environment

Table 7.11. Suggested changes to the ward environment

Sub-category	Number of times raised in responses	Themes	Number of times raised in responses
Changes to hospital environment	47	More midwives/staff/time	20
		Put teenagers together	5
		Reduce visiting times	3
		Breastfeeding clinic/café	3
		Improve privacy/smaller bays	3
		Remove formula milk from bedsides/hospital	3
		Introduce flagging system to identify mothers wanting to breastfeed.	2
		Staff training/ attitude change	2
		Longer hospital stays	2
		More friendly environment	1
		Quiet time	1
		Increase dietary intake	1
Pump loan	1		

The popular assertion that more midwives or staff were needed on the postnatal ward (see Table 7.11 above) suggests that respondents would provide breastfeeding support if time allowed. There was a level of frustration among some hospital-based staff that they did not feel able to do this:

‘with the heavy workloads common on wards today, there just isn’t the opportunity to do that’

(R104, Midwife, Oxford).

In addition to wanting to see more staff on the ward, respondents were clear that the attitude of some health workers would also need to change before appropriate breastfeeding support could be given:

‘change attitudes of midwives in general towards teens’

(R56, Midwife, London).

‘More training needs to be available...then communication will be improved and teenagers can find it easier to engage with professionals’

(R29, Teenage Pregnancy Midwife, South England).

These sentiments were also implicit in calls for a friendlier environment and friendly, empathetic staff.

Other changes suggested to the ward environment appeared to be aimed at making young mothers feel more comfortable and less exposed on the ward, for example by being with other young mothers, limiting visitor access and improving privacy. The rationale behind the suggestion to put young mothers together appeared to be that they were

‘sometimes put off by older women’

(R78, Midwife, Oxford).

Similarly, visitors, particularly if they were visiting other women on the ward, were thought to invade the young mothers’ privacy.

The respondents also suggested ways in which time and space might be created for breastfeeding support. These included a flagging system in the women’s maternity notes to alert staff that a mother wished to breastfeed,

instituting a daily quiet time, and introducing a breastfeeding clinic and longer hospital stay. The longer hospital stay, however, was challenged by another respondent, who commented that young women generally prefer not to stay in hospital.

Network enablers

In order to address the lack of breastfeeding knowledge thought to be present in young mothers' families and communities, respondents to the questionnaire suggested that partners and families should be included in breastfeeding support activities where possible, and that additional support should be present after hospital discharge, such as support groups and extra visits. There was also a suggestion that maternity professionals should work more collaboratively with community-based services such as Children's Centres. The number of responses under each of these themes are outlined in Table 7.12 below.

Table 7.12. Community and network support

Sub-category	Number of times raised in responses	Themes	Number of times raised in responses
Community-based support	12	Peer/postnatal support groups	3
		Follow up visits at home from known carers	3
		Role models	2
		Collaboration between maternity and Children's Centre workers/ public health team	2
		More home visits	2
Improve family knowledge	3	Involve partner/family/friends	3

Discussion of topic two findings

The responses in topic two – maternity professionals' views of appropriate support interventions for young breastfeeding mothers – indicate a belief that more young mothers would breastfeed if they perceived it to be a normal activity, and if they were given sufficient time, encouragement and confidence to succeed. The key importance of normalising breastfeeding was reinforced in comments

made in answer to question four (is there anything else you would like to add), which emphasised a need for breastfeeding education in schools to help precipitate a culture change in society at large:

‘Got to change the culture to make breastfeeding normal’

(R9, Parent Education Midwife, North England).

Although focusing on institutional changes, the responses also include support interventions that might overcome personal and network barriers to young women breastfeeding. The institutional changes put forward indicate a need to change both the characteristics of the support provided and the environment in which it is given.

The emphasis on peer support in the responses reflects the ubiquity of this intervention in practice and in the literature (Phipps 2006, NICE 2008, Children’s Centres n.d). Although peer support has been found to increase breastfeeding initiation among new mothers in general (Dyson et al 2005), more recent research suggests mixed results with this approach (Jolly et al 2012). It is interesting to note that NICE are clear that it should be introduced only in addition to the baby friendly initiative (NICE 2008), and researchers trialling peer support interventions with teenage mothers have encountered innumerable difficulties, as discussed in chapter five (Di Meglio et al 2010).

Whereas national guidance on support initiatives to increase breastfeeding initiation rates focuses on implementing the very practical steps outlined in the baby friendly initiative (NICE 2006), the health professionals in the current study appeared more concerned with initiatives that might help young women feel relaxed and comfortable, such as preparing them for their hospital stay, warding young women together and the presence of familiar faces. This focus on relational aspects of care reflects the findings of the literature review reported in chapter five. The maternity professionals’ suggestions also indicate an awareness of the vulnerability of young mothers as new adults and mothers, and their desire to be validated in these roles. Although some of the suggestions, such as age-specific classes and clinics, reflect national guidelines (DH 2004),

others, such as putting young mothers together on the postnatal ward, are not mentioned in other research.

The initiatives reported by the health professionals and their ideas for improving care clearly indicate an awareness of a need for breastfeeding support on the postnatal ward to focus on relational aspects such as offering time and helping young mothers to feel relaxed and comfortable during their stay. Overall, the initiatives appear to point to the creation of an environment in which young mothers wanting to breastfeed would no longer flounder alone, like fish out of water, but be prepared for a postnatal stay in which targeted, appropriate support would be complemented by visits from familiar faces and sufficient time and privacy to learn this new skill.

Limitations

The comparatively low response rate from midwives and MSWs working at the trust that hosted this research (n=16) diluted their voice in the overall findings. Furthermore, only four MSWs completed the questionnaire, and it would have been interesting to learn more about their views. The high proportion of respondents from the online forum (n=67), means that the views expressed are likely to be those of health professionals with a particular interest in teenage pregnancy. However, there were no obvious differences in theme or tone between the replies received from employees at the Trust and members of the national forum. Very few replies were received from health professionals in Wales and Scotland, therefore the results may not reflect the situation with respect to teenage breastfeeding support, or the views of the health professionals, in these countries.

At the time that this e-questionnaire was circulated, e-mails at the hosting Trust were sent predominantly to group addresses. Today, all employees have a personal work e-mail account. This might make it easier to elicit responses from a larger and more varied selection of maternity professionals in future e-surveys. Overall, however, e-questionnaires provided a simple, quick means of eliciting a national overview of maternity professionals' views of the obstacles to teenage

mothers initiating breastfeeding in hospital and support initiatives that might enable more young women to breastfeed.

Conclusion

This chapter has reported and analysed the results of an e-questionnaire of maternity professionals on the obstacles to young mothers establishing breastfeeding and support interventions that might help them to succeed. The data suggest that young mothers are perceived to be acutely uncomfortable on the postnatal ward, and this discomfort prevents them from breastfeeding. Although some health professionals display negative attitudes to teenage mothers wanting to breastfeed, health professionals are aware that current levels of breastfeeding support for young mothers are insufficient and that more needs to be done to strengthen relational aspects of breastfeeding support.

The apparent acute discomfort experienced by young mothers on the postnatal ward will be explored further in the following two chapters, which report the data from focus group discussions with young mothers themselves. These focus groups were informed by the suggestions of support interventions put forward in the e-questionnaire, which were among support proposals presented to the young women in order to establish their views of essential and acceptable breastfeeding support.

Chapter eight

Personal and cultural influences on young mothers’ breastfeeding experiences

Introduction

Young mothers were invited to take part in focus groups and interviews to discuss their experiences in hospital after giving birth, and how these either supported or discouraged them from breastfeeding. However, the young mothers’ narratives of their post-birth experiences were rooted in and shaped by their personal growth and development during pregnancy and their treatment by their families in the early postnatal period. Time was therefore spent discussing these topics. This chapter presents and discusses the data gathered during the focus groups and interviews relating to these personal and network influences on infant feeding.

In chapter three, it was argued that adolescence can be characterised as a time of transition and change, characterised by dichotomous discourses between the child and the adult/mother. In this chapter, the young women’s descriptions of their early postnatal feeding experiences are rooted in their unique positions as ‘new adults’ as well as ‘new mothers’. The findings reveal that, in common with older breastfeeding mothers, young women consider that breastfeeding will mark them out as good mothers, but rarely feel able to breastfeed in public or in front of male family members. This creates a conflict for young mothers, who have developmental needs to be judged positively and to be accepted by and integrated into their families and communities in their new, adult, mothering roles.

Participant demographics

A total of 15 young women attended the focus groups and interviews overall. 12 of the participants were White British, one was Portuguese, and two were of mixed White/ Black African heritage. They were aged between 16 and 20 at the time of the group or interview (and had been aged between just under 16 and 19 when they gave birth). 11 stated that they had completed their education, and four planned to return to school or college. They had all considered, were considering,

or had actually breastfed their babies. 13 of the women were mothers, with babies ranging from two weeks to 21 months of age. Two of the women were approaching the end of their pregnancies when they first attended a focus group. The group in which these women took part (focus group one) was reconvened after they had given birth, in order to capture their experiences of breastfeeding (these two groups are counted as one in the analysis as the same women attended on both occasions, and the second group was a continuation of the discussion commenced in the first). All but one of the participants had recently given birth to, or were expecting, their first baby. As members of established young parent groups, the participants in each focus group knew one another socially. A summary of the characteristics of each group is presented in Table 8.1 below. In the table and the findings which follow, the focus groups are numbered one to four. The two 'groups' with only one participant are designated as interviews one and two. To protect their identity, participants have all been given pseudonyms. In the direct quotations, '...' signifies that some words have been omitted, and '..' is used to signify a pause, or, in a dialogue, to indicate an interruption. Words in bold indicate an emphasis detected in the speaker's delivery. Square brackets are used to add explanations where necessary.

Table 8.1 – focus group characteristics

Focus group	Location	Number of participants	Age range of participants at baby's birth	Ethnicity of participants		Prevalence of breastfeeding in group	
1	City	3	18 years 11 months – 19 years 9 months	White British White British/ Black African Portuguese	1 1 1	15 days -1 month Still breastfeeding	1 2
2	Town/ rural	2	15 years 11 months – not divulged	White British White British/ Black African	1 1	Once, twice or not at all	2
3	Town/ rural	5	16 years 6 months – 19 years	White British	5	Once, twice or not at all 3-7 days 8 days – 2 weeks Still breastfeeding	2 1 1 1
4	Town/ rural	3	18 years – 18 years 6 months	White British	3	Once, twice or not at all 15 days – 1 month	2 1
Int 1	Town/ rural	1	19 years 3 months	White British	1	Once, twice or not at all	1
Int 2	Village	1	18 years 5 months	White British	1	Over a month	1

Personal influences on decision to breastfeed

The data support previous findings that young mothers choose to breastfeed because it is 'best for baby' and promotes bonding, and that, in common with older mothers, young women find breastfeeding in public or in front of male family members challenging, and support from families and significant others to be an important component of breastfeeding success (Shaw et al 2003, Hall Moran et al 2007). However, in the current study these themes are embedded in an overriding need expressed by young mothers to be a good mother and to be integrated as such into their families and communities.

Breastfeeding and good mothering

The participants considered that other people would disapprove of their decision to have a baby. Their awareness of the stigma attached to young

motherhood was highlighted by the admission that they themselves had made assumptions and judgements about young mothers in the past:

Avril: 'Cos I used to be like that [disapproving]. I won't lie...

Shannon: Yeah, and that stuff helped make me realise that there is a story behind every pregnancy, that might not be the one that you first come to think when you see somebody

(Focus Group 1).

The young women described going to great lengths to present themselves as respectable citizens, including being deliberately vague about their addresses, so they weren't stereotyped as 'council estate' teenage mothers, and taking their partners along to antenatal appointments, so people could see that they were in a relationship. The one participant who was married always made sure people could see her wedding ring, and those who had jobs made sure people knew this was the case.

In this context, breastfeeding was seen as an act that would show the outside world that the young person was a capable and worthy mother. Sarah (Interview 2) expressly links her decision to breastfeed with a need to prove her mothering credentials:

'I think also because I was a teenager I sort of wanted [to breastfeed] to, sort of.. **prove** that I was gonna be a good Mum'.

By choosing to breastfeed, the young mothers felt that they were putting their babies first, and giving them the 'best start' (Sarah, Interview 2). For example, Becky (Focus Group 1) related how she was motivated to start breastfeeding when her son was unwell after birth:

'I wasn't gonna breastfeed until I nearly lost him, and it was that that made me do it, because I know it was kind of the only chance he had'.

The participants rarely mentioned any benefits of breastfeeding for themselves – only one group cited the fact that it helps women lose weight (Focus Group 3). In fact, breastfeeding was held to have several disadvantages for mothers – it could be painful, stressful and difficult. However, young mothers who anticipated or experienced problems with breastfeeding felt that these further reinforced their standing as good mothers, choosing to do the best for their babies despite personal inconvenience.

Breastfeeding was also seen to be a sign of good mothering because it promoted 'closeness for you and your baby' (Jemma, Focus Group 3), creating a bond that formed an important part of participants' maternal identity and boosting self-esteem:

Becky:...but if you really think about it, if you're breastfeeding, all your baby really needs is you...Because you're his comfort, his food. You know, you've got everything he needs. And it's an amazing feeling, it really is

(Focus Group 1).

For some of the young women, breastfeeding was so closely aligned to success as a mother that stopping made them feel 'a failure', and that they'd 'lost a bit of a bond' with their baby (Tanya, Focus Group 4).

Interestingly, mothers who chose not to breastfeed or stopped breastfeeding soon after birth also justified their decisions in terms of what was best for their babies, as illustrated in the following exchange:

Marcia: Yea, but you can't see how much they're drinking.

Lucy: Yea, that's the thing, you don't know if they're full up

(Focus Group 2).

This suggests that presenting themselves as good mothers is a concern of young women however they choose to feed their babies.

Breastfeeding and nurturing

In order to want to breastfeed, participants described how they had to learn to see bodily contact as a nurturing, rather than a purely sexual, activity. Only one participant, who had grown up around breastfeeding, saw breastfeeding as the normal and natural option (Avril, Focus Group 1). For the others, a change in attitude generally happened over the course of pregnancy, as the drive to be a good mother overcame an initial dislike of the idea of breastfeeding. This process is particularly evident in the narratives of Sarah (Interview 2) and Shannon (Focus Group 1). Sarah describes how, when asked about breastfeeding in early pregnancy,

‘I was like ‘oh no, I don’t like it, I don’t like it’.

This attitude changed as she learnt about the benefits of breastfeeding and developed a relationship with her unborn child:

‘...and then, sort of, as I grew bigger, and then obviously saw the scan, I thought ‘oh no, I do wanna’... and then I think learning about it made me realise that I did wanna do it’.

The following comment shows how far her attitude to bodily contact with her baby had changed by the time he arrived:

‘even though I wasn’t breastfeeding [initially] I did do it [skin to skin] on the ward...And I felt like I needed that skin to skin – ‘cos he wasn’t getting breastfed I think that he needed that skin to skin anyway’.

Shannon (Focus Group 1) described rejecting the idea of skin to skin contact when she first heard about it, as her baby would be covered in 'goo stuff'. She also struggled to overcome her association of breasts with sexuality:

'I can see my Baby Dad latched on to the other one!'

Again, however, she came to associate bodily contact and breastfeeding with nurturing and being a good mother:

'Um, well my neighbour, ...she didn't breastfeed...I look at her relationship with her daughter, and then I look at like another relationship with somebody that has breastfed and I just think it does look totally different as an outsider – they don't seem as close...And I just think that's enough to make me not wanna bottle feed. I wanna breastfeed – I want to hold my baby straight away and stuff like that'.

The young women's conceptualisation of breastfeeding as the hall mark of good mothering caused problems as they tried to integrate into their families and communities after giving birth, as the following section illustrates.

Network and community influences on feeding experiences

Problems of community integration

It was apparent that a deeply embedded taboo about feeding in front of other people, particularly men, made being integrated into the community as a breastfeeding mother particularly difficult. The participants described oscillating between acts of bravado and defeat. While Avril (Focus Group 1) is able to follow Shannon's example and breastfeed in a shopping centre -

'Shannon whipped it [her breast] out and I thought 'if she can do it, I'm doing it!' -

the prospect of feeding her baby in front of other peoples' partners at a breastfeeding clinic is too much for Sarah (Interview 2):

'there was all these blokes there.. I was just like – I'm 18, and I didn't want to – you know...So I just sort of said 'oh, we're going for a walk and we'll come back'. And I just sort of.. **ran** out of there'.

In this comment, Sarah acknowledges that as a teenager she is less comfortable with exposing her body than she expects an older mother would be.

The taboo against public breastfeeding extended to feeding in front of male family members, and the women found that this resulted in their desire to breastfeed coming into direct conflict with a desire to be accepted by and integrated into their families. Some young women were even embarrassed to feed in front of their partners initially, and admitted that they would find it hard to accept breastfeeding help from them. Far from bringing praise of their mothering skills, breastfeeding could isolate the new mothers from their families, causing great distress:

Becky: I don't think she [mother] quite understood how hurtful it was when she told me I couldn't breastfeed, and um told me that if I wanted to breastfeed I had to go upstairs...I had to go and sit in the car...it was almost like they rejected me

(Focus Group 1).

Some felt that they had to choose between breastfeeding and spending time with their families:

Sarah: ...most of the time I wanted to be on my own anyway, but – I wanted to be on my own doing it [expressing], but I didn't want to be on my own like missing out on that time with everyone – like I could hear them all laughing downstairs and I was upstairs, sort of feeling like Daisy the Cow

(Interview 2).

This feeling of isolation was further compounded by the perception that, because breastfed babies are totally reliant on their mothers for food, no one was able to provide help and support:

Lottie: Well, like at night time I was the only one that could get up and do it – I just thought that was quite hard that no one else could like get up and do it – it had to be me

(Focus Group 3).

Family support – an emotional minefield

Receiving support and encouragement from their families and friends helped the young mothers feel valued and accepted, and gave them the strength to continue breastfeeding when difficulties or opposition were encountered:

Vicky: 'Cos like when I was in hospital... I was gonna give up, but if it wasn't for him [partner] I think I would of, but he was really encouraging, he kept me going, so..

(Focus Group 3).

It was common, however, for the young women to believe that their partners and families were not always supportive:

Clare: ...he was absolutely useless

(Focus Group 3).

This lack of support was often attributed to a lack of knowledge about breastfeeding (particularly in the case of the women's mothers), or, in the case of some partners, to prevailing cultural norms:

Rachel: He preferred me to bottle feed. It's just a man thing, isn't it?

(Interview 1).

Furthermore, not being able to participate in feeding their babies could exclude partners –

Clare: partners don't get the bond that you get

(Focus Group 3) –

and make men feel left out, thereby putting added strain on the new parents. Avril (Focus Group 1) had discussed this situation with her stepdad, who had admitted feeling very frustrated when her mother was breastfeeding:

'it used to like really upset him because he couldn't do nothing... he just used to sit there and watch her and then like, or he'd go out and be annoyed... even if it was only like 15, 20 minutes but he thought it was like 15, 20 minutes that he wasn't involved, and they wanna be involved sort of thing'.

Participants also described how family members did not always know how to provide support, as the following quote from Jemma (Focus Group 3) illustrates:

'She [foster mother] didn't really breastfeed her kids, so she was giving me the option obviously – it was my choice, so, but she tried helping out as much as she could, but like if I needed to express she would hold the baby while I was kind of like expressing, but she wasn't very helpful – she just kind of let me do it myself, sort of thing'.

Additionally, family relationships could be emotionally charged, making it difficult for mothers in particular to give, and daughters to receive, advice:

Tanya: I'm much happier now I'm not at home. Like me and me Mum have got a much better relationship now, 'cos we're not arguing all the time

(Focus Group 4).

Participants in two groups felt that, even when they had a more positive relationship, their mother was not the right person to support them with breastfeeding:

Shannon: I think my Grandma'd be better, actually **showing** me how to do it, 'cos my Mum's really funny – about stuff like that. She gets – she's – she gets really embarrassed

(Focus Group 1).

In some cases it was the young women who were embarrassed to discuss breastfeeding with their mothers. This point is illustrated in the following exchange with Lottie, who has been asked whether her mother could have provided more support with breastfeeding:

Lottie: I wouldn't really want her to do that to be honest.

Researcher: Yea

Lottie: It would be a bit weird.

Researcher: ... Why do you think it would be weird?

Lottie: 'Cos it's my Mum.

Researcher: So you'd rather have someone – maybe a professional..

Lottie: Yea

Researcher: .. whose like not so involved.

Lottie: Yea, I don't have a bond with them or anything like that, so

(Focus Group 3).

Becky (Focus Group 1) also states that professional help can be preferable to that provided by families. When talking about the support she has received from her local Children's Centre, she remarks that:

'I think the sort of people who are more detached, in a way, actually help more than the people that are too close to the situation'.

It appears that the new mothers find it easier to accept support from health professionals, not only because discussing bodily functions with their mothers is potentially embarrassing, but also because by identifying breastfeeding with good mothering they have made an emotional commitment to breastfeeding success, and are more likely to be overwhelmed by their emotions in front of those closest to them.

Although unwilling to consult their mothers about breastfeeding, the young women really appreciated practical assistance from their mothers and families:

Sarah: The first few days, the steriliser was like going on 7 times a day! ...And she [mother]'d – I'd come down [after expressing] and they'd be sterilised, and I'd be – oh, it was such a weight off my shoulders

(Interview 2).

Participants were asked how they thought partners and mothers could be enabled to provide effective support to breastfeeding young women. Although they thought that a breastfeeding class for partners and families would be unworkable, the young women did want their mothers and partners to be included in the information and support they were given in hospital, and were disappointed that this was not always the case:

Tanya: ...my Mum stayed with me until quite late... but they didn't really say anything to her like

(Focus Group 4).

The participants wanted their mothers and partners to be given information about breastfeeding both so that they could help remember what was said, and so that partners in particular would be helped to discover ways, apart from feeding, of caring for their babies and therefore feel 'slightly more useful'.

The lure of the bottle

Initiating feeding was one thing, being able to sustain it from day to day in an environment that was often unsupportive and in which breastfeeding separated new mothers from their families was something altogether different. This was especially true for the mothers who left hospital expressing their breastmilk. Regular expressing was ultimately an unsustainable commitment:

Jemma: And then in the end I just couldn't be arsed, and had enough when I got home, after 3 weeks I just shoved him on the bottle

(Focus Group 3).

Some of the young women felt that exclusive breastfeeding was not sustainable in their day-to-day lives, and needed to be combined with formula milk feeding to create a perfect feeding method:

Clare: I'd do both bottle and breast...I'd find it easier. It wouldn't always be relied on me

(Focus Group 3).

The participants disagreed with the practice of not offering formula supplements in hospital, believing that this put undue pressure on them and that exclusive breastfeeding was perhaps an unrealistic goal:

Lottie: I think you should [be offered formula in hospital], and then you can choose what you want to do...

Clare: Or even be told what formulas there are, and what they're like

(Focus Group 3).

Mixed feeding, on the other hand, was seen as an option that enabled the new mothers to integrate fully into their families and communities, allowing their partners to be more involved and providing more options for support. It was also considered important that babies become 'used to' feeding from a bottle, as breastfeeding could not be allowed to continue for too long. Even Avril (Focus Group 1), who had grown up around breastfeeding, felt that early weaning was essential:

'it's kind of frowned on to breastfeed from 3 or 4 months'.

Discussion

The findings suggest that young women believe that breastfeeding will mark them out as good mothers who put their babies first and develop a close bond with their offspring. However, breastfeeding often distanced young mothers from their families, who did not always know how to provide support and felt that breastfeeding should be hidden from public view. A decision to breastfeed therefore created a conflict between young mothers and their families and communities. Taboos around feeding in public separated young mothers from the communities into which they sought to be integrated both as adults and as good mothers, and from which they sought support and validation. The paradox of breastfeeding being a hall mark of good mothering and yet something that cannot be seen is particularly problematic for young mothers as they straddle the roles of adolescent and mother. As 'rookie' adults and mothers, young women want to be judged positively and seek affirmation, recognition and acceptance from those close to them (Frankel 1998, Feldman-Winter and Shaikh 2007).

Although the association of breastfeeding with good mothering is well established among older mothers (for example, Earle 2002, Marshall et al., 2007), and previous research with young mothers has found that their awareness of the stigma of young motherhood makes them very keen to portray themselves as good mothers (McDermott et al 2004, Graham and McDermott 2006, Wilson and Huntington 2006, Arai 2009, Alexander et al 2010), breastfeeding was not specifically associated with good mothering in the qualitative research with young

women reviewed in this thesis. Studies of young mothers' attitudes to breastfeeding in the US and UK have pointed towards this idea, noting the belief of some young women that they should put their babies first and persist with breastfeeding in the face of personal discomfort (Nelson, 2009; Stapleton 2010; Brown et al. 2011). One UK questionnaire and focus group study of factors influencing the infant feeding decisions of socioeconomically deprived pregnant teenagers presents a very different view, however, finding that many young women viewed breastfeeding as a morally inappropriate behaviour practised by lazy, 'loose' women (Dyson et al. 2010). Even so, both this and the current study show the importance that young women attach to moral and value judgements around feeding choices. Decisions to breast or formula feed are each defended as evidence of superior mothering by those who practice them. Studies of older women have also found that infant feeding choices are closely bound up with building a positive mothering identity (Marshall et al. 2007, Ludlow et al. 2012). It may be that the need to be, and to be judged to be, a good mother is even stronger in younger mothers, both because adolescents are in the process of developing fragile and easily dented identities as new adults, and because they fear that being labelled a 'bad' mother will result in their babies being taken in to care (Frankel 1998, Price and Mitchell 2004, Dyson et al. 2010).

Dyson et al do not state what stage of pregnancy the participants in their study had reached – the negative views expressed may indicate that many were earlier on in their pregnancies and had not yet come to view breastfeeding as a nurturing activity. Some of the participants in the current study did not view breastfeeding positively at the beginning of their pregnancies, but changed their minds as they developed a relationship with their unborn children as the pregnancy progressed. Additionally, the participants in the current study had all attended teenage pregnancy support groups, where they were likely to have been exposed to health and social professionals expounding the benefits of breastfeeding. This would suggest that antenatal education can play a vital role in shifting perceptions, however deeply rooted they appear to be. The finding of this study that some young women develop a desire to breastfeed over the course of their pregnancies also reinforces the advice from the UNICEF Baby Friendly Initiative that women should not be asked about their feeding intentions at the beginning of their

pregnancies but should be involved in open discussions about the benefits and management of breastfeeding (UNICEF n.d).

The notion that both young and older women consider breastfeeding in public to be embarrassing and unacceptable is well documented in previous research (Brownell et al. 2002, Shaw et al. 2003, Nelson 2009, Dyson et al. 2010). This study adds to the growing body of research that highlights the fact that it is feeding in front of men, even if they are close family members, that is taboo (Benson 1996, Ingram et al. 2008, Stapleton 2010).

Also in line with previous research, the importance of support and encouragement from partners and mothers is highlighted (Hall Moran et al. 2007, Wambach and Cohen 2009, Grassley 2010). However, the emotionally charged and delicate nature of many mother/daughter relationships is exposed, suggesting that health professionals must tread very carefully when enlisting family support for breastfeeding young mothers, and that young mothers might prefer to receive breastfeeding advice and support from health professionals. Bunting and McAuley (2004) also found evidence of discordant family relationships in their review of support for teenage parents. The current study also provides some evidence to suggest that friendship and support from other young mothers can be just as or even more important than family support, helping to increase confidence and self-esteem and enabling young women to challenge social conventions.

The strong inclination towards mixed feeding among the young breastfeeding mothers in this study is also mirrored in other UK and US research, and early formula supplementation has been found to be common among this group (Wambach and Koehn 2004, Grassley and Sauls 2012). It has been suggested that mixed feeding might be a more realistic and practical goal for some young mothers (Nelson 2009) – the findings of the current study would certainly indicate that in order for more young women to be able to breastfeed exclusively either creative solutions must be found to the stresses and dilemmas they face or attitudes and conventions within society at large need to be challenged and changed.

Conclusion

The findings of the focus groups and interviews in respect of the personal and network experiences of young mothers attempting to breastfeed have highlighted a potential conflict in developed, western countries between young women's desire to breastfeed in order to build an identity as a good mother, and their need to be integrated into their families and communities in their new roles. Young women who choose to breastfeed struggle to balance the competing concepts of their ideal for good mothering and the reality of being an adolescent adjusting to adult parenthood within a social milieu that does not tolerate breastfeeding in front of other people and lacks the heritage to provide adequate breastfeeding support. Overall, the views expressed by the small number of young UK mothers in this study suggest that there is a need for midwives to understand and address the developmental, conceptual and community frameworks which shape young mothers' breastfeeding decisions and experiences if appropriate and effective support is to be offered to this group. The following chapter presents the young women's accounts of their time in hospital after giving birth, and explores the effect of their early postnatal experiences on their feeding decisions and behaviour. Suggestions for improving the breastfeeding support available to young mothers are also presented and discussed.

Chapter nine

Inpatient experiences impacting on breastfeeding initiation and continuation among young mothers

Introduction

This chapter outlines and discusses the inpatient experiences that young mothers who took part in the focus groups and interviews considered to have impacted on their infant feeding experiences and decisions. Young mothers' views of support measures that might enable more of them to breastfeed are also presented. The findings demonstrate the importance of environment and carer/mother relationships on feeding outcome. The young mothers' experiences in hospital are divided into time spent on the labour and postnatal wards. Events in both settings influenced infant feeding.

Post birth experience on Labour Ward: disempowered and passive

Although not always directly related to breastfeeding, the participants' experiences just after giving birth impacted on their self-confidence and their relationships with their babies. This then dictated what happened in relation to the newborns being fed. Three themes were identified from the young women's accounts: 'feelings at birth: 'so tired and so dazed'', 'initiating feeding' and 'deliver, stitch, dress'.

Feelings at birth: 'so tired and so dazed'

Many of the young women felt incapacitated by tiredness and pain after giving birth. Although Vicky described feeling 'instant love' for her baby (Focus Group 3), the new mothers were more likely to use words like tired, dazed, scared, hungry and overwhelmed to describe their post-birth experiences:

Rachel: I just fell asleep! I was too tired!

(Interview 1).

Pain featured strongly in the participants' recollections of this time, and appeared to prevent the new mothers from relating to their newborns:

Avril: ...'cos they was like 'do you want cuddles with her while you're having your stitches?' And I was like 'No!' 'Cos I didn't know if it was gonna hurt

(Focus Group 1).

The young women also spoke of feeling terrified at finding themselves immobile and helpless, as the following exchange in Focus Group 4 illustrates:

Tanya: I think that's horrible innit, when you can't move. ...I felt a bit like 'oh my God... like, I couldn't even go for a wee on me own – it was just awful.

Lauren: I know, I was exactly the same..

Tanya: ..I felt like a baby or an old lady..

Lauren; ..I didn't even dress him, or put a nappy on the first time.

At the very moment when they are embarking on their adult, mothering lives, the young women feel utterly incapacitated.

Initiating feeding

The young women's accounts show that they were aware of the importance of skin to skin for initiating breastfeeding, and had intended to initiate this after birth. However, their exhaustion and pain, combined with post-birth hospital rituals and routines such as weighing and dressing the baby and suturing the mother, conspired against this happening. When skin to skin did happen, it was often perfunctory:

Jemma: ...they just like put him on my chest, and his Dad cut the umbilical cord, and he got wrapped up in a blanket.

Researcher: Right, so it wasn't really for very long.

Jemma: About 10 minutes. Probably 15 or something

(Focus Group 3).

The mothers who were able to experience uninterrupted skin to skin contact, however, were usually able to enjoy an unremarkable, successful first breastfeed.

Avril: ...and then we had skin to skin and then she ate a bit

(Focus Group 1).

If babies were not offered or did not feed during skin to skin contact, the first breastfeed was generally initiated by midwives, either during or just after the mother was sutured, or just before the new family was moved from the delivery room to the postnatal ward. Nearly all the new mothers described the first breastfeed as something that was done to them, rather than something they were helped to do themselves. The midwives were in control, and decided when and how the feed happened. Many of the young women described being man-handled, and found the midwives' manner very abrupt:

Clare: I was just left, and then when I was gonna like be moved up onto the ward the nurse come and she just like sort of grabbed [baby] and tried to like ram her on to my breast and that

(Focus Group 3).

Participants in three groups (Focus Groups 2, 4, Interview 1) had intended to breastfeed but were not given any feeding support at all after birth, as staff assumed they would want to formula milk feed. Rachel (Interview 1) had written about skin to skin contact and breastfeeding in her birth plan, but was not offered either:

'I dunno I just didn't get round to – after I had him – they didn't present it as an option really, they just thought I was bottle feeding'.

Lauren (Focus Group 4) related that she was asked about her feeding intentions over the intercom between the midwives' station and her room:

'And they just buzzed through and they went 'do you want – are you bottle feeding or breastfeeding?' So I went 'yea'. 'What milk?' 'Cow and Gate'. That was it, then.. I had no support there'.

Deliver, stitch, dress

The young women's accounts of their post birth experiences portray a culture in which the focus of care is on completing tasks, rather than encouraging the new mothers to get to know their babies and start to breastfeed. The midwives' first task after the birth was to check the baby. This resulted in some of the young women not being able to greet their newborns, as Becky's account (Focus Group 1) testifies:

'And I remember one of the midwives holding him up, like at the end of the bed – and of course I can't see that far [Becky is partially sighted]. And I couldn't see him, and then they took him away'.

Once the baby had been declared healthy, the immediate postnatal period was then dominated by requirements to suture the mother and dress the baby:

Lottie: ...they passed her to me, like when they cut the cord and everything, but then I had to have stitches, so they like took her, dressed her, and then she was just in the cot

(Focus Group 3).

Once the mother had been stitched and the baby dressed, health professionals tended to leave the room, resulting in some of the new mothers feeling abandoned:

Lauren: I got left on my own, the minute I had him – they all went, when they knew he was OK

(Focus Group 4).

Even though they were not getting the help they wanted, none of the participants described challenging or making any demands of their carers in the immediate

post birth period. One, Clare (Focus Group 3), didn't even feel able to ask for her baby to be passed to her for a cuddle after she is left alone in the delivery room, or to move the child herself without permission. Similarly, Katie (Focus Group 3) did not feel able to ask for or initiate skin to skin contact:

Katie: Well I wanted to [have skin to skin] but they, they didn't, they wouldn't let me

Researcher: Why was that?

Katie: Well they didn't say I can't do it, they just didn't say anything to me to do it.

This notion that if something was not offered then it must be forbidden was a common thread in the focus group and interview discussions.

Overall, the participants' accounts indicate that they felt exhausted and disempowered after giving birth, and that the care they received at this time reinforced their perceived helplessness and encouraged a passive acceptance of hospital routines and rituals that discouraged a positive start to breastfeeding. These feelings were exacerbated on the postnatal ward, which the young mothers largely saw as a foreign and inhospitable environment.

The postnatal ward: alien, alone and exposed

Three themes were identified relating to experiences on the postnatal ward: 'an alien environment', 'feeling exposed and judged', and 'miscommunications'.

An alien environment

The young mothers clearly saw themselves as outsiders on the postnatal ward, viewing it as an alien environment in which they didn't always feel comfortable or understand what was expected of them. Even those like Lucy (Focus Group 2), who liked being on the ward because 'it was nice. It was always clean', initially found the set up quite strange:

'it was really weird...you see all these women walking around!... I've never seen so many babies in my life'.

The unfamiliarity of the ward is particularly brought in to focus when the young women's families go home:

Tanya: ...and then like my Mum went home and it was just like 'oh my God I'm here on my own... It was just really, like, creepy – I think of hospitals as where you go to.. die

(Focus Group 4).

The strangeness of the ward was compounded by rules and routines that appeared nonsensical to the young mothers, such as a requirement to transport their babies in cots, rather than carrying them around in their arms. Together with some ward routines, such requirements also disempowered the young women, putting the midwives firmly in charge and disregarding the new mothers' needs:

Sarah: ...she [the midwife]'d come and open my curtains at like six o'clock in the morning, and I was next to the window, and I'd only just sort of got to go to sleep

(Interview 2).

Presumably in an effort by midwives to lessen their discomfort, some of the young women were given single rooms on the postnatal ward, and most were very appreciative of having their own space:

Jemma: ...being in a room where no one can really look at you or anything like that – that's what made me feel a bit more – um, like myself... it wouldn't feel like anyone was peeking round looking at me

(Focus Group 3).

However, although a private room provided somewhere for the new mother to hide from prying eyes, it did not address her need to be accepted as a new mother. Interestingly Vicky (Focus Group 3), who was very happy with the care she received postnatally and felt comfortable with and validated by the healthcare staff, found being in her own room 'lonely' and 'boring'.

Feeling exposed and judged

Alone on the ward, the young women described feeling exposed, watched and judged by both midwives and other mothers. This is evident in Jemma's observation above that no one could 'peek round' at her once she was in her own room, and also in Tanya (Focus Group 4)'s comment that

'I think they [midwives] do talk down to you'.

Their sense of exposure, together with a perceived lack of privacy on the ward, led to young mothers feeling unable to perform intimate mothering tasks such as holding their babies skin to skin, or expressing breastmilk:

Lottie [re skin to skin]: I think that when you're downstairs [on Labour Ward] it's better 'cos you're like on your own, but when you go upstairs there's like other people, and I wouldn't wanna do it

(Focus Group 3).

The young mothers' intense discomfort did result, in some cases, from genuine discrimination –

Sarah: And I can remember she [midwife] kept going round to all the other women like 'oh she's gorgeous! What's her name?' And then she'd come to me and she just wouldn't ask me a thing

(Interview 2) -

however, most of the young women reflected that their perceptions of midwives' and other mothers' unfriendliness may not have been entirely fair, as pregnancy

and new motherhood were emotionally stressful times when they were more likely to feel slighted and take offence where perhaps none was intended:

Tanya: Well I took everything to heart actually, so most probably it wasn't her [midwife], it was probably just – just the way I was at the time

(Focus Group 4).

The young women's lack of solidarity with other mothers on the ward did not only result from their feeling judged due to their young age, but also from their being exposed to different cultures and practices during their hospital stay. It was evident that many of the young mothers had never been away from home before, and had very little experience of life outside their own communities.

Miscommunications

The young women's accounts revealed instances of a basic inability of some health professionals and young women to understand and communicate with one another. This appeared to stem at least in part from the young mothers' not trusting their carers:

Tanya: ...she [midwife] was really nice but I didn't know if she was just being nice to be nice, or if she was genuinely nice

(Focus Group 4).

In particular, the young women often failed to communicate their needs to the health professionals on the ward. This was often because, despite their awareness that the ward was a very busy place and that staff were overstretched, they tended to wait for help to be offered rather than asking for assistance. This meant that breastfeeding opportunities were missed. It was evident, however, that even if they had given their baby a bottle on labour ward, the mothers would still have liked to initiate breastfeeding on the ward. Lucy (Focus Group 2), who bottle fed her baby after birth but was intending to breastfeed, eventually feels able to ask for help with breastfeeding on day three of her postnatal stay, only to have her request dismissed:

'I said to them 'I wanna try and breastfeed at night time'. They said 'oh, it's going to take a while to get used to breastfeeding', and I said 'OK then'. And I just thought 'oh, we'll try it'. But we never did'.

Other participants did receive breastfeeding support when they asked for it, but were unable to communicate their wish to be shown what to do, and not simply to have their baby latched on for them:

Lottie: ...when they helped me they just like put her on, but they didn't actually help me to do it myself... that's why I couldn't really do it myself or anything

(Focus Group 3).

A general discomfort with asking for help lead some participants to adopt more devious tactics to attract the midwives' attention:

Sarah: Sometimes I used to press the buzzer, sort of put it back, and they'd come and I'd say 'oh, oh, I must have leant on it!' And then I'd say 'oh, while you're here..', because I just felt like I was being such a nuisance

(Interview 2).

Other mothers would close down interactions and not communicate their needs when help was perceived as unsympathetic:

Jemma: she came in and she said 'what do you want? We're busy'. Sort of, like that! And I was thinking 'alright, don't bother then! I'll try and do it myself'. And I just said 'don't worry about it'

(Focus Group 3).

As a result of experiences such as those described above, most of the new mothers felt that they had worked out how to breastfeed on their own:

Shannon: ...luckily we [Shannon and baby] worked it out together
(Focus Group 1).

However, when proactive assistance was offered, it was sometimes interpreted as pressure to breastfeed – it appeared that the midwives had to tread a very fine line between giving young mothers enough support and information, and giving them space to feel independent and capable.

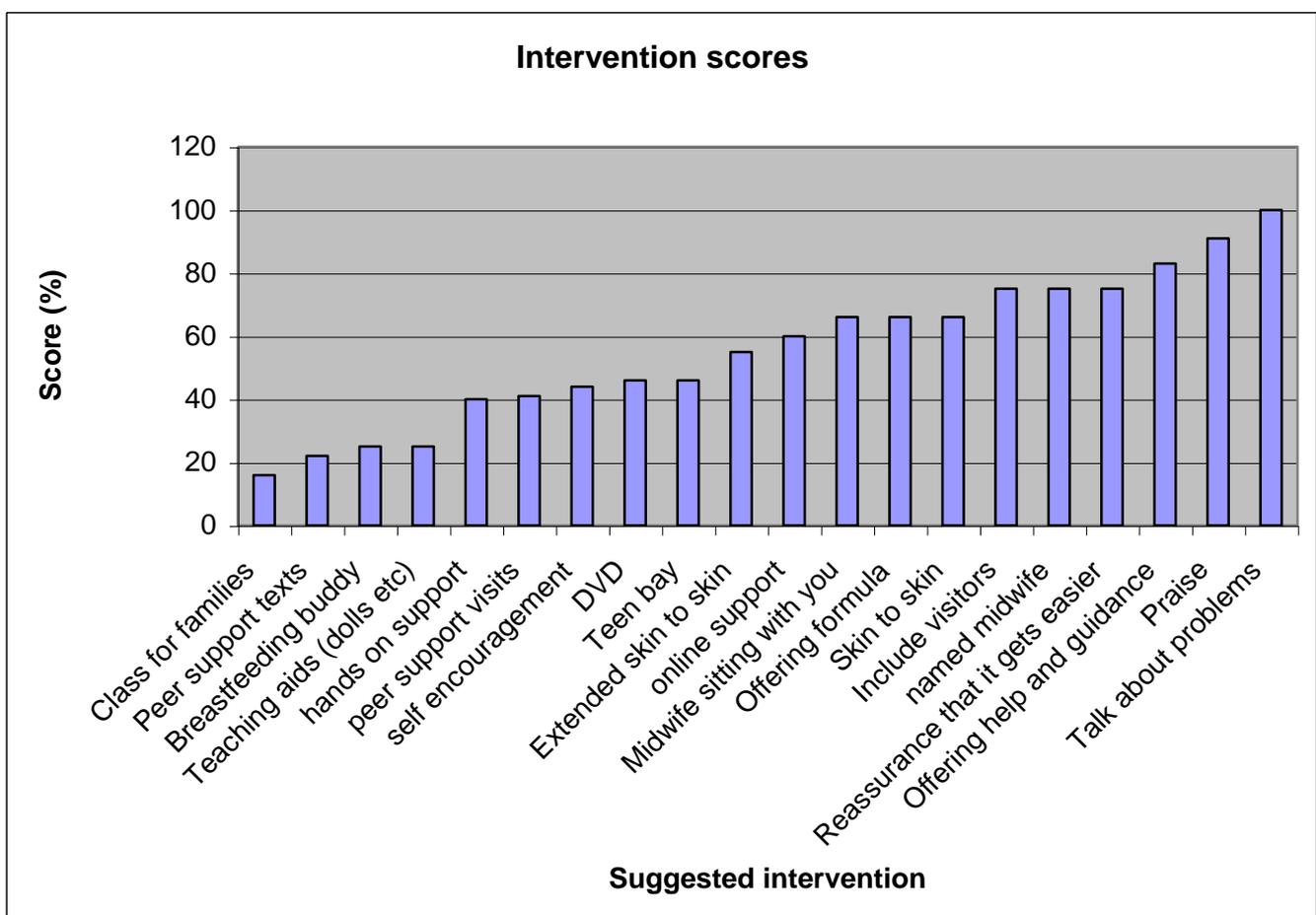
The young women's experiences indicate that, in addition to feeling uncomfortable and exposed on the postnatal ward, attempts to breastfeed were undermined by an inability on the part of the young mothers to communicate their needs, and on the part of the health professionals to respond positively to young women's attempts to secure assistance. Suggestions for improving this situation are discussed below.

Views on support interventions

The young mothers were shown a series of cards outlining breastfeeding interventions that either formed part of the UNICEF Ten Steps to Successful Breastfeeding (UNICEF n.d), were suggested or used as interventions in the literature reviewed in chapters four and five of this thesis, were put forward by respondents to the e-questionnaire or arose from reflection and informal discussion with colleagues undertaken by the researcher. The rationale for this approach was discussed in chapter six, and the wording on the cards is included in Appendix 6.6. During the analysis of the focus groups and interviews, a crude scoring system was devised based on each group having judged each intervention as 'essential', 'very helpful' 'quite helpful', 'wouldn't make much difference', or 'not acceptable/unhelpful'. Three points were awarded if a group or interviewee considered an intervention to be essential, two for 'very helpful' and one for 'quite helpful'. 'Wouldn't make much difference' scored zero, and 'not acceptable/unhelpful' scored minus one. The scores were then converted into percentages based on the total possible score for each intervention (as not every group expressed an opinion on every intervention) and collated into a table in order to indicate the relative popularity of each suggestion (see Table 9.1 below).

For example, four groups or interviewees expressed an opinion on classes for families, making a maximum score of 12 for this intervention. Two groups/interviewees thought the classes would be 'very helpful', and two that they would not be acceptable. This gave a score of 2/12, or 16%. Participants also put forward their own suggestions of appropriate support. The support interventions considered by the women can be divided into two broad categories of relational support and teaching and support strategies. Each of these categories is considered below.

Table 9.1. Young mothers' views of breastfeeding support interventions



Relational support

Relational support covers interventions which have as their basis the relationship between the new mother and either her carers, her baby, her visitors, her peers or herself.

Identity of carers and securing assistance

As can be seen from Table 9.1, the majority of the most popular and well-received breastfeeding interventions centre around the new mother's relationship with her carers. However, as discussed above, the young mothers found it difficult to communicate with ward staff and secure the help they needed with feeding. They discussed who would be best placed to support them, and how this support should be offered. There was a strong consensus that breastfeeding guidance, discussion and praise needed to be provided by a health professional:

Jemma: I wouldn't really wanna talk to anyone else about it, except like a midwife or a nurse or something

(Focus Group 3).

Three of the groups identified that having a specific midwife to look after them during each shift would help address the problems of lack of continuity of care and an inability to get help on the postnatal ward. They pointed out that they wouldn't have to keep explaining their circumstances to a named midwife, who would '[know] what you want, and, like, what support you need' (Lucy, Focus Group 2). However, participants also stated that they very often had an allocated midwife, who would introduce themselves at the beginning of a shift and then disappear, as when they pressed the call bell they always got someone different:

Avril: ...and then, like, just before the shift ends, 'oh, I'm going off my shift now'...it's like 'but I didn't see you the whole shift, so – you wasn't helpful'

(Focus Group 1).

The groups discussed alternative ways of asking for help, such as paging or texting their named midwife, although some people felt that, if the midwife was too busy to answer the call bell, she would also be too busy to reply to a text. However, the young women felt they would be happier asking for help if there was some way of communicating how urgent their request was, so that the midwife could prioritise different peoples' needs:

Shannon: sometimes I feel I think guilty about – that I'm taking time away from another mum that might really need a midwife

(Focus Group 1).

Overall, having a named midwife was considered less important than being offered proactive assistance. Participants in two groups (Focus Groups 1, 3) suggested that there should be 'like a specialist to come round and talk to people' (Shannon, Focus Group 1), or stationed somewhere so that people could go to her for help:

Clare: Like 'cos they come round and show you how to bath your baby don't they, sometimes? So maybe something like that, like where they come round and show you how to breastfeed

(Focus Group 3).

In fact Sarah (Interview 2) suggested that new mothers should not be allowed to go home until they had been given some breastfeeding support, and that before they left hospital

'there should be like a questionnaire – 'do you want to breastfeed?' 'Has the baby latched on?' 'Would you like someone to come out and latch the baby on for you?'

Content and format of support

There was a strong consensus that breastfeeding information and guidance needed to be given postnatally. Information given in the antenatal period was considered useful but was often not absorbed, as it simply held no relevance in the pre-baby context of the teenagers' lives:

Lauren: I don't even remember discussing breastfeeding when I was pregnant. Did we?

MSW (group facilitator): Yea! [Laughter]

(Focus Group 4).

As well as being taught how to breastfeed, young mothers wanted to be given a realistic idea of what to expect, told that difficulties are normal and taught how to overcome them:

Becky: 'cos if you get a problem then, you know, if you don't know what it is or why it's happened you're gonna freak out about it. Whereas if you've got some sort of idea of why it's happening, it's not gonna be quite so scary

(Focus Group 1).

Sarah: No one ever says to you... it's like normal to not be able to do it...I just felt like a complete failure, because no one .. had explained to me .. that I weren't the only one

(Interview 2).

As previously mentioned, the young women also wanted information about formula milk. They interpreted the restricted access to information and supplies of formula milk as a conspiracy to put pressure on them to breastfeed, and were adamant that they should be given free choice, and that formula preparation should be openly discussed.

Honest, open information and guidance needed to be accompanied by praise and proactive support. Participants in the focus groups particularly appreciated midwives spending time with them, reassuring them that they were doing well. Even if young mothers were not having problems with breastfeeding, the midwife's presence was incredibly reassuring, and praise from midwives was deemed to be essential:

Avril: It's like that support, kind of comfort, it's like kind of protecting you, just knowing that you're doing the right thing

(Focus Group 1).

The young women also appreciated midwives who made an effort to chat to them, and who shared their own experiences:

Clare: Even if it's not about breastfeeding – about other stuff as well. Like about helping you to get baby to sleep and stuff like that

(Focus Group 3).

The young women appreciated staff who worked alongside them, showing them how to care for their babies without putting them under pressure or taking control. Mothers who had been shown how to feed and care for their newborns were noticeably more satisfied with their postnatal care:

Lucy:...so they helped me while I changed him, and they helped me dress him and showed me how to do it... And then he had a bath – they showed me how to bath him... So it was alright. It was alright

(Focus Group 2).

If this nurturing aspect of support was missing, however, offers of help or advice could be perceived as putting unwelcome pressure on the new mothers. This was likely to backfire, as Sarah's response in interview two when she is asked if she will breastfeed her next baby shows:

'I dunno whether I'd just wanna say ' do you know what – no, I don't wanna do it [breastfeed]'...just to get them off my case a little bit'.

Nurturing relationships with midwives appear to play a crucial role in building confidence and self-esteem in young women, helping them to feel accepted and validated as adults and mothers. This then leads to them having faith in their own capabilities, which is seen as a fundamental prerequisite to success:

Researcher: So the most important thing is to have someone else that you can go to and..

Avril: I think that's important but I also think it's important that you have faith in, belief in yourself... 'Cos if you don't believe in yourself then you don't believe in anyone else, at the end of it

(Focus Group 1).

Peer relationships

While participants would prefer to receive information and guidance about breastfeeding from a midwife, they looked to their peers for ongoing emotional support and encouragement:

Shannon: I think I'd rather hear I'm doing well from somebody that done it. Quite recently as well...than somebody like, say a midwife that's never had children

(Focus Group 1).

However, they could only really relate to the idea of peer support if it was provided by someone their own age, going through the same experiences as they were:

Katie: ...it might be like easier to talk to someone about it like whose your age...

Clare: ... or even if that person was maybe like pregnant as well, the same way as you. Then when you like give birth you can both talk about like the experience and everything, and what you both find helpful and how they've done it and stuff like that

(Focus Group 3).

The ability to access peers in a similar situation, even online, was considered an important part of coping with motherhood:

Shannon: They [new mothers] can just sit there [at home, online], and they've got their baby and they've got their advice

Becky: Yea

Shannon: And other young mums that are there – not necessarily in the same room, but they're still there to help

(Focus Group 1).

The young women were wary, however, of being approached by 'strangers' offering breastfeeding support. Perhaps because they had all attended young parent groups, these were seen as an important way of making new friends:

Becky: Yea. The amount of times I've felt really down, and I've come here and I've left with a smile on my face is amazing. It really is

(Focus Group 1).

Teen Bay

A 'teen only' bay was suggested by health professionals as something that might make new young mothers feel more comfortable in hospital and facilitate peer friendships. Although this idea was initially greeted with enthusiasm by some of the young mothers, when they began to consider it in more detail it became apparent that defining who should go in the bay was far from easy. Participants welcomed the idea of a bay that was for 'our people' (Tess, Focus Group 4), but 'our people' were defined as those from the same culture, as well as those of a similar age. It could also mean people that were breastfeeding, or people that were having difficulties breastfeeding.

The acceptable age range was also problematic. Sarah (Interview 2), who was initially very enthusiastic about the idea ('oooooh, that should be essential'), changed her mind when she considered its implications:

'I would like to feel I'm quite mature, for my age...I wouldn't wanna be like on a young mums' ward and be with like a 16 year old girl'.

In seeking acceptance as an adult and a mother, Sarah is keen to align herself with older mothers, and not be tainted by association with younger teenagers. Vicky (Focus Group 3), who had recently had her second baby, was also keen to emphasise her affiliation with mothers in general:

'I don't think that would affect me... we're all in the same situation'.

When participants had been warded with other young mothers, however, they felt they had benefitted from their company:

Katie: I was OK 'cos I had a young person with me, so I did have someone to talk to

(Focus Group 3).

It appears that young mothers liked the idea of being with their peers in hospital, and felt more comfortable when they had been with people of a similar age on the postnatal ward, but were sometimes wary of being labelled as different and inferior.

Teaching and support strategies

Hands on care

Contrary to popular belief, the young mothers considered hands on support to be acceptable and helpful, providing it was given in the context of a respectful and enabling relationship.

Tanya: ...'cos they were so nice, I didn't mind, like

(Focus Group 4).

Before using a hands on approach, midwives needed to ask for consent, and then make sure they handled the baby gently and talked through what they were doing, so that the mother might learn to do it herself. When these conditions were met, hands on support was seen as a useful learning opportunity that boosted confidence when it resulted in a good feed:

Becky: And the first time it is a bit like 'oh my God – she's touching me!' But, it really helps. It really does help. Because the first time the midwife gets, gets like your baby to latch on, you think 'ah, well if she can do it so can I!'

(Focus Group 1).

Only one participant (Marcia, in Focus Group 2, who did not breastfeed), felt that hands on support was completely unacceptable.

Providing support online or by text

Although not as popular as face to face contact, online support was considered very helpful, particularly after the new mothers had returned home. None of the participants appeared to have a problem accessing or using a computer, and nearly all of them talked about using the internet to access advice and information, either through social network sites or internet searches. Accessing support online was viewed as an unobtrusive, anonymous way of obtaining help – this was particularly valued by the quieter members of the groups, as they could follow threads without having to participate actively:

Tess: Everyone just suggests things and stuff

Researcher: That sounds quite good

Tess: Even though I don't talk to them much

(Focus Group 4).

Help could be secured online in a timely fashion, negating the need to disturb busy midwives or hoard up questions until the next midwife visit. Some of the participants had found, however, that online groups could be quite difficult to find, and to navigate around. Others felt that the internet was awash with conflicting advice and information. There was also a concern that people online might not be genuine, as illustrated in the following dialogue from Focus Group 3:

Jemma: they could be saying they're a nurse and they might not be... it could be absolutely anyone!...

Katie:... I wouldn't talk to someone if I didn't know who was there...

Vicky: No. I'd rather do it face to face.

Even though some participants texted friends and family who were providing breastfeeding support, texting peer supporters or midwives for breastfeeding support was less popular than contacting them online. Unlike

online support, texting required credit, and was considered to be a less private activity:

Becky: I know my partner, and if I was texting someone, he wants to know who it is and what we're talking about... And if I was talking to someone about breastfeeding, I'm not too sure I'd be able to tell him that...

Shannon: Yea, 'cos I can see myself texting, and the baby's Dad being 'why you texting about breastfeeding for – you don't need to do that'

(Focus Group 1).

In terms of receiving unsolicited text messages, particularly from non-professionals, it was also pointed out that

Sarah: the phone was going off so much anyway after you've had a baby I think I wouldn't of – I wouldn't have read it

(Interview 2).

DVDs and visual aids

There was a consensus that, although face to face instruction was preferable, watching a DVD would be helpful postnatally to access information and be reminded of any antenatal teaching. DVDs were also popular because they could be watched in private (using headphones at the bedside) and without drawing too much attention to the young mothers.

The use of visual aids such as dolls and pictures to show the new mothers how to breastfeed was liked by those who were less comfortable with hands on care. Like a DVD, a picture or demonstration was seen as a useful way of reminding people of what they had been taught antenatally and giving them something to measure their own efforts against:

Clare: ...you could put the baby on and then like compare, like make sure, look and see if it is like kind of right

(Focus Group 3).

Others, however, were not convinced:

Becky: Honestly, I think – if I'm really honest – that would be absolutely bloody useless

Shannon: I wouldn't..

Becky: That doesn't do a thing

(Focus Group 1).

Classes for visitors

Although the participants wanted their families and friends to be included in the information and advice they were given about breastfeeding, a specific class for people visiting them in hospital was the least well received intervention suggested. Even those participants who supported the idea in principle declared that their partners and families would not attend.

Discussion

The findings from this study suggest that young women often feel disempowered and vulnerable immediately after birth, and that care at this time is dominated by routines and rituals that discourage breastfeeding initiation. On the postnatal ward young mothers felt uncomfortable and judged by other mothers and staff. They had difficulties procuring the help and support they required. Young women considered relational breastfeeding support such as praise, proactive assistance and the discussion of coping strategies, to be most effective. Peer friendships also emerged as contributing to breastfeeding success.

Previous research has also indicated that young mothers feel isolated and judged in hospital and are reluctant to ask for help (Benson 1996, Dykes et al 2003, Peterson et al 2007). This was also noted as an obstacle to breastfeeding by respondents in the e-questionnaires reported in chapter seven. Young mothers' needs for emotional, instrumental and informational support have also been highlighted before (Dykes et al 2003, Hall Moran et al 2007, Grassley et al 2012), and were again recognised by e-questionnaire respondents. The current findings support and strengthen the observation that emotional support is

fundamental to the acceptability of other interventions (Dykes et al 2003). The findings of the current study also add to previous research by showing how treatment around the time of birth directly impacts on feeding behaviour. Furthermore, by specifically asking young mothers for their views on support interventions, this study has highlighted the pivotal importance of health professionals in giving breastfeeding information and support in the early postnatal period that includes a realistic appraisal of possible difficulties and praise for the mother's achievements. Support should also include open and honest discussion about formula milk and can include an element of hands on assistance.

The feelings of vulnerability and passive behaviour immediately after birth described in this study resonate with other UK research findings that young women felt infantilised by the medical nature of intrapartum care (Bailey et al 2004, Stapleton 2010). This study shows how, by being placed in a passive, child-like role, young mothers cease to question their care or feel able to make decisions on their own – some do not even feel able to pick up and hold their own babies without permission. This suggests that proactive nurturing and guidance is necessary at this time. It is interesting that the act of leaving mother and baby alone after birth, often seen by caregivers as providing the new family with space to get to know each other in private, is interpreted as abandonment by the young mothers.

The absence of uninterrupted skin to skin contact in many of the mothers' accounts is likely to have further decreased the chance of their successfully initiating breastfeeding (NHS Information Centre 2012). Although other researchers have found young mothers to be ambivalent about skin to skin contact (Stapleton 2010), the results presented in the previous chapter indicated that participants in the current study were very receptive to the idea. The success of uninterrupted skin to skin contact for those mothers who were able to have this indicates that this intervention may go some way to addressing the distress experienced by new mothers, as well as helping their babies initiate breastfeeding.

The young women's scepticism about receiving instrumental and informational support from anyone other than a midwife and their dislike of the idea of peer support provided by older mothers or 'strangers' are important considering the popularity of peer support interventions for breastfeeding mothers. Perhaps in view of this there is an argument for fostering peer friendships antenatally and in hospital in order to provide the emotional support from peers identified as important by the young mothers, rather than investing in peer support programmes that have been found to be fraught with difficulties to initiate with teenagers (Di Meglio et al 2010). The importance of fostering peer friendships among pregnant and parenting teenagers is further highlighted by Clemmens (2003), who points out that young mothers often have to cope with isolation and alienation from their pre-pregnancy peer group. Research by Formby et al (2010) also found that forming alliances with other young parents appeared to contribute to a more positive sense of self worth in young mothers, and Bunting and McAuley (2004) suggest that, although the evidence is limited, social support from peers appears to be significantly related to decreasing parenting stress among young mothers. The current study findings suggest that friendships with other young mothers could be a valued source of emotional support whilst breastfeeding. However, although contact with peers whilst in hospital has been identified as being important for adolescent inpatients on medical wards (Gibson and Nelson 2009), the young women's reactions to the suggestion of a 'teen bay' perhaps indicate that fostering peer friendships is not a straightforward undertaking.

The findings of the current study strengthen the argument that breastfeeding support offered to young mothers needs to acknowledge their unique developmental needs. In particular, the young mothers in this study appeared to mistrust the motivations of those caring for them, anticipate discrimination and be quick to take offence at any perceived slight. These insights are consistent with the young mothers' positions as rookie mothers, trying to find their feet in an unfamiliar environment where they lack confidence and feel self-conscious and exposed. It has been suggested that a propensity to avoid or sabotage interactions with adult carers is a developmental feature of

adolescence, as young people lack the social skills and experience needed to initiate and maintain these relationships (Peterson et al 2007).

Involving the young women in their care and the care of their babies appears to validate them as the responsible, capable adults they are anxious to become, and increases confidence and self-esteem (Peterson et al 2007). Providing young people with coping strategies has been identified as a key tactic in enabling them to take control of and cope with adult life (Frydenberg 1997). The finding that hands on care is acceptable to young mothers is perhaps surprising, but again shows the importance of a trusting, empowering relationship in which a hands on approach is used to show the mother what to do, rather than take control away from her by 'ramming' the baby onto the breast.

Limitations

There are a number of limitations to this study. The overall number of young women participating in the focus groups was small. Participants were also self-selecting, and all attended young parent groups. These factors, as well as the limited geographical area in which the research was conducted, affect the generalisability of the findings. The focus groups and coding were undertaken by the same researcher, possibly creating some bias in internal validity, though transcripts were reviewed and codes were agreed with a third person. Reflexive strategies such as member checking were employed in an attempt to render the participants' experiences as accurately as possible. In addition to offering some new insights, the views and experiences put forward by the participants resonate with many of those expressed in previous research in the UK and US, indicating that they are also true for other young mothers attempting to breastfeed in these countries.

Conclusion to Phase One

This chapter marks the end of the first phase of this study, and of stage one of the realist evaluation framework, which seeks to answer the question 'what is happening now and why?' It has been established that young mothers have particular needs as people taking on a new adult, as well as a mothering, role.

The literature review, e-questionnaire, focus groups and interviews have shown that young breastfeeding mothers face a number of difficulties and challenges, compounded by a cultural heritage regarding formula milk feeding as normal. This has resulted in a dearth of knowledge about breastfeeding and a widely held taboo against breastfeeding in public, or in front of men. Furthermore, young mothers feel isolated and exposed on hospital wards and find it difficult to secure assistance. Health professionals and young mothers agree that proactive emotional, informational and instrumental support is essential in the early postnatal period for young mothers to be able to breastfeed successfully. Young mothers need time, support and encouragement, and a realistic appraisal of the challenges of breastfeeding.

The primary research undertaken during phase one has added to the above picture by revealing that the young mothers' discomfort in the hospital environment is exacerbated by their birthing experiences leaving them feeling overwhelmed and incapacitated, by routines and rituals that further disempower them, and by the negative attitudes of some of their carers. These themes were evident in both the e-questionnaire with health professionals and the focus groups and interviews with young mothers themselves. In a direct contradiction of the view of many health professionals that peer support would increase breastfeeding rates, the young mothers wanted breastfeeding information and advice to be given by health professionals, although they looked to their peers for emotional support. The young mothers also challenged previous research findings by revealing that hands on assistance can be acceptable within a nurturing, empowering relationship. Furthermore, the young mothers' accounts reveal that they consider that breastfeeding marks them out as good mothers, but can be a source of tension and distress when it isolates them from their families.

The next phase of this study uses these findings to develop a support intervention to enable more young mothers to initiate and continue to breastfeed on the postnatal ward. The intervention is then implemented on a postnatal ward and a concurrent evaluation is carried out. This process will complete the realist evaluation framework, answering the questions 'what might happen if?' and 'what

happens when?' and refining the intervention for future testing and evaluation cycles.

Chapter ten

Introducing phase two of the study – developing an intervention to improve breastfeeding support for teenage mothers on the postnatal ward, and devising a strategy to evaluate this intervention

Introduction

The literature review, e-questionnaire and focus groups, which together formed phase one of this research, yielded a rich pool of data on the lived experiences of young mothers wishing to breastfeed, and of the perceptions of the staff looking after them during their postnatal hospital stay. Phase one has thus addressed the first stage of the realist evaluation cycle outlined in chapter two, answering the question ‘what is happening now and why?’ The next phase of the research (phase two), introduced in this chapter, moves on to stage two of the realist evaluation cycle, by using this knowledge to develop a support intervention for use on the postnatal ward. This chapter lays out the aims and objectives of phase two, and outlines the development and content of the proposed intervention. The process of implementing the intervention, and the strategy used to evaluate it, are also presented and discussed.

Phase Two Aims and Objectives

Aims:

- To use the information gathered in phase one of the study to develop a support intervention to use with teenage mothers on the postnatal ward.
- To test whether the intervention is practicable in a ward environment.
- To identify good practice principles for teenage breastfeeding support that are transferable to other settings.

Objectives:

- To discuss the results of phase one with practitioners and infant feeding experts in order to agree an intervention that is appropriate and feasible in the ward environment.

- To train nominated personnel to implement the intervention.
- To implement the intervention on a single site and carry out a concurrent evaluation.
- To identify lessons from this initial and local implementation and modify the intervention for a wider scale implementation.

A decision was taken to develop a support intervention specifically for use on the postnatal ward in order not to overburden the young mothers immediately following their having given birth. Additionally, it was considered that limiting the intervention to one geographical location would make it feasible for a single researcher to monitor and evaluate. Discussing and agreeing the content of the intervention with key personnel in the practice setting was considered essential in order to ensure their support and cooperation during the project. Practitioner involvement is also a key feature of a realist approach (Pawson and Tilley 1997). It has further been observed that any change in practice needs to grow from the already existing environment in order to succeed (Brimdyr et al 2012).

Developing the intervention

The realist paradigm maintains that, in order to be successful, any intervention must address the mechanisms that are maintaining the current status quo. The findings from phase one indicate that on the postnatal ward these include the assumption of some care providers that young mothers will want to formula milk feed, the discomfort of young mothers on the postnatal ward, the poor relationships between young mothers and some care providers on the postnatal ward, and a lack of breastfeeding knowledge and self-efficacy among young mothers. The findings further suggest that these disabling mechanisms might be overcome by a support package that includes:

- proactive support, praise and reassurance, especially from a known carer;
- recognition and acceptance;
- time, respect and privacy;
- a relaxed approach that does not make young mothers feel pressurised, gives them choice and involves them in decision-making;
- the involvement of young mothers' families and/or significant others.

In addition to the above, young mothers who participated in focus groups indicated that any support intervention aiming to help them breastfeed should:

- involve expert instruction and advice from a professional who would take time to get to know them and show them what to do;
- normalise and discuss difficulties;
- reassure them that breastfeeding will get easier over time;
- include emotional support from peers;
- account for the fact that they do not always feel able to breastfeed immediately after birth and may need encouragement to get to know their babies.

Health professionals who participated in the e-questionnaires suggested that young mothers might be warded together postnatally, so that they could support one another. Health professionals also believed that not all of their colleagues were committed to supporting young mothers to breastfeed, and that any intervention needed to address staff attitudes and beliefs.

The findings summarised above were discussed with two managers, the teenage pregnancy lead midwife and the infant feeding specialist midwife at the hosting Trust, and the researcher's supervisor. Following these discussions, an intervention was devised that, in addition to taking account of the results of phase one, incorporated NICE guidance around effective public health interventions (NICE 2007) and was considered to be politically and practically feasible in the hospital environment.

The initial intervention package that was proposed to the Trust comprised structured, proactive breastfeeding support using a series of checklists, the introduction of a designated bay for young women on the postnatal ward with an adjoining office space for staff, and informing community support workers when young women on their caseloads were admitted to the bay. Staff would be trained to institute the package through attendance at a training session. Table 10.1 below lists the findings from phase one that informed this proposal, the component of the support package that addresses each finding, and the mechanism by which it was anticipated that the component would operate. It was envisaged that the package would increase breastfeeding rates among young

mothers by increasing their knowledge, confidence and self-esteem, improving the quality of their relationships with their carers and thereby raising their levels of comfort on the ward, facilitating peer support and increasing the likelihood of timely breastfeeding support.

Table 10.1. Outline of proposed support package

Finding from phase one	Proposed support package	Anticipated mechanisms
Young mothers lack confidence and will not ask for help. →	Introduce structured, proactive breastfeeding support using a series of checklists. →	Build confidence and self-esteem as well as basic knowledge and strategies for overcoming difficulties. Improve practitioner/patient relationship.
Young mothers seek acceptance and validation as mothers and adults. →		
Young mothers want practical support and instruction from a health professional. →		
Not all maternity professionals involved in the care of young mothers believe they have the maturity or inclination to breastfeed. →	Hold a training session for midwives and MSWs that will address knowledge, attitudes and skills around supporting young mothers to breastfeed, and introduce the support package. →	Improve staff knowledge, skills and attitudes about adolescents and breastfeeding. Enable staff to implement support package.
Young mothers have specific support needs due to their unique positions as new adults and new mothers. →		
Young mothers feel uncomfortable on the postnatal ward. →	Institute a designated young persons' bay on the postnatal ward, with an adjoining office space for health professionals. →	Foster peer support and increase the visibility and accessibility of known carers. Help young mothers feel more comfortable on the ward.
Emotional support from other young mothers is highly valued. →		
Young mothers would like to be able to access known carers on the ward more easily and informally. →		

During the consultation process, ward managers argued that providing office space for staff close to the young person's bay would not be practicable because the room was needed to store drugs, and the staff needed to be based at the centre of the ward to access computers and administration support. This

component of the package therefore had to be dropped. Additionally, managers were keen that a baby café that had already been set up on the ward to provide support for breastfeeding mothers should be utilised, so this was added to the intervention package. The baby café was an initiative that had been imported in to the hospital by a community midwife. It was open on 3-4 mornings per week and offered breastfeeding mothers a place to sit and talk, with breastfeeding support available from a midwife and volunteer peer supporter.

The agreed intervention package consisted of:

Infant feeding checklists

A series of three checklists was developed to facilitate the provision of structured, proactive breastfeeding support. These comprised an 'Initial Consultation Checklist', to be completed when a young mother arrived on the ward; a 'Feeding Review Sheet', to be completed at each subsequent feed until the mother no longer required help; and a 'By Discharge Checklist' listing information to be given to the mother before she went home (see Appendices 10.1, 10.2 and 10.3). The checklists were developed and agreed with the Infant Feeding Specialist Midwife at the hosting Trust and based on those developed by the UNICEF Baby Friendly Initiative (UNICEF n.d a). The lists advocated a structured but flexible approach, with help to be provided when the mother was ready to receive it. Every young mother was to be asked how she would like to feed her baby, even if a formula feed had been given initially, and an individualised, ongoing plan of care was then developed and recorded. The lists aimed to build young mothers' confidence and self-esteem by providing timely assistance, basic knowledge and strategies for overcoming difficulties, as advocated by NICE (2007). The checklists required staff to sign each item once completed, allowing the extent of adherence to the intervention protocol to be monitored. Following feedback from ward staff, the checklists were printed on green paper to differentiate them clearly from other paperwork used on the ward, and the 'Feeding Review Sheet' was simplified. Checklists are widely used throughout the hosting Trust, and it was therefore considered that they would be familiar to, and so more likely to be used by, staff.

Staff training

A four-hour training session was developed for midwives and MSWs addressing the knowledge, attitudes and skills around supporting young mothers to breastfeed. The training session was run by the researcher and the Teenage Pregnancy Lead Midwife at the Trust. It covered attitudes towards young mothers, adolescent development, the findings of the focus groups, details of the intervention and checklists, and a revision of breastfeeding knowledge. The session encouraged active participation and discussion. It was envisaged that staff attending the training would take a lead role in providing care in the young persons' bay and disseminate their knowledge about the intervention to their colleagues. Using MSWs to provide breastfeeding support is consistent with policies and procedures in place at the hosting Trust.

Designated bay for young women

A designated young persons' bay was instituted on the postnatal ward. This was a distinct four-bedded area into which all ante and postnatal women aged 20 or under who were admitted to the ward were to be given a bed. It was considered that setting an upper age limit of 20 would include women who were teenagers when they became pregnant and who would therefore have been informed about the project. By mixing ante and postnatal and breastfeeding and formula feeding women, the intervention aimed to maximise opportunities for education and peer support. The ward managers and Teenage Pregnancy Lead Midwife were also keen to develop the potential of the bay by providing additional support and guidance to young mothers such as baby massage sessions and contraceptive advice.

Community support workers

A mechanism was set up to enable ward staff to inform community support workers when young women on their caseloads were admitted to the ward. This gave the support workers the opportunity to contact the young women, visit them on the ward and provide timely support after discharge from hospital. This aspect of the package was provided by the Family Nurse Partnership Scheme, which provides teenage mothers with a named nurse who institutes a structured package of support (including breastfeeding support) from pregnancy until two

years after birth. Family nurses agreed to put stickers on the front of their clients' notes, highlighting that the young women were part of the scheme and alerting ward staff to the fact that the named nurse's contact details would be on the inside cover.

The Baby Café

Young mothers were actively encouraged to access a ward 'Baby Café' for additional breastfeeding support. The baby café is open on the ward for two hours on three week day mornings. It is hosted by a midwife and a peer supporter (a mother who has breastfed). All breastfeeding mothers are invited to attend for advice and support, and to socialise. It was anticipated that including the baby café in the intervention package would provide an additional source of emotional and practical support for the young mothers and facilitate the provision of peer support, both from the designated peer supporter and from other mothers.

Implementing the intervention

The hosting ward

The ward managers of a mixed ward of ante and postnatal women agreed to implement the intervention for a six-month period. The maternity hospital in which the ward is situated is a large tertiary referral unit, with around 8,000 births per year. In a recent survey of UK maternity services by the Care Quality Commission, the Trust scored the same as, and in a few instances better than, most other Trusts that took part in the survey (Care Quality Commission 2013). The hospital does not currently have UNICEF Baby Friendly status. The ward is set up to care for 37 women in seven single rooms, two family rooms and seven four-bedded bays. There are two further four-bedded bays which are used as 'overflow' when the unit gets very busy. Typical shift cover consists of three-four midwives and two MSWs. Around 29 midwives and 17 MSWs make up the workforce on the ward at any one time. These numbers represent a mix of full and part-time staff. Most of the midwives hold rotational posts, spending six months of every year working on the ward, and six months in labour ward. There are usually a majority of postnatal women on the ward. It is customary within the hosting Trust to discharge women home from the labour ward where possible.

Postnatal women on the ward had generally therefore had long or complicated deliveries or caesarean sections, or social issues which prevented an early departure.

The implementation process

Funding was obtained from the Radcliffe Guild of Nurses to provide a four-hour training session for fourteen midwives and maternity support workers. Following the training, the ward manager identified a suitable bay, and a date was set to launch the project. Posters were placed in key positions on the ward (such as the staff room and staff toilet) outlining the intervention and its underlying rationale. Ward staff were asked to admit women aged 20 or under into the designated bay, and to use the checklists with all postnatal women who were given a bed there. Detailed instructions and packs of checklists were placed in a study file in a locked room adjacent to the bay. Separate information posters were placed in locations from which women were admitted to the ward (such as Labour Ward and the Maternity Assessment Unit) asking midwives to send young women to the bay. Reminders were also placed on phones in these locations. A longer article giving information about the project was placed in a staff newsletter.

At the beginning of the implementation period, the researcher visited the ward once a day for two weeks to offer support to staff members. These visits lasted around an hour and became less frequent over time, as more staff became familiar with the support package. The researcher also had regular informal meetings with the two ward managers, and attended staff meetings and handover sessions in order to talk to staff about the intervention package. The researcher's contact details were clearly displayed on the study file, and staff were invited to contact her if they had any queries or problems.

Evaluating the intervention

A concurrent evaluation was set up in order to identify the mechanisms supporting and blocking successful implementation of the intervention and explore the acceptability of the different components of the support package to staff and young mothers. According to realist philosophy, an intervention reacts

with the context into which it is placed to produce mechanisms and outcomes. Outcomes can only be changed or replicated if the mechanisms which support them are identified and understood. It is usual in realist evaluations to use a number of different methods to identify the mechanisms at work in a particular context (Kazi 2003). The current evaluation set out to assess the areas below in the following ways:

Effect of training on knowledge and attitudes

Changes in the attitudes and knowledge of midwives and MSWs attending the training were assessed via anonymous pre and post course questionnaires. Pretest posttest evaluations are commonly used to assess breastfeeding teaching interventions (Martens 2001, Walsh et al 2008 for example). This is usually done quantitatively, in the context of a randomised trial, with the questions in both the pre and posttest being identical. In the current instance a more qualitative approach was taken, as the knowledge and attitudes being evaluated covered a broad area around teenagers and breastfeeding rather than focused and specific facts and figures. The pre and post tests were not therefore identical but sought to explore baseline attitudes and beliefs (pre-course questionnaire) before encouraging participants to reflect on any ways these had been challenged and changed (post course questionnaire). This approach is consistent with the principles of adult learning outlined by Fry et al (2009), and has also been used elsewhere to evaluate the impact of training interventions (Hodson et al 2002). Whilst this approach made it difficult to attribute some of the attitudes evident in the post course questionnaire to the training, it provided insight into participants' views of the effects of their learning.

Both questionnaires comprised a mix of closed and open questions, allowing some specific information to be collected while also giving respondents the opportunity to introduce their own ideas and express individual points of view (Brindle et al 2005). The pre-course questionnaire included two demographic questions, ascertaining the respondent's role and the number of years they had worked for the NHS. There were a further eight questions: two asked respondents to list the first three words or phrases they thought of in relation to teenage mothers and their attitude towards breastfeeding; and three asked

respondents to indicate their level of agreement with a series of statements about teenage mothers and breastfeeding by circling one of four possible responses ('strongly agree', 'agree', 'disagree' or 'strongly disagree'). These were followed by two questions asking whether respondents felt 'very comfortable or confident', 'comfortable or confident', 'a little uncomfortable or unsure' or 'very uncomfortable or unsure' supporting young mothers in general and with breastfeeding. The final question asked whether there was any support the respondents felt they needed in order better to support young mothers to breastfeed. The questionnaire is included in Appendix 10.4.

The post-course questionnaire repeated the demographic questions, in order that responses from midwives and MSWs could be differentiated. It also contained eight further questions, two of which asked respondents to identify how, if at all, the session had changed the way they thought about teenage mothers, and what they considered the key components of breastfeeding support for young mothers to be. The two closed questions from the pre-course questionnaire eliciting confidence and comfort levels supporting young mothers were then repeated, in order to ascertain whether responses changed as a result of the session. There were then four questions asking which aspects of the session respondents found useful or unhelpful, whether they thought the session would help other health professionals develop a more positive attitude towards teenage mothers and breastfeeding, and what they would have done differently if they were running the session. This questionnaire is included in Appendix 10.5.

Facilitating and destabilising mechanisms, and level of fidelity to the intervention protocol

Facilitating and destabilising mechanisms and the level of fidelity to the intervention protocol were ascertained via ad hoc researcher observations of practice, semi-structured interviews with ward staff and an analysis of the feeding checklists. Observations are particularly suited to a realist approach, enabling the researcher to see what is happening, and how it is happening, at first hand (Donovan 2006, Dykes 2006). Through observation, a researcher can discover more than what people might report during an interview, for example by identifying culturally learnt behaviour that may not be articulated (Agar 1996,

Dykes 2006, Bowling 2009). Observations can be structured, using checklists and rating scales, or unstructured, simply recording events as they occur (Bowling 2009). The latter approach was adopted in the current evaluation as it enabled an inductive approach in which mechanisms were identified from the data gathered. Comprehensive field notes were kept, which included ad hoc discussions with staff being observed, as well as unprompted comments that staff made, but no formal evaluation tool was used. By recording everything, the researcher hoped to avoid the risk of bias associated with observational enquiries (Bowling 2009).

Observations were conducted at the beginning, in the middle and towards the end of the six month implementation period. The dates for the observations were agreed in advance with the ward manager. Ward staff were informed that they would be taking place at some point but had no advance notification of the actual day. This was to try and observe practice in as normal a way as possible. On the day of the observation, midwives and MSWs who consented were followed by the researcher as they carried out their work.

During the observations, the researcher attempted to adopt a 'peripheral' status, blending in to the environment as much as possible in order to limit the effect of her presence on the behaviour of those being observed (Burns et al 2012). The researcher's 'insider status' as a midwife working in another area of the Trust, and her frequent presence on the ward while the intervention was being set up, meant that most staff were used to and appeared comfortable with her presence. Where this was not the case, assurances were given regarding participant anonymity and the independence of the research. Efforts were made to build trust and put staff at ease.

Semi-structured interviews were conducted with a purposive sample of ten midwives, MSWs and ward managers involved in the delivery of the intervention. Semi-structured interviews and observations are widely held to complement and inform one another – what is seen informs what is asked about, and what is talked about illuminates what is seen (Agar 1996, Dykes 2006). In the current instance, interviews enabled the researcher to understand the implementation process from the point of view of the participants and to reflect with them about

what had happened and how to move forward (Bluff 2006, Arthur et al 2007). The interviews also provided participants with an opportunity to identify mechanisms and themes that the researcher may have missed (Arthur et al 2007). A mix of staff who had attended the training session and staff who had not were invited to take part in this process, in order to gather a range of views (see 'Recruitment and inclusion criteria' below). The interview topic guide is included in Appendix 10.6. It included questions about participants' attitudes to the support package, as well as to difficulties they had encountered implementing different aspects of the intervention. The interviews were conducted by the researcher towards the end of the evaluation period. It was anticipated that the participants' familiarity with the researcher by this point would encourage them to talk openly (Rooney 2005). Further information regarding the level of fidelity to the intervention protocol was obtained by collating and reviewing completed checklists.

Views of young mothers

Feedback was sought from young mothers receiving the intervention via an anonymous self-completed evaluation form, which they could either give to their carers in a sealed envelope before being discharged or return in a pre-paid envelope. The evaluation form, which is included in Appendix 10.7, contained a mix of closed and open questions in order to collect data on feeding behaviour and encourage young women to reflect on their care on the ward. The closed questions were mainly in tick box format and sought information about how the young woman responding had intended to feed her baby and her feeding practices post birth. The open questions aimed to elicit more detail about the young woman's experience on the ward and the support she received. It was hoped that the opportunity to complete and return the questionnaire before leaving hospital would overcome the problem of low response rates associated with postal questionnaires (Bowling 2009). The questionnaire format was chosen for the convenience of the young women, who could complete it whenever they chose, and because the anonymity of the method might encourage more honest responses than face-to-face interviews (Bowling 2009).

Reach and effect of intervention

The reach of the support package was to be ascertained by monitoring the numbers of young women giving birth in the hosting hospital over the six-month implementation period, and numbers of young women who received the intervention, through data routinely collected by the participating hospital. The effect of the intervention was to be estimated by collecting data on exclusive and partial breastfeeding rates among young women receiving the intervention on discharge from hospital, at the Primary Birth Visit, and at six weeks. This information should be collected routinely by NHS Trusts, and could be retrieved for the relevant women via their hospital numbers, which were recorded on the checklists. Due to the non-randomised nature of the pilot, it was not envisaged that a reliable estimate of the effect of the intervention would be produced (MRC 2006).

Outcome measures

- Knowledge, attitudes and skill levels of staff before and after training in the intervention.
- Staff willingness/ability to incorporate the intervention into their working day.
- Young mothers' satisfaction with breastfeeding support received on the postnatal ward.
- Exclusive and partial breastfeeding rates among teenage mothers on hospital discharge, at the Primary Birth Visit from the health visitor, and at six weeks.

Recruitment and inclusion criteria

Midwives and MSWs either volunteered to attend the training session or were put forward by their manager. They were invited to complete an anonymous questionnaire at the beginning and end of the session, and consent was assumed if they chose to do this. Ward managers and staff were eligible to take part in the evaluation process if they provided care to young women and consented to being observed during a shift and/or to being interviewed by the researcher. Information leaflets for staff (see Appendix 10.8) were placed in the staff room and given to

individual midwives or MSWs prior to their being observed or interviewed. Consent forms were also discussed and signed at this time. The consent forms are included in Appendices 10.9 and 10.10.

Young mothers were eligible to take part in the evaluation if they were between 16 and 19 years of age at the 31st week of their pregnancy, spoke and understood English, were planning to keep their babies and were not subject to any care proceedings regarding their unborn child. They also needed to have received part or all of the intervention package, consented to records of their care being accessed by the researcher, and/or completed an evaluation form. All young women due to deliver in the host hospital during the implementation period who were potentially eligible to take part were given written information about the study during their 31 week home visit by a teenage pregnancy support worker (see Appendix 10.11). This information was also given out at hospital appointments around this time. The information leaflet contained the contact details of the researcher and an invitation to contact her with any questions. Further information about the study was given verbally and in writing on admission to the ward, and young women were asked formally to give consent before they were discharged home. The consent form is included in Appendix 10.12. Ethical approval for the evaluation was obtained from the researcher's university and the NHS Health Research Authority National Research Ethics Service.

Ethical Considerations

Ward staff were given verbal and written information about the evaluation process in advance of and immediately before their consent was sought. They were assured that all data would be anonymised, and that they were free to withdraw their participation at any point. A decision to withdraw, or not to take part, would not affect their work in any way.

During the observations of practice, consent was not sought from the women receiving care from the staff being observed. However, the staff were asked to introduce the researcher and explain that she was observing staff

practice. The researcher stood outside patient interactions, usually on the other side of the curtains drawn around the patient's bed. It was inevitable that the researcher witnessed incidents and heard comments from staff and women who had not consented to being observed. Other researchers have taken very different stances with respect to this material: Dykes (2006), goes out of her way to be out of earshot of encounters involving individuals who have not consented to take part in her research. Kusow (2003) however includes direct quotes from people who refused to be interviewed for her study. In the current project, an overheard comment from a woman is used. The comment was made in a public space by a woman who was aware of the researcher's presence and purpose.

Young women were given information about the research during a home visit at 31 weeks of pregnancy in order to give potential participants time to make an informed decision and ensure that they did not feel coerced into giving access to their records or completing a questionnaire. Potential participants were assured that their participation was voluntary and they were free to withdraw consent to their records being accessed, or decide not to complete an evaluation form, without prejudicing their future care (Jackson and Furnham 2000, Matthews 2006). As recommended by the MRC, consent was viewed as a continuing process, with participants invited to re-confirm their consent at each stage of the project (MRC 2004). As in phase one of this project, a lower age limit of 16 was set for mothers in order to prevent very young pregnant women being approached to take part.

Participants' confidentiality was protected by keeping all records pertaining to the intervention in a locked room. Pseudonyms were used in all project reports. It was considered very unlikely that any harm would come to young mothers as a result of giving permission for a researcher to access their notes or filling in an evaluation form.

Challenges to the evaluation process

The evaluation was unable to proceed as anticipated due to unforeseen obstacles to collecting quantitative data. Infant feeding data is routinely collected

by NHS Trusts in the UK. However, in the year before this evaluation took place, a new electronic records system was introduced at the hosting Trust and the previous data collecting system was closed down. The new system was withdrawn shortly after its introduction in order to be modified, and paper records were re-introduced. During this time, which included the evaluation period, unbeknownst to the researcher no infant feeding data was collected in the Trust, and no demographic information of women staying on the ward was recorded. It therefore proved impossible to ascertain how many young women were admitted to the ward during the pilot and evaluation period, or how many young women initiated or continued to breastfeed.

Final evaluation process and methods of analysis

The final evaluation comprised:

- 12 pre- and post-training questionnaires – eight from midwives, and four from MSWs. The open questions were analysed thematically.

- 15 sets of checklists and three feedback forms completed by young mothers were returned to the researcher for analysis. These were examined to ascertain fidelity to the intervention protocol and satisfaction with care.

- Three six-hour observations of practice, during which the researcher followed five midwives and two MSWs as they cared for young and older mothers. Concurrent field notes were written during the observation periods. These were read and re-read by the researcher in order to identify themes. Data were then cut and sorted by theme, and a scrapbook of themes was created. Where links between themes were identified, they were joined together to form more abstract categories of behaviour patterns. Analyses of practice observations, particularly when they are conducted by someone familiar with the practice area, risk replicating the assumptions and political standpoint of the researcher (Rooney 2005). In the current instance, the scrapbook helped to create a degree of objectivity

by providing a visual indication of the number of times specific behaviours were observed. It also enabled patterns of behaviour to be identified.

- Ten semi-structured interviews were conducted with seven midwives (including the two ward managers) and three MSWs. The interviews lasted between ten and thirty minutes and were recorded and transcribed verbatim. The short length of some interviews reflects the fact that they were conducted during the participants' working day. Busy staff tended to answer questions quickly and directly. Transcripts were read and re-read to identify new themes and further material for themes already identified in the practice observations. Data from the interviews was then cut, sorted into themes and added to the scrapbook. Amalgamating data from the observations and interviews further helped to ensure that the themes identified emanated from the ward staff as well as the researcher.

Conclusion

Following stage two of the realist evaluation cycle, this chapter has described the development of an intervention package to support young mothers to breastfeed on the postnatal ward. The mechanisms by which it was anticipated that this package would be effective have been outlined, and the process developed to evaluate the intervention has been explained and discussed. The next chapter presents the findings of the evaluation process, identifying the mechanisms and outcomes that resulted from introducing the intervention package onto a postnatal ward.

Chapter eleven

Findings of a realist evaluation of an intervention to improve breastfeeding support for young mothers on the postnatal ward

Introduction

A breastfeeding support package comprising targeted support for young mothers was implemented on a postnatal ward for a six-month period from October 2012 to April 2013. A concurrent evaluation of the package was undertaken using a variety of approaches, as outlined in the previous chapter. The findings of this evaluation, which followed the retroduction process of observation and analysis of realist methodology (as outlined in chapter two) are discussed below. The aim of the evaluation was to establish what works, for whom, in what circumstances (Rycroft-Malone et al 2010), by identifying the mechanisms supporting and blocking the implementation of the intervention. The findings of different components of the evaluation (questionnaires, practice observations, an analysis of completed checklists, and interviews) are considered together in relation to each separate element of the intervention package (staff training, checklists, young person's bay, baby café, community support workers). Mechanisms affecting the implementation of the intervention as a whole are then outlined, before revisions to the support package are proposed.

Staff training

Ten midwives and four MSWs attended one of two identical training sessions. The midwives had between two months and over 30 years' experience in the NHS, and the MSWs had been in post for between two and five years. Although their exact ages were not ascertained, both groups appeared to contain a mix of younger and more mature women. The impact of the training on staff attitudes towards teenage mothers wanting to breastfeed, and staff feedback from the session, was measured via a pre and post course questionnaire, and using comments made by staff who were interviewed between five and six months after attending the training. 12 questionnaires were returned (eight from midwives and four from MSWs). Five of the staff who attended the training (three midwives and two MSWs) were also interviewed later in the study.

The replies from the closed questions in the pre and post-course questionnaire are presented in tables. The replies from most of the open questions are summarised in a series of wordles. A wordle is a pictorial representation that puts more frequently expressed responses in proportionately larger type. For example, in Figure 11.1 below, four midwives wrote that teenage mothers were vulnerable, two that they were scared, and one that they were embarrassed. The results are presented in this way to give the reader an overview of all the responses while clearly marking out the major themes. Relevant findings from the interviews are presented in the conventional manner towards the end of this section.

Staff attitudes to teenage mothers

In order to ascertain the attendees' attitudes towards young mothers, the pre-course questionnaire asked respondents to write down the first three words or phrases they thought of in respect of teenage mothers. The replies are summarised in Figures 11.1 and 11.2 below. The responses of the midwives and MSWs are displayed separately. The midwives' comments centred on the vulnerability of young mothers and their need for support. Their responses indicate that they felt comfortable caring for teenage mothers, with only one admitting to finding them difficult to communicate with. The MSWs, on the other hand, considered that young mothers were difficult to talk to and had a negative attitude. The MSWs answers to some of the closed questions in the pre-course questionnaire also indicated that they felt uncomfortable or lacked confidence supporting young mothers postnatally, both generally and with breastfeeding: two of the four MSWs felt a little uncomfortable supporting young mothers postnatally, and either a little unsure or very unsure about supporting them to breastfeed. Only one of the eight midwives who submitted a questionnaire fell into these categories. This may be a result of the midwives being more concerned to give a politically correct response, or be a consequence of the fact that MSWs receive less training in communication skills and are consequently less confident in dealing with vulnerable people.

Figure 11.1. 'List the first three words or phrases that you think of in connection with teenage mothers' – midwives' responses (n = 8)

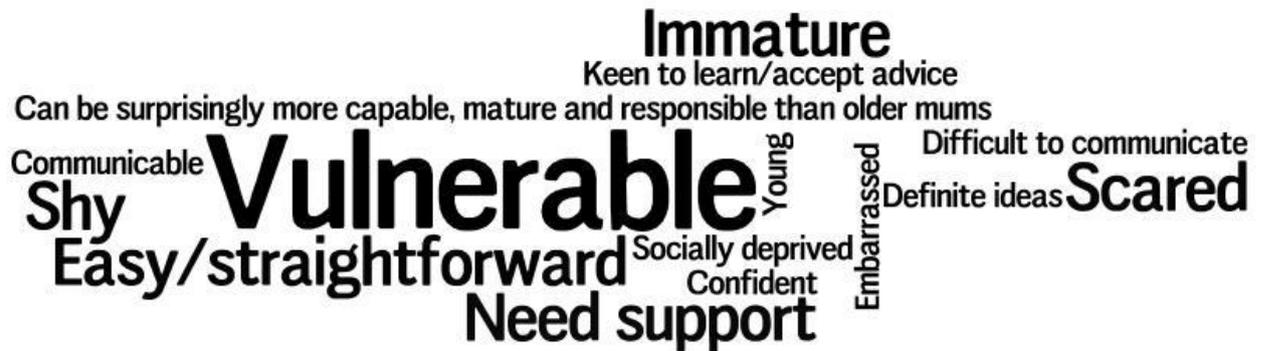
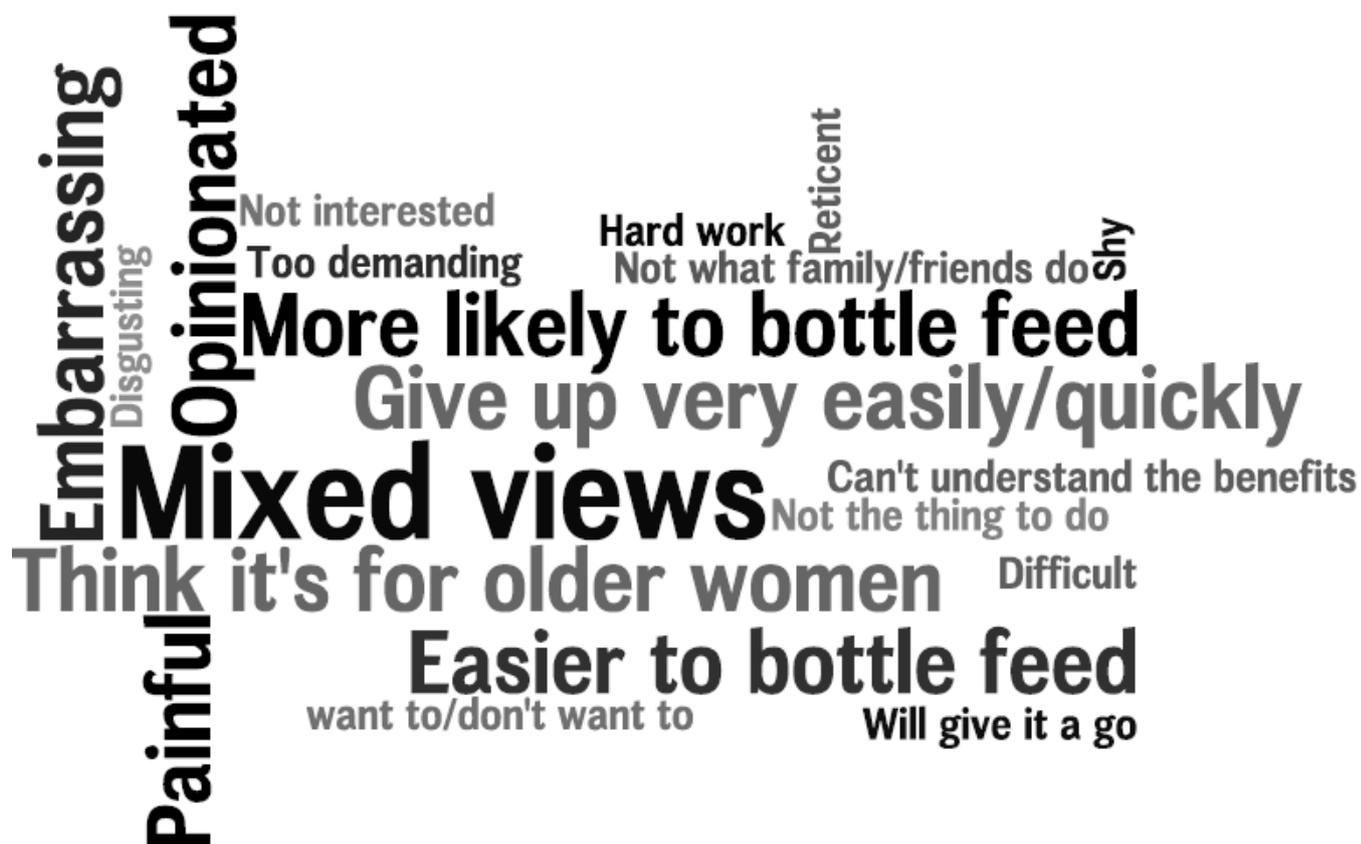


Figure 11.2. 'List the first three words or phrases that you think of in connection with teenage mothers' – MSWs' responses (n = 4)



When asked to write down three words or phrases that described the attitudes of teenage mothers to breastfeeding, the participants revealed an overwhelmingly negative mindset, as illustrated in Figure 11.3 below. The midwives' and MSWs' responses are presented together here, as there were no marked differences between the two groups. The most positive perceptions were that young women tended to have mixed views about breastfeeding and might 'give it a go'. Formula milk feeding was regarded as the usual choice for young mothers.

Figure 11.3 'List three words or phrases that, in your view, describe the attitude of teenage mothers towards breastfeeding' – midwives' and MSWs' responses (n = 12).



Despite believing that young mothers have a predominantly negative attitude to breastfeeding, both midwives and MSWs were split over the issue of whether teenage mothers wanted to breastfeed or not. Seven participants agreed that teenage mothers generally do not want to breastfeed, while five disagreed with this statement (see Table 11.1 below).

Table 11.1. Responses to closed questions regarding teenage mothers' attitudes to breastfeeding (n = 12)

	Strongly agree	Agree	Disagree	Strongly disagree	No answer
Teenage mothers do not generally want to breastfeed	0	7	5	0	0
Teenage mothers are not mature enough to persist with breastfeeding	0	2	7	2	1
Teenage mothers can breastfeed successfully, given the right support	11	1	0	0	0

Overall, a perceived desire not to breastfeed was not considered to be linked to the teenagers' level of maturity. Although 11 of the 12 respondents agreed that young mothers can breastfeed successfully given the right support, two respondents felt that they had to qualify this statement with the comment 'if they really want it'. It seems that some practitioners have difficulty believing that young mothers are sincere in their wish to breastfeed. There was further evidence of this attitude in an MSW's reply to a question asking what information respondents felt they needed in order to be able to support young mothers:

'...what their real feelings towards it are'.

Impact of the training session

Responses in the post course questionnaire indicated that the session had encouraged participants to reflect on the challenges faced by teenage mothers and appreciate the rationale behind behaviour that they had previously considered to be negative and obstructive. Seven of the twelve respondents singled out the discussion about teenage psychosocial development as being most influential in changing their views:

‘reminded me of the hormonal and developmental elements that mean they can’t ‘just grow up’, and they can’t help being moody sometimes’

(Post-course questionnaire, midwife 7).

Respondents also identified a heightened awareness of the need of young mothers for support and understanding, and an appreciation of the rationale behind the proposed intervention. Only one participant (midwife 2) declared that the training had merely reinforced her current practice, as she felt she was already acting appropriately.

Comments on the post-course questionnaire, and comparison between answers to closed questions in the pre- and post-course questionnaires suggest that the training helped to make participants feel more comfortable about supporting young mothers postnatally, and more confident about helping them to breastfeed:

‘I now understand that their attitude is a defence mechanism and will feel more confident with dealing with them’

(Post-course questionnaire, MSW 1).

This is further illustrated in Tables 11.2 and 11.3 below.

Table 11.2. How comfortable do you feel/now feel about supporting young mothers postnatally? (n = 12)

	Very comfortable	Comfortable	A little uncomfortable	Very uncomfortable	No response
Pre training	4	5	3	0	0
Post training	5	6	0	0	1

Table 11.3. How confident do you feel/now feel about supporting young mothers to breastfeed? (n = 12)

	Very confident	confident	A little unsure	Very unsure	No response
Pre training	3	6	2	1	0
Post training	5	6	0	0	1

Responses to an open question in the post course questionnaire asking participants to outline the key components of breastfeeding support for young mothers indicated that they had listened and responded to the feedback from the focus groups with young mothers. Although it is not possible to make a direct comparison, as the same question was not asked pre-training, Figure 11.4 below shows how, following the training session, the respondents particularly appreciated young mothers' needs for time, proactive support, praise and encouragement, and a relaxed, calm approach.

Figure 11.4. 'What, in your opinion, are the key components of breastfeeding support for young mothers?' – midwives' and MSWs' responses (n = 12)



The five staff (three midwives and two MSWs) who attended the training and participated in semi-structured interviews five-six months later were able to talk in the interviews about ways in which the training had challenged and altered their views, indicating that the positive effect of the training held true over time.

Again the discussion of teenage development appears to have been particularly influential, as is illustrated by the quote below:

'The one thing I think was really interesting is, um, and it's going back to your study day, you know – the realisation that teenagers do need more sleep. And just because they've had a baby...they still need more sleep. And it's just realising that if they don't get that sleep they are mega grumpy... and it's taking that on board and allowing them to be that little bit grumpy, and getting past the grumpiness'

(Interview 10, midwife).

Interviewees were also able to recall findings from the focus groups presented at the training, which they cited as having helped them understand the rationale behind the intervention package:

'I really did think that they [teenagers]'d feel alienated in a ward [designated bay], and that [feedback from focus groups with young mothers presented at the study day] alone, changed my whole.. 'oh, actually, no, they don't see it.. like they're being alienated and made to feel special – that's what they want'

(Interview 8, MSW).

The presentation of findings from the focus groups, together with the suggestion that young mothers should be asked about their feeding intention on admission to the ward, was credited in the following exchange as having instigated a lasting change in one midwife's practice towards all new mothers:

Midwife: I'd say it's made me a little bit more aware of women who maybe give bottles but do want to breastfeed...

Researcher: And have you found that people do change their minds, or..

Midwife: A lot. Yea, a lot. A lot of people do. Um – teenagers and non-teenagers.

Researcher: Mmmm.

Midwife: More than – more than you would imagine

(Interview 6).

Despite the training being well evaluated by participants, and the evidence that it did lead to some changes in attitude and practice, the session was less successful in producing staff who would take a lead role in the implementation of the intervention package. Of the ten midwives who attended, four either left the Trust or were moved to posts in different areas in the month following the training. A further three midwives were rotated to labour ward three months into the project. This meant that only three midwives who attended the training were on the ward for the whole of the implementation period. Two of these midwives were very newly qualified, and the ward managers were therefore reluctant to give them a leadership role. The remaining midwife was a ward manager, but due to her workload was unable to take a lead role in implementing the project. The four MSWs who attended the training worked on the ward throughout the project. However, perhaps because they were used to performing a supporting rather than a leadership role, they did not disseminate the information they had been given at the training session to their colleagues, and they rarely initiated the checklists with young mothers – only two of the 15 initial checklists returned to the researcher were completed by MSWs. One MSW who attended the training declined to be interviewed six months later, on the grounds that ‘I haven’t had much to do with them [young mothers]’. A comment made by another MSW during an interview indicates that she did not consider it to be part of her role to educate other staff about the intervention:

‘Because I don’t think everybody came on the study day did they? So, there’s still midwives that aren’t.. don’t know what they’re meant to be doing with the paperwork and things’

(Interview 8, MSW).

The reluctance of MSWs to take a leading role in initiating the support package, and of managers to give a leadership role to newly qualified midwives, is likely to

reflect the prevailing culture on the ward itself. This is explored further in the next chapter.

Overall, findings from the pre and post course questionnaires indicate that MSWs feel less positive towards, and are less confident about caring for, young mothers than their midwifery colleagues. Seven of the 12 midwives and MSWs who responded believed that young mothers did not generally want to breastfeed, and there was a consensus that young mothers had a predominantly negative attitude towards breastfeeding. The four-hour training session appears to have challenged some of the negative perceptions around teenage mothers and breastfeeding and increased practitioners' levels of comfort and confidence in supporting young mothers. Data from the interviews suggests that this change persisted over time. All 11 participants who answered the question in the post-course questionnaire thought that the session would help other health professionals develop a more positive attitude towards teenage mothers wanting to breastfeed. The mechanism that enabled attitudes to be changed on the study day appears to have been raised awareness and new knowledge, particularly of adolescent psychosocial development, facilitated by an opportunity to reflect on and discuss the information and ideas presented. Three participants commented on the post-course questionnaire that they had found the informal, discursive nature of the training particularly helpful.

The unwillingness of managers to assign leadership roles to newly qualified midwives who attended the training suggests that this expectation should have been made clearer in advance. Both junior midwives and MSWs may have been more prepared to disseminate the information they learnt on the day, and take a leading role in implementing the support intervention, if barriers to doing this, and ways of overcoming them, had been discussed during the training session.

These findings are gathered from a very small sample in a single location, and so cannot be generalised to other settings without further research being undertaken. If these results were to be replicated amongst other, larger, populations, it would suggest a need for the training of MSWs to devote more

time to developing communication skills, and for all health practitioners to be made aware of the psychosocial challenges faced by young mothers.

Breastfeeding checklists

The 15 sets of checklists returned to the researcher were analysed to establish completeness of application of the intervention package. Several sets of checklists were sent home with the young mothers, and the researcher was unable to retrieve them. Staff views of the checklists were collected during the interviews.

During the interviews, staff recounted how the breastfeeding checklists were initially almost universally viewed as ‘daunting’, ‘too much’, and a ‘hassle’ or ‘problem’. Of the 15 checklists returned to the researcher, only seven feeding review sheets and four discharge checklists had been completed, indicating that much of the intervention was not carried out, or that support was given but not recorded. There was also evidence of role differences in terms of completing paperwork, with midwives being more likely to document care given. During the practice observations, neither of the two MSWs observed documented the breastfeeding support they gave, and only two of the 15 initial checklists were completed by MSWs.

However, interview participants described how, once they started using the lists they came to regard them as a valuable prompt, ensuring that all the relevant ground was covered:

‘you develop your own little spiel don’t you – and it just brought up little things – ‘oh, yea, I’ve been.. forgetting to say that’. So yea, I have found it really really good’

(Interview 5, midwife).

Using the documentation was not felt to add to staff workload, as interviewees had originally feared, because they were simply recording information in a different format:

'you just record what you do. It's no big... that's what we always do'

(Interview 4, MSW).

Interview participants further related that the checklists provided a record of advice and support, so that information wasn't repeated unnecessarily and each successive carer could build on what had been done before (it was interesting that they did not appear to have been using existing care plans to fulfil this role):

'being able to provide a record of the care helps the next person that comes along – they can see what's been done, what needs to be done'

(Interview 7, midwife).

Only one midwife expressed a dislike of the checklists. This appeared to be because she felt that all postnatal women should be receiving the care outlined on the lists as a matter of course:

Midwife: So I was moderately surprised that – doesn't everyone do that? And that's – it's quite frustrating.

Researcher: Mmm. Well I think the answer is that everyone doesn't do that.

Midwife: I know. But it's quite shocking, because it's quite fundamental stuff...

(Interview 2).

This midwife, along with two of her colleagues who were interviewed, thought that the care enshrined in the checklists, and even the checklists themselves, should be used for all women, rather than specifically for young mothers:

'I do think it's something we should – I think we should be doing it with everybody as well, but focussing on these groups that quite often statistically do tend to bottle feed'

(Interview 7, midwife).

The following comment from an MSW indicates that many of the ward staff were also unhappy with the concept of singling out young mothers for support:

'There was very much the kind of opinion that.. all mums should be treated the same'

(Interview 9, MSW).

The evaluation indicated that the checklists were initially unpopular with staff, and that many were not completed. However, once they started to use the lists staff saw them as a vehicle for improving breastfeeding support for all women by acting as a prompt and facilitating communication between different caregivers. Singling out young mothers for support appears to have been a controversial approach, and midwives indicated that they thought all women should be offered the same care.

Designated young persons' bay

Evaluation data on the designated bay for women aged under 20 was collected during practice observations and in the semi-structured interviews with staff. The designated bay was perhaps the most controversial aspect of the intervention, and also the one that appeared least likely to become established in the long term. A pressure for beds on the ward made it very difficult to keep specific beds available for young people, especially during busy periods:

'what tends to happen is that those beds [in the designated bay] are then taken for other women, and then we do have a teenager, who could go into the teenage bay, and... the only bed free is in another bay, and where there aren't any teenagers anyway'

(Interview 3, midwife).

The designated bay was being used as a general bay, accommodating women of all ages, during all three of the practice observations, even though there were young mothers in other areas of the ward. The bay would periodically be emptied and reinstated as a teenage bay, but one of the newly-qualified midwives who was interviewed indicated that her efforts to re-introduce the bay were blocked by other staff, who considered that they were too busy to assist:

‘um, it seems – you’ll say to somebody, ‘we should do this as the teenage bay’, ‘oh no no no – we haven’t got time to be doing that’

(Interview 5, midwife).

Staff were quick to consider that there weren’t enough young people to warrant maintaining the bay if it did not fill up within a short space of time, as the following comment illustrates:

‘I’ve emptied the bay to leave it [ready for young mothers], on a couple of my shifts..., and yet over the course of the day, um, I’ve found that I’ve had maybe one person in there’

(Interview 10, midwife).

The interview data revealed that some staff, particularly those who had been young mothers themselves, saw the young persons’ bay as an unwelcome vehicle for singling out and labelling young mothers as ‘naughty’ and deviant. One midwife reported:

‘they [other ward staff] were saying ‘well, well why are they picking out these young mums? You know, why are they sort of segregating them into this – you know, I would have felt, sort of.. put away. You know, why aren’t I normal, the same as everybody else’

(Interview 2, Midwife).

There was an indication that other ward staff were less sympathetic towards young mothers, but still objected to the young mothers' bay on the grounds that young women should not be given additional support:

'one of the things I.. knew would happen, was there was gonna be certain.. midwives who were of the impression that, you know, teenagers, if they're old enough to get pregnant then they should be treated like adults, etc etc – that kind of attitude'

(Interview 5, midwife).

The bay was particularly felt to stigmatise young mothers when only one of its beds was occupied. It was interesting that a teenager on her own in a four-bedded bay was seen to be isolated, kept apart from, and somehow missing out on the company of other mothers, whereas young (or indeed any) mothers in single rooms were seen to be privileged recipients of superior accommodation. During practice observation 2, the researcher witnessed a doctor and a midwife making plans to move a patient who was on her own in a four-bedded bay into a single room, on the grounds that being alone in a bay was 'isolating'.

Not all of the feedback about the bay was negative. Some staff thought that it was a useful vehicle for facilitating peer support:

'I think just having the extra support of somebody their own age that they can talk to'

(Interview 3, midwife).

Others had found, however, that getting young mothers to talk to each other was challenging:

'In my personal experience, when I've looked after the teenage bay, um, they've all kept their curtains drawn, and just been texting on their phone – they haven't actually spoken to each other at all'

(Interview 6, midwife).

It was noted during the observations of practice that nearly all the women on the ward kept the curtains around their beds closed – a phenomenon that is discussed further in the next chapter. During the interviews, staff suggested that simply putting young women in a bay together was not enough to ensure that they would interact with one another, and that they should perhaps be provided with a communal sitting area, or staff should initiate group discussions or activities (such as nappy changing demonstrations) with the young women.

Other interviewees believed that young mothers would benefit more from being in a mixed-age bay and interacting with older mothers:

‘if they are with [an] experienced mum they can share experience with them’

(Interview 4, MSW).

Overall, staff appeared to believe that mixed-age bays were more practical and equitable, while still allowing targeted support to be given:

‘picking up on the fact that they are teenagers and working through it with them, individual basis, wherever they are on the ward, would probably work better’

(Interview 2, midwife).

The introduction of a designated bay for women under 20 proved difficult to implement and sustain because logistical pressure on beds meant that it was often filled with older women, and staff were either ambivalent as to its value or considered that it stigmatised young mothers. Staff particularly disliked placing a young person in a four-bedded bay on their own, and considered that further measures would need to be taken in order to foster interaction and peer support between young mothers when they were in a bay together. Although some staff suggested that the bay could be developed by adding a sitting area or instituting group activities, most considered that it would be more practical to support young mothers in a general ward area.

The Baby Café

Feedback on the ward baby café was given by staff during the interviews. Comments made by young women were noted during the practice observations, when the café was also observed by the researcher. Although the baby cafe was in general supported by the ward staff, its potential impact was reduced by its restricted opening hours, its not being open on all advertised days, and the reluctance of some women of all ages to use it – indeed, on several occasions when the researcher visited the ward there were no mothers in the cafe at all. The following midwife’s frustration with the café was typical of responses obtained during the interviews:

‘The problem with the baby café up here is that it seems to be a bit hit and miss when it’s run.. Um, none of us know precisely what days it’s supposed to run on, and even when – when people who usually run it aren’t here we don’t really get any notification of that’

(Interview 6, midwife).

This suggests that communication between the ward and baby café could be improved.

Although there were instances of young mothers accessing the café, staff felt that they may be more likely to find it

‘a bit daunting [...] having to go into a busy breastfeeding clinic’

(Interview 7, midwife).

This midwife’s perception that the café was ‘busy’ is at odds with the researcher’s observations, and suggests that the ward staff were unaware of the nature of the café and may have been painting a misleading picture to the women on the ward, making them less likely to access the café for support. This suggestion is perhaps confirmed by the following interaction noted during practice observation two:

Midwife: Did the midwife come round from the breastfeeding café [to invite you to attend]?

Young mother: Yea, but I didn't wanna sit round in front of loads of people.

The young mother's depiction of the café is not challenged by the midwife.

As well as believing that the café was busy, during the interviews some midwives related a belief that the café would attract more prosperous women – the implication being that it wasn't a suitable means of providing support to young and disadvantaged mothers:

'I think the type of people that access the baby cafes are going to be the middle class.. affluent, probably white, individuals... I don't think it's going to be the young people, I don't think it's going to be the disadvantaged people'

(Interview 2, midwife).

This midwife's view is supported by the practice observations, during which the researcher witnessed two young mothers decline repeated invitations to attend the baby café.

The impact of the baby café was further limited by the fact that it was run entirely separately from the ward, by a midwife who did not work on the ward, and used entirely separate documentation. Thus, although its intention was to support women, it resulted in a further fragmentation of care. If a woman went to the café, ward staff had no idea what she had been told and what, if any, plan had been made for future feeds, as this information was recorded on a form that was kept in the baby café and not in the woman's maternity notes. The ward staff could, of course, ask the mother herself and frequently did so; but the fact that ward and café staff were so obviously not working together, and not building on the advice and support that each had given, created stress for the mother (who was not sure whose advice to follow), and weakened the impact of the support she was given. The impact of this was seen during observation one, when an articulate mother

sought breastfeeding help from her midwife, two MSWs, the baby café and a midwife conducting her baby's initial check at various points during a morning. Neither the MSWs, the baby café midwife or the midwife conducting initial checks wrote in the woman's notes (although the latter did seek out the woman's midwife and relay to her what she had advised). By the end of the morning the woman, despite having received a considerable amount of 'support time', was in tears – she had been given a slightly different (but not necessarily incorrect) take on her situation by each individual support person, and didn't know which way to turn.

Data from the interviews and practice observations indicates that, although they supported the baby café, ward staff regarded it as a place for more prosperous women. There was perhaps some truth in this view, as young women were witnessed displaying a reluctance to attend the café during practice observations. A lack of communication between the café and the ward meant that ward midwives and MSWs were rarely sure when the café would be run and hence when to encourage women to attend. Furthermore, if women did attend the café, care givers on the ward did not know what advice they had been given, making it very difficult for consistent support to be maintained. It also appears that the ward midwives' erroneous belief that the café was 'busy' may have deterred younger mothers in particular from attending.

As a result of the reluctance of some young women in particular to attend the baby café, during the course of the intervention baby café midwives were asked to come onto the ward when the café was quiet and offer support to young and other mothers who were less likely to access their services. One midwife was even paid extra hours to offer breastfeeding support on the ward, outside baby café hours, on one day each week. This was a universally popular initiative with staff, who felt that such proactive assistance benefitted women:

'[Someone] to just.. go and see them, and spend that bit of extra time, so we know that someone's had the time to sit and talk through feeding with them... someone who was dedicated to breastfeeding could go round and support people'

(Interview 3, midwife).

This comment also suggests that time is in short supply on the ward, and midwives are consequently not able to offer time to women themselves. This is a theme that will be explored in more depth in the following chapter.

Community support

The impact of informing community support workers when young mothers on their caseloads were admitted to the postnatal ward was evaluated during the interviews with ward staff. This component of the package was extremely well received by the ward staff, who particularly appreciated the fact that it was extremely quick and easy to implement:

'I think it's a really good way of doing it. Because it's obvious and it's right there, and as soon as you pick up the notes, you know that they've got a family nurse practitioner involved'

(Interview 6, midwife).

The ward staff reported that family nurses did come and visit the young mothers after being phoned, and they appeared to regard the continuity of carer that the initiative promoted as being highly valuable:

'um, I think it's a really good idea, with the stickers there. Because that's somebody who they've had contact with throughout the pregnancy, and they're gonna see postnatally as well. So it's – it's that.. continuity of carer isn't it'

(Interview 5, midwife).

Staff who had been caring for young mothers who were visited by a family nurse described the initiative as 'a really good thing' (Interview 3, midwife) that was 'making a difference' (Interview 2, midwife). The family nurse visits may have been more highly valued than the baby café because they could be set up easily by ward staff (rather than having to wait and see if they would happen, as with the café), they were more highly visible as they took place at the young mother's

bedside and not in a separate room, and they provided continuity of carer which the ward staff considered to be very valuable.

Overall impact of intervention package

Although the findings discussed in this chapter are principally qualitative in nature, it is clear that the principal outcome of the implementation was non-compliance with the proposed changes. The staff training session did improve staff attitudes towards teenage mothers and breastfeeding, but did not result in staff implementing the proposed support package. Instead, elements of the intervention were only partially implemented, if at all. The partial implementation of the intervention impacted on the evaluation, as only 15 checklists and three evaluation forms were returned to the researcher. Furthermore, the aforementioned problems ascertaining how many young women stayed on the ward during the implementation period mean that it was impossible to determine the reach of the intervention. This limits the validity of the findings. However, the researcher was still able to conduct practice observations and interviews, and comprehensive data and feedback were collected during these processes. The data indicates that the checklists, when used, were helpful and were considered by staff positively to influence the breastfeeding support given to young mothers. Indeed, the very limited feedback received from young mothers via the three returned feedback forms indicated that they appreciated the proactive support, praise, and education regarding hand expression advocated in the checklists. One respondent described the help she was given as 'awesome'. Additionally, staff who were involved in implementing the package described engaging in the process as 'delightful' and as increasing their job satisfaction:

'the last [young mother] I specifically looked after, she was really positive about how it all worked... and she really kind of appreciated the extra support that we gave her. So it was nice seeing that kind of tidy up and her be happy with it ... It is nice.

(Interview 7, midwife).

Findings from the evaluation process also indicate that putting young mothers together in a designated bay will not, of itself, facilitate peer interaction and support. Furthermore, there is some evidence to suggest that offering breastfeeding support at the bedside will reach more young women than offering support in another location, such as a baby café.

The key mechanisms impacting on the implementation of different elements of the support package are discussed below. Identifying these mechanisms will enable the intervention package and implementation process to be modified in order to ensure a more favourable reception by ward staff in the future.

Underpinning mechanisms

A number of mechanisms leading to the potential success or failure of each element of the support package can be inferred from the evaluation findings. Leadership and management issues affected the planned implementation of the support package following the training session. Time and convenience, control and personal beliefs further affected the extent to which staff were willing to implement aspects of the intervention package.

Leadership and management

It was envisaged that staff attending the training sessions would take a lead role in implementing the intervention and cascading information to their colleagues. However, MSWs did not appear to regard leadership as part of their role. Furthermore, four of the midwives who attended the training session were moved to other areas at short notice or left the Trust shortly afterwards. Managers on the ward did not have the time to play a leading role in the implementation, but were reluctant to delegate this role to newly-qualified staff. Finally, although the training was timed to take place at the beginning of the rotation of new staff to the ward, different members of staff are rotated to new areas every three months. This meant that additional staff who were given information about the study by their colleagues or during the researcher's visits to the ward left half way through the project.

Time and convenience

The time taken to complete each element of the intervention, together with its perceived convenience (the ease with which it fitted with other aspects of work), impacted on its reception by ward staff. Staff described initially finding the checklists 'daunting', but finding them more acceptable once they realised they did not take more time to complete than existing documentation. There was an indication that some staff were unwilling to reinstitute the designated bay because of the time this would take. The community support initiative, however, was well liked because it was quick and easy to implement.

Allied to time and convenience is communication. Elements of the support package were more acceptable to ward staff if they improved communication between different caregivers – thus proving both convenient and time saving. The checklists were praised for acting as a prompt and communication tool, and the community support initiative for providing a communication pathway with family nurses. The baby café, on the other hand, was criticised for causing communication problems, as ward staff were never sure when it would open. It can also be seen as an initiative that doesn't promote communication between care providers and can lead to conflicting advice and fragmented care, as there is no shared documentation.

Control

Ward staff were more likely to support elements of the intervention they were able to control. For example, the baby café only opened when other people arrived to run it, and pressure for beds could result in older women being put in the designated bay. However, an individual midwife or MSW could contact a community support worker, or complete a checklist.

Personal belief

Elements of the support package were more highly rated and therefore more likely to be implemented by ward staff if they aligned with their personal beliefs about good care. Thus the designated bay was judged to be of questionable value, while the community support was well liked for promoting continuity of carer, and the baby café midwife providing support on the ward was

lauded for being able to give women time. The baby café itself suffered from an erroneous perception that it was 'busy', and a belief that it was a more suitable support medium for more advantaged women. Interestingly, although the designated bay and checklists were criticised for singling out and even stigmatizing young mothers, and staff suggest that a more universal approach would be more acceptable, there was unanimous support for the community support worker initiative, which involved Family Nurse Partnership nurses providing targeted support to young mothers on the ward. This may be because targeted community support has been in place for young and vulnerable mothers for a number of years, whereas targeted support provided by hospital staff is a new idea.

In view of the findings of the evaluation process, and the mechanisms identified above, a revised programme specification is proposed below. The revised package attempts to capitalise on the enabling mechanisms identified and address and overcome disabling mechanisms.

Revised programme specification

Reflection on implementing the support package, analysis of the practice observations, and discussions during interviews with ward staff, resulted in a number of recommendations for refining the intervention package before future evaluations are carried out. Revisions are recommended below both to the package itself and to the way in which it is implemented on the ward.

Modifications to support package

Caring for young women in a designated bay proved to be unpopular with ward staff and logistically difficult to sustain. Additionally, staff felt that the support given on the bay should be given to all mothers, and not just teenagers. It is therefore recommended that, in future, the majority of the intervention package should be used with all mothers, adopting the principle of proportionate universalism outlined in the Marmot Review – that is, a single approach that focuses on the particular needs of those most disadvantaged by current provision (Marmot 2010). The support measures should therefore continue to focus on the

needs of young mothers, such as for proactive assistance, but offer this to all women.

The breastfeeding checklists, when used, proved popular with staff. However, it was noted that MSWs rarely filled them in. Additionally, documentation was not shared by different care providers, such as the midwives working in the baby café. This contributed to a fragmented and disjointed approach to care, as illustrated above. A universal breastfeeding support document that all care givers used might enable the provision of a more joined up approach and prevent care being duplicated. If each care giver consulted the documentation to see what the woman had already been advised, and built on that support, documented and helped her initiate any agreed plan of care, then communication between caregivers and with the woman might be improved. Embedding the documentation into existing maternity notes may be more convenient for staff and thus further ensure that it is completed. Steps should be taken to ensure all staff and support services are aware of and use the appropriate documentation during future interventions.

The baby café was poorly attended and criticised for its sporadic opening hours. There was a consensus among staff who were interviewed that bedside support would reach more vulnerable and disadvantaged women. It is therefore recommended that a universal breastfeeding support package needs to include proactive support at the bedside. While it is acknowledged that providing a dedicated breastfeeding supporter to fulfil this role has financial implications, it is probably less expensive than raising midwifery and MSW numbers to a level at which all staff would have time to complete all their other duties and provide adequate breastfeeding support.

The inclusion of community support workers in the intervention was well received, and no modifications are suggested to this component of the package. Overall, therefore, a revised package would consist of proactive breastfeeding support offered to all women using universally adopted checklists that particularly address the needs of young and vulnerable mothers. Named community support workers would be contacted when young women in their care were admitted to

the ward. Omitting the Baby Café and using universal documentation would give individual staff more control over implementing the package, facilitate communication and maximise convenience. The addition of a designated breastfeeding supporter would ensure that time was available for breastfeeding support. The intervention would not preclude the provision of support to young people in a designated bay where this was deemed practicable, but this aspect of the package needs further investigation, particularly in respect of young mothers' views and experiences of being separated from older mothers.

Changes to implementation process

Regarding the implementation of the intervention, staff training sessions appeared to be an effective way of discussing and gaining support for the study. However, the expectation that those attending the training would cascade information about the intervention and its underlying rationale to other staff on the ward and take a leading role in providing care to young mothers should have been made more explicit. Guidance, including a discussion of potential barriers or challenges to informing and instructing colleagues, together with suggestions as to how these might be overcome, should also have been provided. Reconvening attendees at the training sessions to trouble shoot and problem solve might also have added momentum to the implementation process and secured more widespread adherence to the intervention protocol. This strategy would also have provided an opportunity to praise participants for any progress made – participation, support and praise have been identified as essential prerequisites to introducing change (Kirkham 1999, McLachlan et al 2008). Attempts were made to praise staff during the intervention by passing on positive comments made by young mothers. This might have had more impact if the comments were displayed on staff notice boards. Ward managers could also have been asked to support staff who attended the training to lead and implement the intervention package. It is considered likely that, as the training session successfully changed staff attitudes and beliefs with respect to young mothers and breastfeeding, the attitudes and beliefs of other staff on the ward could have been challenged and changed if those who had attended the training had cascaded information from the day.

Conclusion

This chapter has presented the findings of an evaluation of a breastfeeding support package for teenage mothers in relation to each individual component of that package. Mechanisms supporting and blocking the implementation of the intervention have been identified, and a revised support package proposed in light of these. However, the evaluation has so far largely considered the effect of the intervention in isolation from the general context encountered on the ward. It has therefore answered the question 'what works' (or does not work) from the point of view of ward staff, but not 'in what circumstances'. A consideration of the environment on the ward may shed further light on why there was such an apparently high level of non-compliance with aspects of the intervention package, and indicate why staff attending the training failed to take a lead role in the implementation process. Furthermore, an exploration of the ward context might explain why time and convenience, control and personal beliefs emerged as key determinants of the level of implementation of different elements of the breastfeeding support package. The ward context is therefore explored in the next chapter.

Chapter twelve

The environment encountered on the postnatal ward

Introduction

According to realist theory, an intervention reacts with the context in which it is placed to produce mechanisms (processes or modes of action) and outcomes (results) (Pawson and Tilley 1997, Rycroft-Malone et al 2010). An evaluation of the constituent parts of a support package to increase breastfeeding rates among young mothers, presented in the previous chapter, has indicated that leadership and management issues, time and convenience, control and personal beliefs affected the acceptance and degree of implementation of the package on the postnatal ward. This chapter presents data from the practice observations and interviews with staff that detail and illuminate the culture of the ward, and explores ways in which this impacted on the implementation of the support package. The data suggests that inadequate time and staff, and a lack of control of time and space are responsible for a busy, stressful and chaotic environment with a task-orientated, individualistic focus, in which breastfeeding support is not prioritised. There were, however, some enabling mechanisms in evidence on the ward, such as the willingness of staff to reconsider their initial reactions to the proposal and their views about the support needs of teenage mothers, and a widespread frustration with current ways of working. The implications of the findings regarding the ward environment for a revised support package are considered.

Lack of time and staff

The ward was described in the interviews as 'manic' (Interview 3, midwife) and as a 'fast process unit' (Interview 9, MSW). Without exception, participants attributed this to inadequate staff cover:

'I think the main problem... is that we're really short staffed, and we are too busy'

(Interview 4, MSW).

During each practice observation, there were between 31 and 33 patients on the ward, of whom five were antenatal. Usual staff cover was four midwives and two MSWs in the morning, and three midwives and two MSWs in the afternoon. Managers acknowledged that this was less than ideal – target cover for the ward was four-five midwives and three MSWs, but due to staff sickness, maternity leave and budget constraints this was rarely realised. The maximum staff cover observed was eight (six midwives and two MSWs) at the beginning of observation one, as additional staff had been drafted in for two hours to help with discharges.

Staff acknowledged that time pressures created on days when they were expected to care for ten or more women each impacted on the quality of their work:

‘I give the best care I possibly can on a very busy day, but it’s not necessarily the same care I would give on another day’

(Observation 1, midwife).

In particular, staff considered that low staff: patient ratios prevented them from spending time relating to and supporting women:

‘Just not having the time – literally not having the time to spend with people... say you were on a 12 hour day shift... well 12 ½ hours we’re here for – if you take off half an hour at the beginning and the end for handover, um, take off your hour for lunch, so that’s – you’re already down to ten and a half hours. If you’re looking after ten women, that’s an hour each. And if you’ve got to do their postnatal check, baby’s postnatal check...write their paperwork, you might have to talk to the doctors, you’ve got to do the doctors’ round. It physically – there genuinely actually isn’t the time in the day’

(Interview 6, midwife).

In addition to the number of women they were caring for, administration and management tasks were observed further to restrict the time available for

face to face contact with individual women. During observation one, the midwife who was shadowed spent less than half of her six hour shift interacting with women. The rest was taken up with administration (writing in notes, ordering and finding drugs, entering data into the computer and discussing care plans with other staff). She had no break. There also appeared to be established routines on the ward that were particularly time consuming. For example, there was an expectation on the part of some doctors that midwives would accompany them on their rounds. During this time, the midwives were expected to wait while the doctors reviewed and examined the women's maternity notes, and then watch while the doctors consulted with the women, repeating many of the questions and procedures already undertaken during the midwife's postnatal check. Additionally, on each observation an MSW spent the entire shift sorting the relevant paperwork for and bringing mothers and babies to a paediatrician or specialist midwife conducting newborn initial checks. Therefore, although the ward was indeed short staffed, established ways of working that took up a significant amount of staff time did not appear to be questioned or streamlined. The following comment made by a senior midwife during the interviews indicates that there was perhaps an awareness that work could be organised differently:

'... maybe we're not using our time.. as wise as we'd like. And sometimes you do have to stop and stand still and think 'what's really important here?'

(Interview 10, midwife).

Stress and survival strategies

The amount of work that midwives and MSWs on the ward were attempting to cover during their shifts created a highly pressured and stressful working environment, as the following quote illustrates:

'you're trying to help somebody breastfeed but you're also running the clinic, and you've got buzzers going off, and you're meant to be doing this, and you're doing that – you haven't – even when you're standing with somebody trying to help, in your

head you're going 'oh my God, I should be doing this, I should be doing this, I should be doing this' – and you just can't .. relax and actually .. be able to give that woman the help that you're meant to be'

(Interview 8, MSW).

Stress was also observed to be affecting employees' health, wellbeing and morale. During the observations, midwives described how stress at work was affecting their home lives. A main topic for the snatched conversations between staff witnessed by the researcher was plans to leave midwifery or transfer to another area. Over the three observations, one midwife and one MSW were seen in tears due to work stress.

In order to try and cope with the stress generated by a shortage of time and staff, care on the ward appeared to have been stripped back to a series of tasks to be completed in the shortest possible time – activities such as measuring urine, dispensing medication and ensuring that every woman is wearing TED stockings appeared to be prioritised, perhaps because they can be completed reasonably quickly and give the midwife a sense of achievement and control over her day. The relational aspect of care was often reduced to the task of information giving – telling women about recovery and baby care but not often offering practical or emotional support unless women were very upset.

Midwives were also observed trying to manage their stress by reducing their workload. Individuals would assign themselves whatever they considered to be a reasonable workload, and leave others to pick up whatever was left. An example of this was seen at the beginning of observation two, when a reasonably inexperienced midwife left the ward for a short while for a meeting with a manager. By the time she returned her colleagues had assigned her the role of coordinator for the day (even though another midwife was named as coordinator on the off duty and there were more experienced midwives on the shift) and she had 12 postnatal women to care for (another midwife had only three). This suggests that the midwives had adopted an individualistic approach to managing

their workload and its associated stresses, and were not acting as a team or supporting each other.

Breastfeeding support – an added extra

A shortage of staff, time-consuming routines and an individualistic focus clearly militated against the successful introduction of additional support for young mothers. Furthermore, in the time-pressured, task-orientated ward environment, breastfeeding support itself was seen as an added extra by the midwives, which they didn't have time to provide – it was either left to the MSWs, or given in

'a rushed 5 minutes here and there when we can fit it in'

(Interview 3, midwife).

The MSWs, however, also had many other demands on their time, and so breastfeeding support was not a priority for them either:

'we need to do lots of things, plus breastfeeding support'

(Interview 4, MSW).

In line with the focus on information giving outlined above, when it was offered breastfeeding support was often condensed into a series of mini set-piece lectures on supply and demand or, where necessary, expressing. After these lectures, women were told by the midwives to 'call when you need help'. This was almost a mantra, enabling staff to feel that they were being supportive without actually spending time with women. If women did ring for help, the call bell would generally be answered by someone else, and often not in a timely manner:

'They buzz the bell. Half an hour after they've rung somebody arrives, and it's all gone'

(Interview 2, midwife).

When practical support was provided, it was often in the form of hands on help – possibly because this enabled the caregiver to retain control and finish the ‘task’ in the shortest amount of time. Once the baby was on the breast, the caregiver would generally leave to attend to something else –

‘no one really stays with someone through the feed’

(Interview 6, midwife).

The breastfeeding support package was not only, therefore, not embraced due to staff shortages but also because it addressed a subject that was not prioritised by staff, and advocated a proactive, facilitative, relational style that was at odds with the task-orientated approach commonly used on the ward.

Lack of confidence in breastfeeding

Alongside being dictated by a lack of time, midwives’ and MSWs’ breastfeeding interactions with women revealed, in some instances, a fundamental lack of confidence both in the process of breastfeeding and their ability to support women establish lactation. One experienced midwife commented during observation one that she felt deskilled in supporting breastfeeding mothers as she always had to delegate this to MSWs. During observation two, a midwife does stay with a young mother while she attempts to latch her baby to the breast, but this appears to be purely for the researcher’s benefit – the midwife is clearly uncomfortable in this role, often watching the mother in silence and asking ‘how does that feel?’ but giving very little encouragement, praise, or pointers about signs of a good latch or feed. Others are quick to pathologise breastfeeding difficulties – an MSW was observed taking blood sugars from a healthy baby who she had been unable to latch to its mother’s breast. When the blood sugars were normal, she then proceeded to take the baby’s temperature. As well as indicating a lack of comfort with, and confidence in, the process of breastfeeding, the two scenarios outlined above portray a lack of knowledge and skill in the provision of breastfeeding support.

The midwives' and MSWs' lack of confidence in breastfeeding is shared by, or perhaps percolates down to, the women – Leap (2010) has written of how midwives' confidence in women's abilities in turn inspires confidence in women, and some of the interactions witnessed on the ward showed this process in reverse. 'I'm not producing as much as I would like' (Observation 3, mother) was a common response to midwives' asking how feeding was going, and many women were giving their babies additional formula feeds as they didn't think they were producing enough initially to satisfy their babies. The midwives and MSWs tended to reinforce the women's uncertainties. For example, during observation one a woman asked her midwife if she thought it would be a good idea to give her baby some formula 'until my milk comes in'. Initially the midwife was very reassuring, explaining that the baby only needed small volumes of feed and that formula would interrupt the process of supply and demand. However, she then went on to tell the woman that sometimes, 'giving an artificial feed gives you confidence' (Observation 1, midwife).

Linked to a prevailing lack of confidence and discomfort with breastfeeding was an anxiety by the midwives and MSWs not to be seen to be putting women under pressure to breastfeed. All three of the MSWs who were interviewed talked about respecting peoples' choices:

'obviously it's up to them how they're feeding... I don't like..
pushing breastfeeding on anybody'

(Interview 8, MSW).

A perception that women are pressurised into breastfeeding was also discussed in the following exchange with a senior midwife in Interview 10:

Researcher: Mmm. It's a really difficult line to tread isn't it?

Midwife: It's a very difficult line... And you don't want to bully,
and what you perceive as support somebody else may feel 'well,
I wasn't given the choice'...

Researcher: Mmm

Midwife: So it, it is ultimately you know you want, you want it to work for them, you want it to go really well, but you don't want to stress people to the hilt, so, anyway. We're still learning where the balance is I think.

This midwife felt particularly bruised by letters of complaint about care received on the ward, and the interviews also coincided with comments in the press characterising those supporting breastfeeding as the 'breastapo'. This negative feedback had perhaps hit home partly because the staff lacked confidence in the process they were promoting, or because they didn't feel able to change their working practices. The ward staff's lack of confidence in breastfeeding may also have impacted on the implementation of the support intervention, as midwives and MSWs are perhaps unlikely to adopt a support intervention unless they feel comfortable both with the subject matter and with their ability to promote it.

Lack of control of time and space

During the practice observations, the ward appeared to the researcher to be a rather chaotic, disordered environment - an impression that was strengthened by the myriad of different health professionals, domestic staff and trades people present, all of whom wanted access to patients, often with the midwives' assistance. Domestic staff patrolled the ward offering bed changes, a Bounty representative offered a bag of free samples and a photography service, physiotherapists gave advice and anaesthetists provided a post-epidural visit, to name but a few. There was evidence that some of the women on the ward resented the almost constant flow of uninvited visits. During observation three, one woman was overheard snapping at her partner that

'you stay in hospital to get a rest, but you don't get a rest, you get people coming in all the time - stupid people - like a physiotherapist come and tell me how to move my legs'

(Observation 3, patient).

It was common practice on the ward for patients to keep the curtains around their beds closed. This appeared to be a way of marking out some personal territory and private space, and trying to shut out the incessant comings and goings around them.

It was evident that the ward staff had no control over who visited the ward when, and although none of the visitors were necessarily unwelcome, the constant and unpredictable comings and goings resulted in midwives and MSWs having little control over their time, or of the space in which they carried out their work. For example, the midwives were often interrupted when carrying out checks or interacting with the women in their care, either by other staff wanting access to the women they were with, or requesting assistance to find equipment or notes needed to provide care elsewhere. On one occasion a midwife was called away from a consultation to help find some equipment needed by the doctors, while the doctors themselves waited in the coffee room eating the staff's chocolates.

Since the midwives' and MSWs' time was often diverted elsewhere, it was observed that ancillary staff repeatedly became involved in patient care, an occurrence which further contributed to the sense of disorder on the ward. A house keeper was observed taking babies to and from women's beds, and a member of the hearing screening team brought a mother and baby to the baby café. A ward clerk informed a midwife that one of the babies under the midwife's care was 'snuffly'. However, when the lift got stuck during one observation, it appeared to be up to the midwives to sort this out.

Another symptom of the lack of control exercised over the physical environment of the ward was the finding that equipment needed by midwives was often missing or faulty. During observation one, stocks of a commonly used drug had not been replenished so had run out, and, in observation two, a sink where midwives usually washed their hands was full of dirty coffee cups. These occurrences indicate an environment in which staff are omitting to undertake basic procedures due to lack of time, direction, or personal sense of responsibility for the smooth running of the ward.

The appearance of disorder was particularly evident when the ward managers were not working on a shift. For example, during observation one, when no manager was present, the midwives all migrated into the small ward office after receiving handover. The tasks they needed to complete in the office had not been divided up between them, resulting in everyone, as the midwife being shadowed observed,

‘trying to do the same job’ (Observation 1, midwife).

There was also no manager present during observation two. During this shift, midwives seemed to cluster around the bed board, and there was much discussion over where women were and where they could be moved to, but no decisions were made and therefore no action was taken. The shift observed during observation three, in contrast, was led by a manager and appeared calmer and more orderly, although the manager herself was clearly extremely busy as she was both looking after a quota of women and fielding all the problems and queries relating to the general running of the day. This resulted in her feeling overwhelmed and out of control, as the following comment shows:

‘Can I just say, I do not feel in control today. I do not feel in control’
(Observation 3, midwife).

A belief that only managers can and should manage was also seen in the unwillingness of the MSWs who attended the staff training carried out as part of this project to take a leading role in implementing the intervention or pass on their knowledge to their colleagues. It appears that, although midwives are rostered to coordinate shifts when managers are not present, they are either unwilling to organise and lead the work, or lack the authority to instruct and make decisions on behalf of their colleagues.

The above observations served to create the impression of an environment over which midwives and MSWs had little control, and in which it was assumed that only managers should take responsibility for decision-making.

Rather than, as the midwife quoted above suggested, stopping and asking what was important, staff remained at the mercy of time-consuming routines, constant interruptions, and lack of clarity as to their role and standing within the multi-professional team. This made introducing new ways of working, such as the support package, very difficult. Even if staff were keen to use it, they were not in control of how they spent their time. Also, the prevailing belief that only managers could and should lead meant that no one else was either willing or able to drive the intervention forwards.

Non-compliance with intervention package

The lack of staff time, and of control over how they spent their time; the unwillingness or inability of anyone apart from the ward managers to try and take control of and direct the work on the ward; a propensity to organise their workload individually rather than as a team, and lack of prioritisation of, confidence in and knowledge of the process of breastfeeding described above all militated against the successful introduction of a breastfeeding support package. Rather, the situation encountered on the ward resulted in a level of non-compliance with the proposed changes. This non-compliance could manifest itself as subversive action, passive resistance, or criticism of implementation methods.

Subversive action included dissuading colleagues from instigating the changes and repeatedly removing any references to an identified bay for young mothers from the ward bed board. This wish to expunge all traces of the intervention was also expressed in a proposal to move it elsewhere. During the interviews, staff discussed the need for breastfeeding support to be provided antenatally, or postnatally in the community, or in a different ward, or even, on one occasion, in a different hospital:

‘Or possibly even moving it.. from the [hosting hospital] completely, and maybe moving it – I mean I don’t know how big the [another Trust hospital] is, or if [it] has facilities, or if one of the community places...’

(Interview 9, MSW).

Passive resistance included not identifying young mothers during handover and not warding them in the appropriate bay or instigating the paperwork:

‘And people aren’t necessarily saying to us, or people aren’t asking, the age, before they’re accepted to the ward. So delivery suite aren’t telling us, and we’re not asking. And then, they are where they are. And then it’s like ‘oh well, they’re there now’, and then its not quite happening’

(Interview 2, midwife).

Another factor contributing to passive resistance was the fact that breastfeeding support was seen as an ‘added extra’ to the core work on the ward. This meant that additional breastfeeding support for young mothers was seen by many as an even more peripheral activity. This view was encapsulated by a senior midwife, who remarked that, of course, the young mothers’ bay was

‘your add-on bay’ (Interview 10, midwife),

to be taken on in addition to a midwife’s normal workload.

Criticism of implementation methods was put forward, particularly by MSWs, to justify their own non-compliance. During the course of the observations and interviews it was suggested that the intervention was more likely to be implemented if posters were put up, or one-to-one or group information sessions were held for staff – all these things had in fact been done (there were even posters in the staff toilets, placed to be directly in peoples’ line of sight when they sat down), and yet people chose not to be involved.

Mechanisms supporting non-compliance

In the busy, stressful environment of the postnatal ward, where staff exercised very little control over their time and space, it is easy to see why the issues of leadership, time and convenience, control and personal beliefs identified in the previous chapter were so pivotal in determining the acceptability

of different aspects of the support package. It is now clear that the limited implementation of the intervention package was due to a number of mechanisms generated by the situation on the hosting ward as well as by the content of the support package itself. These can be summarised as:

- Shortage of time. This led to aspects of the intervention package that were considered quick and convenient to carry out being more likely to be implemented. Lack of time is also likely to have contributed to the failure of staff attending the training to disseminate information to colleagues, and to communication issues between the ward and baby café staff.

- Lack of confidence in breastfeeding. Breastfeeding support was not a priority for ward staff, and some midwives and MSWs lacked knowledge and confidence in this area. This reduced the likelihood of a support package advocating additional, targeted breastfeeding support being implemented.

- Lack of control. This includes leadership issues and an individualistic orientation. Midwives and MSWs had little control over how they spent their time or of the space in which they worked. Staff were also unwilling, or, in the case of newly-qualified midwives, unable, to take control by assuming a leadership role or assume any personal responsibility for the smooth running of the ward. Instead, ward staff focused on their own workloads, attempting to limit them to a manageable size. A failure to work together to claim authority and control over their work environment prevented the intervention from gaining a foothold.

- Personal beliefs. A lack of control and team identity resulted in different visions and beliefs about good care or acceptable working practices being able to continue unchallenged. Midwives and MSWs were free to pick and choose which parts of the intervention package they chose to implement based on their own personal beliefs as to their worth and usefulness, and their own judgement as to whether they were able to incorporate them into their working day.

Other mechanisms were identified, however, that supported the limited use of the support package on the ward. These are discussed below.

Potential enabling mechanisms

The mechanisms that supported the implementation of the intervention were a willingness by staff, when challenged, to reconsider their beliefs; widespread frustration with the current situation; a recognition of the importance of relational care and a desire to do more to support young and vulnerable women. In addition to overcoming the barriers identified above, the implementation of a revised support package would be strengthened by building on and incorporating these enabling mechanisms.

Despite acting in accordance with their personal beliefs rather than adopting a team vision and approach, there was evidence that individuals were willing to change their opinions if their views were challenged and the evidence supporting the initiative was explained. This willingness to reconsider initial reservations was evident during the staff training sessions, and was also described by an MSW who had disagreed with the idea of offering targeted support before discussing the intervention at a Trust update day:

‘At first I suppose I, like possibly many people I, I didn’t really understand why.. um.. any.. section of women were being specifically .. targeted ... And I think the last update day ... I came out of that feeling like I, I had more of an understanding ... I kind of understood where I may have.. not seen before, um, you know, the various needs – the differing needs of younger mums’

(Interview 9, MSW).

It was further seen in an interview with a midwife who had not attended the training, when she is asked why she thinks a mother on her own in a four-bedded bay is such a different proposition to a mother on her own in a single room:

‘You’ve made me really think about the room thing, so – whereas I kind of had reservations about them being in a bay on

their own, it would just be exactly the same as being in a room on their own, so – I think it's fine'

(Interview 7, midwife).

In addition to being open to challenges to their beliefs, midwives and MSWs who were interviewed expressed a profound dissatisfaction with the current situation on the ward, as giving time and care to women

'is why I think we're all in the job in the first place' (Interview 8, MSW).

In particular, a number of the newly qualified midwives had been students while the local university was undergoing UNICEF Baby Friendly Initiative (BFI) accreditation, and were very frustrated not to have time to use their knowledge and skills:

'Having spent two years being drilled in baby unicef friendliness, to then sit and think I don't have the time to put all that into practice is.. really disheartening. It's, it's.. yea, it's not what I trained to do'

(Interview 6, midwife).

Midwives and MSWs identified time, proactive support, consistent advice, education and positive relationships with caregivers as being key to breastfeeding success, and expressed a wish to be able to provide these in their practice:

'I think it comes back to time ... time and consistent advice.. and being available'

(Interview 1, midwife).

'And if we had more time, or more staff, then you would happily spend that time with the mums and build up a stronger bond'

(Interview 9, MSW).

There was evidence that, despite a perception that they lacked the time to provide adequate care and support, the BFI-trained midwives were using some of

their training, and the midwives and MSWs were managing to make some time to support and build relationships with the women in their care. For example, during ward observations, BFI-trained midwives were more likely to engender confidence in women's abilities to provide nourishment for their offspring – without necessarily spending any more time with the women, they would nevertheless seize opportunities to compliment and reassure. A bottle of milk expressed by a young mother is 'amazing', the news that another baby is producing golden yellow stools is 'so good', and another mother is reassured that she has 'oodles of colostrum'. These compliments visibly relax and build the confidence of the women, leading them to ask questions, air concerns, and share and laugh about their experiences. When conducting postnatal checks, all midwives would make a real effort to put other demands to one side and focus solely on the needs of mother and baby. They would introduce themselves, use the women's names and acknowledge and ask permission to look at the baby, as well as congratulating the women, providing reassurance and explaining the checks that they were carrying out. Efforts were made to chat and build a rapport, before the midwife signed off with the inevitable 'call if you want help'.

In addition to efforts to find space for relational care within the existing ward set-up, examples were observed of practices that indicated efforts by midwives to adopt a team approach and try and exert some control over their working environment. A public health midwife with responsibility for safeguarding issues was a frequent visitor to the ward – her presence was highly valued by the midwives and she acted as an information and referral point, liaising with social services. Another midwife had health issues which made it difficult for her to walk all day, and so was put in charge of sorting out discharge paperwork for all the women who were ready to go home, thus streamlining the process and freeing up other midwives' time.

Finally, there was a recognition, particularly by the ward managers, that more needed to be done to support young mothers:

'these girls who are vulnerable, who, that we should be..
prioritising... so that, you know... we do our job properly. They

get stuff thrown at them antenatally, and then once they've delivered.. they're sort of cast adrift a bit in hospital'

(Interview 1, midwife).

This comment echoes the depiction in phase one of this project of young mothers as 'fish out of water' on the postnatal ward. Furthermore, the findings of the evaluation support the observations in phase one that the institutional barriers to providing breastfeeding support included busy staff, and the medical focus of care (seen here in a task-oriented approach). The negative staff attitudes towards young mothers wanting to breastfeed that were identified in phase one were not so apparent in phase two, and appeared to be easily challenged and changed where they did exist. However, breastfeeding support was nevertheless a non-priority activity, to be fitted in where time allowed. Despite the presence of some enabling mechanisms, the breastfeeding support package was not able to overcome established ways of working on the ward, perhaps indicating the power of context in disabling change. This is explored further in the next chapter.

Implications for future implementations of a revised intervention package

The findings outlined in this chapter indicate that non-compliance with the breastfeeding support intervention can be attributed, at least in part, to the ward context. The busy, disordered environment could not accommodate many of the components of the package. Successful implementation of the revised support package proposed in the previous chapter would depend on modifications being made, where possible, to the ward environment. In particular, the revised intervention included proactive breastfeeding support provided at the bedside by a breastfeeding specialist. The finding that some of the ward staff lacked confidence in breastfeeding suggests that the specialist's role should include the education and empowerment of staff. However, in view of the number of different professionals already accessing women at the bedside, it is unlikely that this component would succeed unless changes were made to the free access currently in operation on the ward. It is suggested that access to women be limited to midwives and MSWs for an agreed time at the beginning of every shift,

to allow time for checks to be completed and a plan made with each woman for the day. Other professionals could then be invited to see individual women, with their consent. Planned visits could be highlighted on an actual or virtual bed board.

In order to overcome the dissenting personal beliefs of some staff, the implementation of a revised support package should highlight the additional support needs of young mothers. This could be done by ensuring that staff attending training sessions were aware of, and trained to, act as ambassadors for the project and disseminate evidence to their colleagues.

Enabling mechanisms already in evidence on the ward, such as the knowledge and skills of the BFI-trained midwives, and the frustration with the existing situation expressed by many of the ward staff, should be used to drive change forwards. This might best be achieved by encouraging staff to take control of the project and of their working environment - it has been argued that change is more readily accepted if those affected by it are involved in the planning and implementation of the change, and if they stand to develop both personally and professionally from the new arrangements (Lindberg et al 2005, McKellar et al 2009). Although the current project included the views of ward staff in the intervention package through the use of an e-questionnaire, and attempted to involve staff in the implementation of the package through a training session, it did not succeed in facilitating this implementation role.

Limitations

The evaluation of the breastfeeding support intervention package was unable to establish the reach or affect of the intervention due to the unavailability of routinely collected data over the implementation period. Furthermore, assessing the acceptability of the package to young mothers was not possible as only three evaluation forms were returned. However, in exploring the mechanisms produced when the intervention was introduced, valuable insights have been learned which can be applied in future testing cycles. Many of these insights were gleaned through the three practice observations. It is possible that if more observations had been conducted by different people, different themes and

mechanisms would have been identified. However, this does not invalidate the small snapshot of working practices observed here. The resonance of the current findings with other research is discussed in the next chapter.

Conclusion

The previous two chapters have presented the findings of an evaluation of the implementation of a breastfeeding support package for young mothers on the postnatal ward. It has been established that the principle impediment to the success of the package was its failure to be put into practice. Mechanisms responsible for this failure, and mechanisms that might support future implementations, have been identified. Revisions to the support package and implementation process have been proposed. In particular, it has been argued that the environment encountered on the postnatal ward resulted from the midwives and MSWs who worked there not being in control of their time or space. It is suggested that their taking such control is a necessary prerequisite to achieving change.

Phases one and two of this project have highlighted the power of the postnatal ward to determine possibilities and experiences. Young women described it as an alien environment in which they felt uncomfortable and exposed – a situation which prevented them from seeking breastfeeding support. Ward staff adopted an individualistic, task-oriented approach to care that minimised building relationships with women or working as part of a team with their colleagues. The following chapter seeks to develop a theoretical framework to account for the environment encountered on the postnatal ward and suggest a possible template for change by comparing the current findings to wider literature and research. It is hoped that this will contribute to an ongoing debate about the failure of a number of breastfeeding support interventions in the UK to record meaningful increases in breastfeeding initiation or continuation (Hoddinott et al 2011).

Chapter thirteen

Issues emerging from evaluation findings of the context encountered on the postnatal ward

Introduction

This chapter discusses the issues emerging from the evaluation findings regarding the environment on the postnatal ward, considers these with reference to other research and examines their significance for future research and the wider context of improving care in the NHS. The context into which interventions are introduced is receiving an increasing amount of attention from UK researchers, particularly in light of the fact that nine consecutive UK randomised controlled trials testing breastfeeding support interventions have showed no positive results (Hoddinott et al 2011). Hoddinott et al argue that this failure has arisen because researchers neglect adequately to account for the social and historical milieu into which interventions are placed. The realist paradigm developed and deployed in this study has argued that, in order to produce favourable outcomes, the environment hosting an intervention may need to be manipulated, as well as or even instead of making changes to the intervention itself. Therefore, understanding and accounting for the situation encountered on the postnatal ward is a necessary precursor to developing strategies to modify the environment for the benefit of new mothers of all ages, as well as for staff. In the current study, resistance to the proposed intervention was observed to stem from a busy, frenetic environment over which staff exercised little control, and in which breastfeeding was seen as a peripheral activity. An individual, rather than team, orientation was seen to perpetuate the status quo and militate against change. In this chapter it is argued that, in order to enable support interventions to take root, midwives and MSWs must first take control of the time and space in which they work. An action learning approach, which encourages and enables staff to critique their own working environment and practices, and develop and action solutions, may provide a template for enabling staff to work together to exercise control over their working environment and implement changes to working practices at the core of established, resistant environments (Leggat et al 2011).

Lack of control of time and space – discussion and implications

The staff's experiences of pressure and busyness, which they attributed to short staffing, resonate with nursing and midwifery research going back to at least 1989 stating time and time again that inpatient care is provided in a fragmented fashion by time-pressed staff juggling competing demands in a highly pressured, chaotic environment (McGrath et al 1989, Deery 2005, Kirkham 2007, McLachlan et al 2008, Deery and Hunter 2010, Kessler and Griffin 2013). This situation has arguably worsened over recent years as changes within the NHS have resulted in nurses and midwives being expected to do more and more with fewer and fewer staff (Hughes et al 2002, Deery 2005). In midwifery, pressure on staff has been exacerbated by a rising birth rate and an increasing number of women with perceived complex social and physical needs (Hunter and Warren 2013, Kessler and Griffin 2013). Overstretched maternity services are a trend shared with other countries, and UK and Australian research has shown that it has had a particularly large impact on postnatal wards, as women are discharged home sooner and yet midwives are expected to provide them with increasing amounts of checks, instructions, advice and support before they leave (McLachlan et al 2008, McKellar et al 2009). Trying to incorporate the same or more routines and practices into less time has resulted in distressed, frustrated and exhausted midwives who are constantly racing against the clock, and a rushed, brusque and chaotic approach to care (Lindberg et al 2005, Dykes 2006, McLachlan et al 2008, McKellar et al 2009, Deery and Hunter 2010).

In the current study, the frenetic activity on the postnatal ward is seen to stem from midwives and MSWs having little control of their time, of the organisation of their space, or of access to their patients. This lack of control was evident in the constant interruptions to their work, and in the non-availability of commonly used drugs and equipment. Furthermore, time-consuming practices such as midwives following doctors on their rounds and MSWs acting as runners and facilitators of paediatric clinics continued unquestioned. The fact that midwives and MSWs were expected to leave their own work to undertake such activities, or to find equipment for their medical colleagues, clearly indicated that

medical activities were seen as more important than the relational aspects of midwifery care.

The midwives' lack of control was exacerbated by their being rotated to other areas, sometimes at very short notice. For example, following the training session carried out as part of this research a number of the participants were unexpectedly re-deployed, and other staff were rotated to a different ward half way through the implementation and evaluation process. Dykes (2006) noted in her ethnographic study of breastfeeding support on the postnatal ward that midwives were liable to be moved to cover staff shortages on labour ward at very short notice. These planned and ad hoc movements of midwives to different areas can be seen to contribute to an atmosphere of disarray and militate against midwives taking ownership of, and seeking to control their own time and space (Kirkham 2010).

Unless midwives and MSWs are able to exercise some control over their working environment, it is unlikely that midwifery support interventions will be able to take root. There is a large body of psychological research showing that a lack of control over working conditions leads to a stressed, demotivated workforce which, somewhat ironically, becomes resistant to change (Bandura and Locke 2003, Cooper 2012). The ways in which efforts to counteract and cope with the stress they were experiencing led staff to adopt working practices that further embedded a medical model of care and militated against change are discussed below.

Stress – discussion and implications

It has been observed that stress at work is generally the result of a combination of a high level of demand and little control over one's activities (Savery and Luks 2001, Hunter and Warren 2013). The lack of control that midwives and MSWs exercised over their working day in the current study was associated with high levels of stress among staff. Concern about the effects of stress in nursing dates back at least to the seminal study of Menzies in the 1960s

(Menzies 1960, McGrath et al 1989). This indicates that the stress observed during the current study is not unique to the ward observed.

Stress has been defined as the response of an organism to demands which exceed its coping resources (Matheny et al 2000, Birch 2001, Haslam and van Dick 2011). It has been found that coping with daily 'hassles', such as the constant interruptions witnessed during the practice observations in this study, is more strongly correlated with stress than facing major life events (Lazarus and Folkman 1987). Workload, low levels of autonomy and administrative and organisational factors have a corrosive effect over time – they have even been identified as the strongest predictors of stress in psychiatric nursing (McGrath et al 1989, Healy and McKay 2000, Dykes 2009). The persistence of low levels of staffing, the resulting organisational issues and changes, and a lack of staff support encountered in one UK ethnographic midwifery study led to such an outpouring of negative sentiment from the participants that the researchers felt overwhelmed and were unsure how to deal with the data (Hughes et al 2002).

It is increasingly recognised in nursing and in business that overloading a workforce decreases job satisfaction and causes stress levels that put peoples' mental and physical health at risk (Healy and McKay 2000, Matheny et al 2000, Haslam and van Dick 2011). Prolonged exposure to stress can lead to burnout, a syndrome particularly associated with human service professions such as nursing and teaching, characterised by exhaustion, a lack of motivation and accomplishment, and callousness towards service users (Haslam and van Dick 2011). Although callousness towards service users was rarely seen in the current study, there was clear evidence of exhaustion, low morale and lack of motivation, as witnessed by plans to leave midwifery, the fact that staff were seen in tears and resistance to the proposed changes.

Stress has been found to be more prevalent among employees who lack a sense of pride in, and a feeling of belonging to, the organisation that is the source of stress. For example, flight attendants working for low cost airlines report higher levels of work-related stress than their colleagues working for more prestigious carriers (Haslam and van Dick 2011). Thus the run of 'bad press' that the NHS

has received in recent times is likely to increase stress levels amongst its staff. In relation to breastfeeding support, the characterisation of midwives as the 'breastapo' in the popular media, together with letters of complaint which were brought up and discussed by staff in the current study, are likely to have added to the stress that staff were under.

It has been argued that midwives face the added stress of working with women and families at emotionally intense times (Hunter and Warren 2013). Furthermore, the fact that administration and other job requirements prevent their giving emotional support creates further stress, as midwives juggle the ideal of being 'with woman' with the requirement to be 'with institution' (Hunter 2004). This friction was evident in comments made in the current study, for example about not being able to put breastfeeding support training into practice.

Coping mechanisms – discussion and implications

Reductionism and task orientation

People exposed to stressful working environments tend to develop ways of limiting and coping with stress. In the current study, the coping mechanisms employed by staff underlined the central importance of control, as, lacking control of their own time and space, they sought to limit and control individual tasks and encounters. This resulted in a reductionist, task-orientated approach and individualistic outlook, as individuals attempted to limit their own workloads without reference to the effect on other members of the team. Reductionism and task-orientation are coping mechanisms widely observed amongst midwives (Hunter et al 2008, McLachlan et al 2008, McKellar et al 2009, Deery and Hunter 2010, Dykes 2006, 2009). The reduction of information-giving to a mechanical, formulaic exercise has been dubbed by Kirkham as the 'linguistic non-touch technique' (1989, p125). Similarly, the tactic of closing down encounters with an assurance of future help has been noted elsewhere (Dykes 2006). In the current study, midwives would invite women to 'call if you need help', when call bells were often not answered in a timely manner. In Dykes' study, midwives would tell the women they would come back and give them more help later, but rarely did so.

It has been observed that reductionism and task orientation enable midwives to exercise some control over their daily activities at the expense of overlooking the emotional and relational needs of women (Dykes 2006, Deery and Hunter 2010). Completing tasks brings a level of job satisfaction, albeit one that ignores the emotional elephant in the room (Dykes 2006). Relationships involve loss of control – especially of one’s time. There is a sense that midwives and MSWs feel they cannot afford this – they need to maintain a tight control of their schedule or chaos may ensue. This was particularly evident in the MSW’s description, quoted in chapter ten, of rising panic when helping a woman to breastfeed:

‘even when you’re standing with somebody trying to help, in your head you’re going ‘oh my God, I should be doing this, I should be doing this, I should be doing this, I should be doing this’

(Interview 8, MSW).

Implicit in this statement is also the assumption that other aspects of the MSW’s work were more important than breastfeeding support.

Task orientation also allows midwives and MSWs to disconnect themselves from their work by following routines and standard procedures which minimise responsibility and decision-making (Deery and Hunter 2010). A tendency to focus on individual workloads, and a reluctance to address and manage the bigger picture on the ward, was seen in the current study in the off-loading of work onto a junior colleague, and a failure to coordinate and organise work when managers were not present.

Task-orientation is further encouraged by a system that prioritises speed and efficiency; staff on the current ward certainly felt that it was a ‘fast process unit’. A management emphasis on getting women through the postnatal ward as quickly as possible has perhaps been a response to the rising birth rate in the UK. Hunter and Deery (2010) argue that a mentality of processing and dispatching women home is so deeply embedded in modern postnatal care that even if units were fully staffed, emotional aspects of care would still be neglected.

This view is challenged in the current study by the frustration expressed by some staff, and their declaring that they would willingly spend more time with women if time allowed. However, the time-consuming routines observed on the ward indicate a need for fundamental re-organisation before this could take place.

Task-orientation can also be seen to reflect and perpetuate a medical culture built around the observation and monitoring of physical symptoms (Foucault 2003). This was seen in the current study in the midwives' preoccupation with measuring urine output, and an MSW dealing with a baby that was reluctant to feed by measuring its blood sugar level and temperature. Foucault talks of the 'incessant disorder of comings and goings' (1980, p177) generated by a system that demands that patients are prodded, poked and endlessly observed and tested – a phenomenon that was in evidence in the frustration expressed by a woman who wanted to rest in the current study.

A desire to exercise control through measuring and treating can also be seen in the mistrust of lactation observed in the current study, which led to many new mothers giving supplementary formula milk feeds on the postnatal ward. Feminist thinkers such as Robbie Davis-Floyd have argued that within obstetrics women's bodies have come to be viewed as defective machines which cannot be trusted to produce and nurture babies unaided (Davis-Floyd 2001). While this argument is usually applied to intrapartum care, the findings of the current study indicate that this mistrust of women's bodies also exists in relation to breastfeeding.

Task-orientation therefore provides a way of coping which maintains the medical status quo rather than addressing the problems on the ward. It is one of three escape-avoidance coping strategies first identified by Menzies in 1960 as being employed by nursing staff to manage distressing situations with patients. The other two strategies are denial of emotions (which can be seen to be aided by an avoidance of the relational aspects of care) and resistance to change. Resistance to change was also a feature of the current study - it would appear from the current and other recent research that nurses and midwives have employed tactics developed to manage stressful caring situations in an attempt to

cope with organisational stress. However, although such tactics might enable staff to continue functioning in a challenging environment, they prevent the introduction of changes that might improve both working conditions and care for women.

Resistance to change

Resistance to change was apparent in the strategies employed by staff in the current study to prevent the intervention from being implemented, and has again been widely observed amongst nurses and midwives (McGrath et al 1989, Healy and McKay 2000, Birch 2001). The pressures and stresses identified by staff in this and other research indicate that they feel they are working at full capacity, and change is seen to generate additional work and stress which they simply do not have time to accommodate (Deery 2005, McKellar et al 2009). Additionally, task-orientation builds barriers against a reality that midwives feel powerless to change and by which they are in danger of being overwhelmed, so any change, even one that might be for the better, is potentially destabilising and therefore perceived as a threat (Kirkham 1999, Schoolfield and Orduna 2001). It has been suggested that hostility to change can itself become a coping strategy, providing a 'sense of security in a rapidly changing world' (Kirkham 1999, p 737). Somewhat ironically, it has been found that within the workplace people who are most stressed and disempowered by their current working conditions, such as the midwives and MSWs on the postnatal ward, are particularly resistant to change (Lindberg et al 2005). Focusing on tasks and maintaining the status quo, midwives are perhaps able to shut out the problems faced by their profession, the institution for which they work, and the women for whom they care.

Other researchers in the UK and Australia have also found that attempts to introduce changes in the community and on the postnatal ward were met with hostility and resistance (Deery 2005, McKellar et al 2009, Hoddinott et al 2010a). On occasion attempts to introduce changes have resulted in hostility being shown to researchers (Deery 2005). Deery interprets this reaction as displaced anger from frustrated and unsupported staff (Deery 2005). Although frustration was certainly evident during the current study, hostility towards the intervention appeared to be more about midwives and MSWs taking back a little of the power

and control they lacked in other aspects of their work, for example by removing any mention of the proposed young persons' bay from the ward bed board.

Reluctance to take control

Despite their frustration with the working conditions on the ward, midwives and MSWs were reluctant to take control of their working environment. This was seen during the ward observations when managers were not present and nominated coordinators did not take a leadership role. Furthermore, newly qualified midwives who did suggest changes (such as re-instituting the designated young persons' bay) were dissuaded from taking any action. This conformist and subservient behaviour, together with the task orientation, individualistic outlook and resistance to change already identified in this study, is a typical behaviour pattern of an oppressed group (Kirkham 1999, Hughes et al 2002, Deery 2005). Mavis Kirkham in particular has argued that midwives in the UK are oppressed, and that in England and Wales this oppression dates right back to the 1902 Midwives Act, which was overseen by doctors keen to claim ownership of childbirth. Thus the precepts of subservience and obedience were enshrined in the birth of modern midwifery, creating 'right' ways of being and doing and labelling alternative approaches as 'wrong' (Kirkham 1999, 2007). Midwives are accustomed to being dictated to, and although today they are increasingly controlled by managers rather than doctors, the culture of conformity and obedience remains (Kirkham 1999, Hughes et al 2002, Deery 2005). Psychological tests have found that, fearing repercussions and negative judgements from colleagues and managers, midwives tend to conform to direction from superiors and accepted group norms (Kirkham 2007, Hollins Martin and Bull 2008). A proclivity to obedience is strengthened by the ever-present stick of risk management – researchers have found that midwives (and their obstetric colleagues) fear that if they do not follow protocols to the letter, or document that they have done so, they will have no defence should legal action be brought against them (Kirkham 1999, 2010; Hughes et al 2002).

Implications for current understanding of ward dynamics

The busyness, stress, task orientation and resistance to change witnessed in the current study clearly resonate with the findings of other research. The findings of the current study add to this body of work by identifying the central role of a lack of control exerted by midwives and MSWs over their time and space in determining behaviour that privileges medical activity and does not support breastfeeding or a more relational approach to care. The ward staff's individualistic outlook and apparent reluctance to take control of the ward environment or assist others attempting to implement change is attributed to and seen to perpetuate an underlying oppression of midwives by a medical and managerial culture that focuses on the observation and control of bodily symptoms, evinces a deep mistrust of women's bodies and seeks to move women through the maternity service as quickly as possible.

The resonance of the current findings with other UK and Australian research suggests that the environment described in this project is not peculiar to the postnatal ward observed. In fact, the challenges encountered appear to be long-standing and deeply rooted in medical and midwifery history and culture, exacerbated by staff shortages and an escalating workload. If interventions are to be introduced successfully to improve the support given to young or indeed any mothers on the postnatal ward, the environment of the ward itself needs to be challenged and changed.

The power of the medical observational model within hospital environments has led others to call for postnatal care to be removed from hospitals completely and provided in homes and smaller, midwifery-run community units which function at the margins of medical power, where its hold is less strong and alternative outlooks can flourish (Wagner 2001, Dykes 2006, Walsh 2007, Kirkham 2010). While this idea is attractive, the mushrooming of birth centres in the UK in recent years has perhaps, by removing any pretence at 'normality' from the hospital ward, heightened the problems of the midwives and women left behind. There will probably always be women who need or choose to have postnatal care in hospital, and midwives who are tasked with caring for

them, so the prevailing hegemony of task-focused, routine-bound care needs to be challenged there, where it is at its strongest.

It has also been argued that challenging and changing the environment on hospital maternity wards will be impossible as many of the midwifery staff who work in medical environments are so acclimatised to their associated routines and procedures that they cannot see anything wrong with them. Wagner (2001), for example, compares hospital staff to fish who cannot see the water they swim in. The findings of the current study, however, suggest that postnatal midwives and MSWs are extremely frustrated with their current ways of working, and would like to be able to spend more time building relationships with the women in their care. However, the reluctance of midwives to take control or to initiate change witnessed in the current study does suggest that changing the environment on the postnatal ward will not be an easy task – especially since it involves challenging deeply embedded attitudes and practices.

More recently, the concept of resilience has been explored as a way of enabling midwives to cope with work stress (Hunter and Warren 2013). Proponents of resilience building suggest that midwives should be encouraged to use strategies such as maintaining work-life balance, developing emotional insight and nurturing social support networks in order to cope with stress at work (Jackson et al 2007, Hunter and Warren 2013). Like the escape-avoidance strategies in evidence in the current study however, resilience does not challenge and change the status quo or offer a way of improving care for women. Furthermore, a key element of resilience identified by Hunter and Warren (2013) was 'protective self-management'. The authors themselves ask whether this might include protecting the self at the expense of colleagues and women.

Towards an alternative approach

The findings of the current study indicate that challenging the current situation on the postnatal ward will best be achieved by midwives and MSWs taking control of their working environment. Empowering employees by giving them more control over their work has been shown to be both an effective way of

combating stress and a means of achieving lasting change (Savery and Luks 2001, Bandura and Locke 2003, Leggat et al 2011). Such participative management is not a new idea in the NHS, although policy documents struggle with how it might be implemented (Bate et al 2004). There is a growing recognition that organisations (like people) are not machines with predictable, controllable moving parts but complex webs of relationships (Stacey 2001, Sobo et al 2008). The parts are capable of transforming the machine just as much as the machine dictates the form and function of the parts.

Rather than maintaining their current individualistic coping strategies, taking control will involve midwives and MSWs working together towards a common goal. As Hunter and Deery (2005) note, withdrawal and distancing creates a silence in which there is little room for developing effective solutions. Conversely, a psychological experiment conducted by Haslam and Reicher in 2006 illustrated the way in which an oppressed group can successfully challenge the prevailing hegemony through a shared social identity and joint action (Haslam and van Dick 2011). In the experiment, participants were assigned to play the roles of prisoners or guards in a closed environment for eight days. At first the guards were firmly in control, as prisoners worked individually to gain favour with them and improve their lot. However, conditions were then manipulated in the environment so that the prisoners started to work together to challenge the guards' authority, and the guards' regime ultimately became unworkable (Haslam and van Dick 2011). This example is not intended to suggest that midwives should use militant and aggressive means to achieve change, but rather make the point that as a group they possess the power and authority to take control of and influence the environments in which they work.

It is suggested that midwives and MSWs need to recognise and claim their own power by working together to set their own agenda for postnatal care, for the benefit of themselves and new mothers. Rather than operating as individuals, midwives and MSWs need to form communities with shared goals and a clear agenda for change. A 'community' implies more than a collection of people who share the same space. It implies a commitment to building relationships and creating an environment in which agreed ideals are able to flourish. It is

increasingly acknowledged that the quality of relationships between maternity colleagues is fundamental to the quality of maternity care (Hunter et al 2008). The findings of this project relating to attempts to introduce a breastfeeding support intervention on a postnatal ward illustrate this vividly. Moreover, the evaluation findings suggest that midwives and MSWs are aware of the challenges on the postnatal ward and able to articulate a need for a more relational approach to care. The training sessions held in advance of introducing the intervention indicated that maternity staff are open to adapting their beliefs in response to evidence and discussion. This study was less successful, however, in getting people to implement the ideals agreed in training on the ward. An action learning approach, outlined below, might be better able to translate theoretical ideals into practice.

Action Learning

Action Learning is a semi-experimental approach to problem solving and change in which a group of employees follow a cycle of diagnosis – action – review – learning – action (Leggat et al 2011). Its focus on identifying and exploring an issue, and hypothesising, implementing and reviewing a change make it align well with a realist approach. Within the NHS, action learning is usually employed at management or consultant level and used to direct strategic change (Young et al 2010, Phillips and Byrne 2013). However, the process of bringing practitioners together to explore workplace issues and develop and implement solutions could equally well be used for frontline staff. Furthermore, action learning has been found to be an effective way of increasing employees' control over their work, exploring, challenging and changing beliefs, and facilitating and promoting peer support and group identity (Young et al 2010, Leggat et al 2011, Phillips and Byrne 2013). It thus appears to address the problems encountered in the current study.

Such an approach is a far cry from the current concentration in the NHS on producing ever more standards and guidelines that nurses and midwives are expected to follow, rather than attempting to heal the fractured communities that lie at the heart of substandard care. The recent Francis Report, for example, which was written in the wake of some appalling standards of care at one NHS

Trust, contains a plethora of standards but does nothing to nurture and protect the communities of professionals charged with carrying out the compassionate, relational care it mandates (Mid Staffordshire NHS Foundation Trust Public Inquiry 2013). Kirkham (1999, 2007) argues that the way people treat others mirrors the way they are treated themselves, therefore supportive relationships with colleagues are a prerequisite to supporting women. The events in Mid Staffs also gave rise to the 'Six Cs of nursing and midwifery' – proposed by the Chief Nursing Officer to encapsulate good care (DH 2012a). The six Cs are care, compassion, competence, communication, courage and commitment. Again, the supportive relationships with colleagues which are fundamental to creating an environment that facilitates compassionate, relational care are missing from this maxim. Community among professionals should perhaps be added as a seventh C.

Conclusion

Analysing the environment encountered on the postnatal ward has shown that high workload and stress are common features of hospital wards, and have resulted in an individualistic, task-oriented approach to care which overlooks emotional and relational aspects of nursing and midwifery and side-lines breastfeeding support. Attempts to manage stress have also resulted in a resistance to change. It has been shown that current ways of working have deep roots in medical and midwifery culture and history, and argued that the current hegemony, which sees women's bodies as defective machines, is also responsible for the mistrust of the process of lactation witnessed in the current study.

Using the realist evaluation framework, it has been possible to deduce that the mechanisms supporting the current medical approach to care on the postnatal ward worked against the implementation of an intervention designed to foster a more relational approach to breastfeeding support. Before any such intervention could succeed, it is likely that fundamental changes would need to be made to the ward environment and working practices.

This study has identified midwives' and MSWs' lack of control of their working time and space as a principal barrier to change. It has been proposed that an action learning approach, which fosters group action, would enable midwives and MSWs to form communities to challenge and change the prevailing culture on the ward, take control of their time and space, and develop and implement a more relational approach to care. If shown to be successful, empowering communities of midwives and MSWs through action learning could be used more widely to improve patient care within the NHS. Following the recent revelations in Mid Staffordshire, compassionate, relational care has become a focus for the health service as a whole. However, current proposals to remedy the situation (such as those enshrined in the Francis Report and Six C's) do not address the need to heal and empower broken communities of care providers.

The realist evaluation framework used to explore and address the support needs of breastfeeding young mothers in the current study has necessitated an engagement with the wider issues encountered on the postnatal ward. An exploration of these issues has dominated phase two of this study. The next chapter concludes this thesis by returning to the original study aims and asking whether they have been met.

Chapter fourteen

Conclusion. Re-envisioning the postnatal ward: the importance of 'knowing your place'

Introduction

The two phase of investigation carried out in this thesis aimed firstly to understand how teenage mothers' experiences in hospital prevent many of them from initiating breastfeeding, and ascertain support measures that might enable more young women to breastfeed. Then, in phase two, the aim was to use the information gathered in phase one to develop a support intervention to use with teenage mothers on the postnatal ward, test whether the intervention was practicable in a ward environment and identify good practice principles for teenage breastfeeding support that are transferable to other settings. This concluding chapter examines whether these aims have been met and identifies ways in which this thesis has added to existing knowledge in respect of teenagers and breastfeeding support. The four phases of the realist evaluation framework which has underpinned and directed this research are again used to provide a structure to this final summing up, which demonstrates the need for a closer alignment between the breastfeeding support needs of young mothers, the ideals and beliefs of ward staff as to what constitutes good care, and the culture and environment of the postnatal ward. Young mothers are unlikely to be able to initiate breastfeeding in hospital unless both the people caring for them and the place itself are able to meet their support needs.

What is happening now and why

We know that teenage mothers in the UK and other developed nations are less likely to breastfeed than older mothers. It is also widely believed that teenage mothers require additional, targeted breastfeeding support due to their unique developmental needs and the fact that many of them come from disadvantaged backgrounds where there is a dearth of breastfeeding knowledge and experience. Developmentally, teenage mothers straddle the worlds of childhood and adulthood. They yearn to be accepted, validated and empowered as adults, but, as rookies operating in a new and unfamiliar world, they feel uncomfortable and

exposed, and so need the nurturing, guidance and protection of childhood. The focus groups undertaken in this thesis added to existing knowledge firstly by ascertaining that teenage mothers choose to breastfeed to demonstrate their standing as good, adult mothers. Secondly, the focus group results demonstrated that breastfeeding set young women apart from the families and communities into which they sought to be integrated in their new status – thus preventing their completing the incorporation phase of the rite of passage into motherhood and increasing their vulnerability and need for professional support and a sense of belonging in the early postnatal period. The findings also added to a limited body of knowledge showing that young mothers feel disempowered by their birthing experiences and utterly exposed and alienated on the postnatal ward. The care they received there did not meet their needs, particularly in respect of the emotional and esteem support which has been identified as fundamental for young people. Coupled with a lack of proactive help, this resulted in many young mothers not being able to fulfil their breastfeeding intentions.

The e-questionnaire of health professionals conducted in phase one of this research indicated that the lack of appropriate breastfeeding support given to young mothers on the postnatal ward stemmed from the negativity of some maternity professionals towards young mothers (the attitudes of health professionals towards young mothers had hitherto been a poorly researched area), and short staffing and lack of time in the midwives' and MSWs' working day. These findings were reinforced in the later staff training session, during which MSWs revealed a nervousness about caring for young mothers based on a lack of knowledge about their behaviour and needs. Staff and timing issues were also encountered during the observations of practice and staff interviews. Furthermore, the observations of practice revealed that some staff were mistrustful of the process of lactation itself, and unconfident in their abilities to support any women to breastfeed. However, data gathered in the e-questionnaire and staff interviews revealed a widespread frustration with current practice. Participants also recognised that young women needed time, recognition and encouragement in an environment where breastfeeding was considered normal in order to be enabled to breastfeed.

What might happen if...

A breastfeeding support intervention was developed to address the issues ascertained during phase one of the research. It was hypothesised that young mothers would be better enabled to breastfeed if they were given proactive, structured support including reassurance and praise. This support was to be led by a group of midwives and MSWs who had attended a training day during which they were given an opportunity to consider and discuss the developmental needs of young mothers and the findings of the focus groups conducted in phase one. It was further hypothesised that teenage mothers would feel more comfortable on the ward, and therefore would be more likely to breastfeed, if they were placed in a designated area with other young mothers, and if known community support workers were made aware of the presence of young mothers on their caseload on the ward and invited to come and visit them. Additionally, breastfeeding knowledge and skill might be improved if breastfeeding young mothers were actively encouraged to attend a ward baby café.

What happened when...

The breastfeeding support package outlined above was introduced onto a postnatal ward in a large, UK hospital for a six-month period and a concurrent evaluation was carried out. The evaluation focussed on identifying elements in the ward environment that facilitated or militated against the success of the support package. The staff training and interviews conducted as part of the evaluation process showed that midwives and MSWs were open to their views about teenage mothers being challenged, and willing to adjust their beliefs and alter the care they gave in response to discussing the developmental needs of young mothers and the findings of phase one of this research. However, breastfeeding support was not regarded as a priority in the highly-charged, stressful environment of the postnatal ward itself, and staff were unable to implement the majority of the support intervention in practice. The different elements of the package succeeded or failed depending on the time they took to deliver, their perceived convenience, the extent to which they were dependent on individual control, and the extent to which they aligned with individuals' beliefs about good or appropriate care. Time and convenience, control and personal

beliefs appeared to have become yardsticks in a time pressured, chaotic workplace in which midwives and MSWs exercised little control over their working environment. The lack of control exercised by midwives in the current study over their time and space adds to current understanding of the stressful environment in which they work. Furthermore, the prevailing culture on the ward was underpinned by a medical focus on checks, tests and attempts to regulate and control bodily functions which was inimical both to the facilitation of breastfeeding and the provision of the relational support that is so important for young mothers. Relational support involves attending to emotional aspects of care such as nurturing and confidence building. These have no place in a medical environment where women's bodies are regarded as defective machines that need to be controlled and fixed. This medical focus was propagated and strengthened by midwives' and MSWs' attempts to cope with the stress they were under by submitting to the medical hegemony - adopting a reductionist, task-oriented approach to their work and becoming resistant to change. Although it has for some time been suggested that there may be factors in the UK health system that are uniquely hostile to breastfeeding support (Hoddinott et al 2011), and other researchers in Australia and the UK have encountered hostility when introducing breastfeeding support interventions on the postnatal ward and in the community (Deery 2005, McKellar 2009), this study has added to existing knowledge by identifying specific tactics adopted by midwives and MSWs on a postnatal ward to impede change, such as subversive and passive resistance. It has also exposed inherent difficulties to providing relational care in a medically-oriented environment.

Revised programme specification

Revisions were suggested to the support package in the light of the evaluation findings. These included extending the support package to all mothers but maintaining its focus on the needs young mothers, who are most disadvantaged by current provision; ensuring that documentation is both written in and referred to by everyone offering breastfeeding support, including MSWs, specialist and lay supporters; and offering proactive, specialist support at the bedside. Using the same structured, proactive approach for everyone is likely to

benefit all women as well as being more acceptable to staff. Shared documentation is likely to improve the consistency of support and increase the perceived control of women (if they are given access to it) and staff, as well as being more time-efficient and convenient (by improving communication and preventing duplication of work). Proactive support at the bedside, provided by a dedicated breastfeeding specialist, was an intervention proposed by both staff and young women as a way of ensuring time for relational breastfeeding support in an environment where this is not seen as a priority. These revisions, together with staff training addressing knowledge and attitudes, and the involvement of known community support workers, constitute good practice principles for providing breastfeeding support to young mothers and are transferable to other settings. However, it was acknowledged that they are unlikely to have a major impact unless fundamental changes are made to the culture of the postnatal ward itself. Rather than being a place in which mothers are monitored and checked, the postnatal ward needs to assist young mothers in particular to acquire the knowledge, skills and resources required to build an identity as a good mother. For many young women, breastfeeding is part of this process. The professionals and young mothers who participated in this research clearly indicated that such assistance necessitates a relational approach to care which nurtures and validates young women in their new roles, builds and strengthens the support available to her from friends and family, and promotes the peer interaction which is so necessary for this age group.

Considering the central importance of control (or a lack thereof) in determining actions in the findings of this research, it was argued that an environment able to support and sustain relational, midwifery support interventions will require midwives to take control of their working time and space. It was suggested that in order to do this midwives will have to relinquish their individualistic focus and build local communities of practitioners who can use shared goals to transform their environment. The findings of this research clearly show that midwives and MSWs are aware of the need for a more proactive, relational approach in respect of breastfeeding support but feel unable to provide this on the postnatal ward. An action learning approach, which provides groups of professionals with the time and space to work out what change is necessary in

their workplace and how this might best be achieved in practice, could provide a template for achieving lasting change. Creating communities of frontline staff to explore and address workplace issues marks a radical shift from the current NHS tactic of providing staff with ever more guidelines and protocols, checks and balances, when problems are identified. The constant imposition of change from above, over which frontline staff have no control, is known to increase stress and demotivate a workforce. This thesis has suggested that, instead, 'community' needs to be added as a seventh 'C' to the 'Six C's' underpinning good nursing care. If shown to be successful, the action learning approach may pave the way for a more participative approach to NHS improvements in general.

Knowing your place

This thesis has established that the gulf between the breastfeeding support needs of young mothers and their treatment and experiences on the postnatal ward prevents many of them from initiating breastfeeding. Moreover, the mechanisms working against breastfeeding support on the ward are deeply-rooted, therefore fundamental change is required to the ward environment before young mothers' support needs can be met. The realist evaluation framework followed in this research has underlined the central importance of place in the success of breastfeeding initiation and the provision of breastfeeding support. The places in which support is provided have increasingly been suspected of having a pivotal influence on outcomes following the failure of nine consecutive UK breastfeeding support trials (Hoddinott et al 2010a, 2011). In the current study, young mothers did not feel able to breastfeed because they did not 'know the place' of the postnatal ward – that is to say, they did not feel comfortable there, or understand how it worked. They also felt that their treatment on the ward reinforced their place as outsiders – people who didn't belong. Midwives and MSWs were not able to provide relational support because they were made to 'know their place' as less important than, and subservient to, the medical norm. Within this medical norm, breastfeeding itself occupied a low place, or importance. The breastfeeding support intervention developed in this research failed adequately to recognise and account for the disabling mechanisms in the place into which it was deployed.

The micro-environment of the postnatal ward therefore determines the behaviour both of the women who stay there and the staff who look after them. Its medical focus has far-reaching consequences for breastfeeding support, sapping the confidence of midwives and the women in their care in the process of lactation. If breastfeeding support interventions are to succeed on postnatal wards, those wards must become places that are conducive to supportive behaviours and believe in breastfeeding. Future research in this area needs to identify interventions that successfully challenge the medical culture endemic on postnatal wards. Midwives and MSWs must be enabled to create a place which supports the provision of the relational breastfeeding support which they recognise that new mothers need, particularly when they are young.

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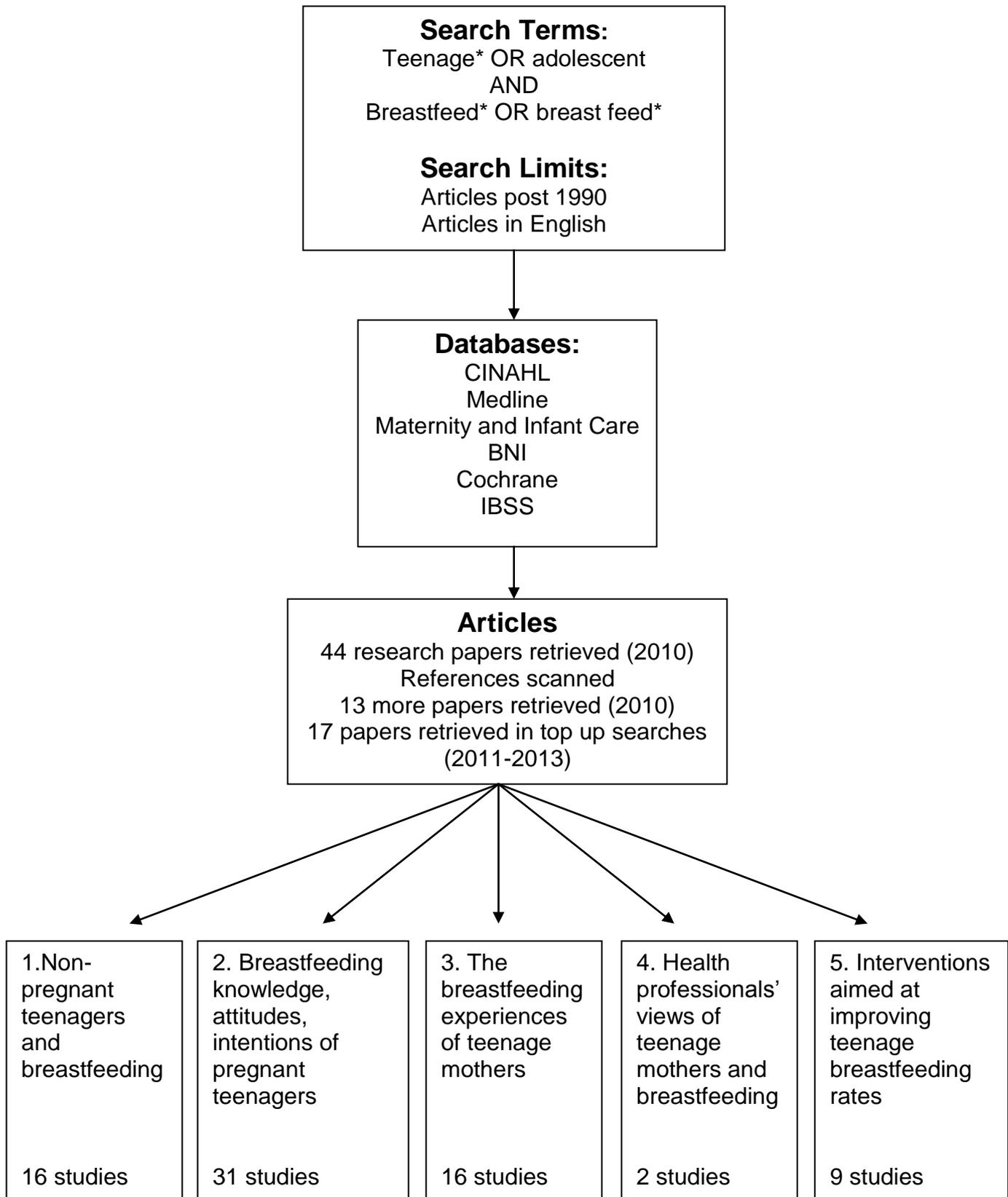
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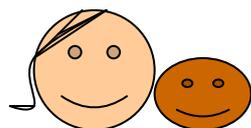
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Appendix 4.1 Search strategy Flowchart



Appendix 6.1 E-questionnaire covering letter



Supporting Teenage Mothers to Initiate Breastfeeding

A research project

Ethics number 09-H0606-114

Dear Health Professional,

Supporting Teenage Mothers to Initiate Breastfeeding is a research study aiming to develop and begin to test a support intervention to enable more young women to initiate breastfeeding. The intervention will be used in hospital.

In order to try and ensure that the intervention is acceptable to and addresses the needs of teenage mothers, we will be running focus groups with young mothers who attempted to breastfeed to establish what helped and what hindered their efforts to feed their babies in hospital.

We would also like to find out what health professionals who work with teenagers think the barriers to young mums initiating and establishing breastfeeding are, and how these can be overcome.

If you work with teenage mothers, either in hospital or in the community, we would love to hear your views – they will help ensure that the support intervention we develop is both appropriate and practical. You can either complete and return this survey by e-mail, or contact us for a phone interview if you would prefer.

Before you decide whether you wish to complete the questionnaire, please read the information below.

Who is organising the research?

The research is being organised by a Midwife as part of a PhD. It is being sponsored by the Oxford Radcliffe Hospitals Trust.

Who has reviewed the research?

This study has been reviewed and given a favourable opinion by Oxfordshire Research Ethics Committee C.

Will my taking part in this study be kept confidential?

In order to record the range of people who respond to this questionnaire, we have asked for a small amount of demographic information. However, we have not asked for your name or contact details, and your reply will be printed out and your e-mail deleted so that you cannot be identified from your e-mail address.

What will happen to the results of the study?

The information from the focus groups with teenage mothers and the survey responses from health professionals will be used to help design an intervention to support young mothers who wish to breastfeed after giving birth. Once the intervention has been designed it will be tested in a feasibility study, in order to establish whether it is usable in a hospital setting. A larger trial would have to be carried out before we knew for certain how well the intervention worked.

If you like more information before deciding whether to complete the survey, or would prefer to answer the questions over the phone, please contact the Chief Investigator, Louise Hunter, on 07775501989 or at louise.hunter@orh.nhs.uk.

If you have any reason to complain about your treatment during this study, please contact the Chief Investigator, and she will do her best to deal with your complaint. You can also contact the study supervisor, Chris McCourt, on 02082094287 or at chris.mccourt@tvu.ac.uk.

If you would like to receive a copy of the findings of this questionnaire, or of the research, please e-mail louise.hunter@orh.nhs.uk, and you will be sent the information when it becomes available.

Thank you for reading this information.

Appendix 6.2

Principles of ethical and effective user involvement

1	Roles of service users are clearly defined and agreed by all parties
2	Service users are made aware that they can choose whether to be involved and withdraw at any time.
3	Service users are reimbursed for direct and indirect costs, and provision is made for this in research budgets
4	Researchers recognise and respect the differing skills, knowledge and experience of users, and structure meetings to be inclusive.
5	Service users are offered training, personal support and advocacy where appropriate
6	Steps are taken to reach out proactively to marginalised groups, and to build the confidence and self-esteem of all participants
7	Researchers ensure they have the necessary skills to facilitate the above steps
8	Service users are involved in decisions about the recruitment of participants and the dissemination of information to potential participants
9	Service user involvement is described in research reports
10	Research findings are available to service users in formats they can easily understand

From Telford et al 2004 and Beresford 2007

Appendix 6.3. Focus Group Information Leaflet

We would like to publish the findings from the focus group in a professional journal so that other health professionals can read about them – we may quote parts of the focus group discussion directly in the report, but pseudonyms (false names) would be used so that no one taking part would be identified. We will also prepare a report of the focus groups and feasibility study for you if you would like one.

Who is organising the research?

The research is being organised by a Midwife as part of a PhD. It is being sponsored by the Oxford Radcliffe Hospitals NHS Trust.

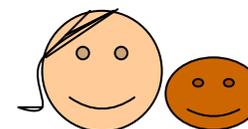
Who has reviewed the research?

All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given a favourable opinion by Oxfordshire Research Ethics Committee C.

Further information and contact details

Thank you for taking the time to read this information. If you would like to know more, or have any questions, please contact Louise Hunter, 07775501989.

N.B All leaflets are presented in print-ready format



Supporting Teenage Mothers to Initiate Breastfeeding

A research project

Ethics no 09-H0606-114.

An invitation to take part in a Focus Group

At a glance:

What?

‘Supporting Teenage Mothers to Initiate Breastfeeding’ is a research study looking at the sort of support young mothers would value to help them breastfeed in hospital. There are 2 parts to the study: a ‘design’ stage, which involves talking to young mothers and health professionals to find out what sort of support they believe young mothers need in hospital, and designing an intervention based upon their views; and a ‘feasibility’ stage, when the support intervention will be tried out to see if it works in practice. You are being asked to participate in the design phase, during which we will be talking to small groups of young mothers.

Why me? You have had a baby recently, and you intended to breastfeed (it does not matter whether you felt able to in the end)-your experiences and opinions would help us find out what sort of support young mothers want to help them breastfeed.

What would I have to do? Attend a discussion or ‘focus’ group with 5-8 other young mothers and tell us about trying to feed your baby in hospital.

Will I be paid?

No, but reasonable expenses will be covered.

How long will it take?

About 2 hours

You do not have to take part, but if you think you might be interested, please read on....

What if I am harmed or suffer as a result of taking part?

In the event that something does go wrong and you are harmed during the research due to someone else’s negligence, you may have grounds for a legal action for compensation against the Oxford Radcliffe Hospitals NHS Trust. You may, however, have to pay your legal costs. The normal National Health Service complaints procedure will still be available to you.

Will my taking part in this study be kept confidential?

Any information which is collected about you during the study will be kept strictly confidential. Your name and contact details will be kept separately from your answers to questions about your age and ethnicity. A pseudonym (false name) will be used when any contributions you make to the discussion are used in written reports. We will only keep your name and contact details and the tapes of the focus groups until the project is completed – they will be kept in a locked cabinet and destroyed securely when they are no longer needed.

What will happen to the results of the study?

The information from the focus groups will be used to help design an intervention to support young mothers who wish to breastfeed after giving birth. We will also be talking to Health Professionals to see what form they think the intervention should take. Once the intervention has been designed, and you have commented on it if you would like to do so, it will be tested in a feasibility study. This will involve trying the intervention out to see how well it works in a hospital setting and how it is received by patients. A larger trial would have to be carried out before we knew for certain how well the intervention worked.

Why have I been invited?

You have been invited because you have recently had a baby, and you have indicated that you intended to breastfeed. It does not matter whether you started or have carried on breastfeeding.

Do I have to take part?

No, it is up to you whether you decide to join the study. We will describe exactly what you will be expected to do. If you agree to take part, we will ask you to sign a consent form. However, you are free to change your mind at any time, without giving a reason. A decision not to take part will not affect your future care in any way.

What would I have to do?

You will be taking part in a discussion, or ‘focus’, group with 5-8 other young mums.

The group will be arranged on a day and time convenient for you, and will last about 2 hours.

When you arrive at the group, we will ask you a few questions about your age, ethnic group etc, so that we can record the types of people who took part.

When the session begins, one of the research team will lead a discussion about your experiences feeding your baby in hospital.

You do not have to answer all the questions if you don’t want to.

Any information that you choose to share during the discussion will be treated as confidential – the researchers will not identify you when they write about the discussion, and all the participants will be asked not to discuss confidences outside the group.

There will be another researcher at the group who will tape the discussion and make notes about what is happening. After the group, the researchers will write up a record of what was said,

and you will be invited to have a look at this and say whether you think it is a true reflection of what happened.

Once the support intervention has been designed, you will also have an opportunity to say whether you think it will work.

You are welcome to bring your baby to the focus group with you.

Would I be paid for taking part?

You would not be paid for taking part in this study. However, we will provide refreshments on the day and reimburse you for any travel and childcare costs. You will also receive a certificate of attendance.

Are there any benefits to taking part?

We do not anticipate that you will benefit directly from taking part, although sometimes people find it helpful to discuss their experiences. You would be helping us work out what kind of support would benefit future young mothers.

Are there any risks to taking part?

If you found any aspect of your care unpleasant or upsetting, you may find it distressing to discuss it (although you may also find it helpful). We very much hope that this is not the case, and that you will feel that the focus group provides a secure and comfortable environment in which to discuss your concerns. You are also welcome to contact the research team at any time to debrief or discuss your experiences further. You could also contact your Health Visitor or GP for help or advice.

What if there is a problem?

If you feel you have any reason to complain about the way you are treated while taking part in this study, please discuss your complaint with the research team, who will do their best to help you. If you would prefer, you can contact the research supervisor, Chris McCourt, on 0208 209 4287 or the Oxford Radcliffe Trust Research Department, on 01865 222692.

Will my taking part in the study be kept confidential?

Yes. We will not tell anyone about your involvement without your permission. There are strict ethical and legal requirements regarding communicating and storing information given by research participants, and we will make sure we follow them.

If the above information has interested you and you are considering taking part, the information below gives a little more detail about systems in place to protect you.

What will happen if I decide to take part and then change my mind?

You are free to leave the focus group at any time. Unless you ask us not to, we would probably text you to make sure you were OK, but then we would leave you alone. If you do leave before the discussion has finished, we would still like to use any contributions you made, but if you would rather we didn't, we would respect your wishes.

If you decide that you would like to take part in the focus group, but would not like to be invited to look at the report of the session or the support intervention, then that too is fine – you just need to let us know.

Introduction

We would like to invite you to take part in a research study to develop an intervention to support teenage mothers to breastfeed. You are being asked because you have had a baby recently, and your insights and experiences could help to ensure that young mothers who wish to breastfeed get appropriate support in hospital.

Before you decide whether to take part we would like you to understand why the research is being done and what it would involve for you. Your Midwife or a member of the research team will go through this information sheet with you and answer any questions you have. If you have any further questions, please feel free to text or call the researcher, Louise Hunter, at any time on 07775501989. Please also consider discussing the research with those close to you – your partner, parents or friends. We can give you extra copies of this information leaflet to give to them.

What is the purpose of the study?

We wish to talk to young mothers about their experiences feeding a new baby in hospital, to find out what they found helpful and not helpful, and to ask them what sort of support they think young mothers need in hospital in order to be able to breastfeed successfully. We will then use that information to design a support intervention which will be tried out on a group of new mothers. We know that many young mothers say that they want to breastfeed their babies, but give them formula milk soon after birth. We would like to be able to support them to breastfeed for longer, if this is what they want to do.

Appendix 6.4. Focus group consent form

Practice Development Midwives
 Level 5
 Women's Centre
 The John Radcliffe
 Headley Way
 Headington
 Oxford
 OX3 9DU

Supporting Young Mothers to Initiate Breastfeeding Focus Group Participant Consent Form

Study Number: 09-H0606-114

Chief Investigator: Louise Hunter RM

Please initial box

1. I confirm that I have read and understood the information leaflet dated 18/12/09, version 3, for the above study.
2. I confirm that I have had time to think about and discuss the information, ask questions and have had these answered satisfactorily.
3. I understand that my taking part is voluntary and that I am free to stop taking part at any time, without giving a reason and without my medical care or legal rights being affected.
4. I understand that the focus group will be tape recorded and consent to this.
5. I understand that data collected during the study may be looked at by responsible individuals from the research team, NHS Trust and ethical committee. I give permission for these individuals to access my study data.
6. I understand that parts of the focus group discussion may be quoted directly in any written reports of the study, but pseudonyms will be used to identify individuals. I consent to my words being used in this way.
7. I agree to take part in the above study.

 Name of participant

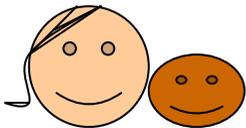
 Signature

 Date

 Name of person taking consent

 Signature

 Date



Supporting Teenage Mothers to Initiate Breastfeeding

A research project

This is to certify that

.....

attended a Focus Group on

.....

And contributed to a discussion on how best to support teenage mothers to breastfeed.

The ideas generated by the group will be used to help design a support intervention to help young mothers in the future.

.....

Chief Investigator

Version 2 21/10/09. Study number 09-H0606-114

Appendix 6.6 Focus group prompts

Ice breakers/warm ups

Can you each introduce yourselves and say the first word that comes into your head when you think about breastfeeding.

What are the good things about breastfeeding?

What are the negative/difficult things about breastfeeding?

If a nutty professor came and offered to develop a new way of feeding babies, what sort of ways would you suggest to him? What properties or outcomes would you like the new method to have? How would it differ from breastfeeding? How would it be the same?

First Moments – setting the scene

Thinking back to when your baby was born, how did you feel?

What happened?

What did you want to do?

Who was looking after you/ giving you advice?

What did they do/say?

How did you feel about looking after your baby?

First Feed

Can you describe what happened when your baby first fed?

Who else was there?

Did the baby latch on straight away?

What did it feel like?

Did anyone help?

Care on the postnatal ward

What was it like being on the postnatal ward?

How did you get on with feeding your baby there?

Did anyone help?

What were the good things about your care?

What aspects of your care on the ward were unsatisfactory?

Supporting young mums to breastfeed

How do you think Mums could best be helped to breastfeed in hospital?

When is the best time to give help?

What advice would you give a mother-to-be about breastfeeding her baby in hospital?

What advice would you give the midwives looking after young mums about helping them feed their babies?

Other influences

Who or what was the biggest influence on the decisions you made about your baby in the early days?

Who did you look to for help and advice?

Appendix 6.7. Support Intervention Cards

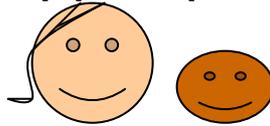
Wording on focus group card	Source
Giving you time (up to an hour) after birth to hold your baby 'skin to skin', so that baby can find his/her own way to the breast and breastfeeding can have as natural a start as possible. No one else would take or cuddle baby during this time.	UNICEF 10 steps E-questionnaire
Making sure you are offered help and guidance to start breastfeeding within an hour of giving birth.	UNICEF 10 steps
Encouraging you to cuddle your baby 'skin to skin' on the ward, so baby would be helped to feel calm and ready to feed.	UNICEF 10 steps
Someone coming along regularly to offer help and guidance with breastfeeding and to check that baby is feeding well.	UNICEF 10 steps Literature review E-questionnaire
Not offering any formula feeds to your baby unless medically necessary.	UNICEF 10 steps
Making sure you understand that dummies and pacifiers can interfere with breastfeeding and make it difficult for you to tell when your baby is hungry.	UNICEF 10 steps
Having access to a facebook type group via a laptop on the ward, where you could chat to other young Mums who had breastfed and hear their stories and advice.	Reflection/discussion E-questionnaire
Show you and the people close to you a DVD on breastfeeding while you're on the ward.	Reflection/discussion E-questionnaire
Making sure the people close to you (for example your Mum or partner) are included in the information and support you're given in hospital.	Literature review E-questionnaire

<p>Invite the people close to you, who are going to support you while you're breastfeeding, to attend a talk on breastfeeding immediately before visiting time.</p>	<p>Literature review E-questionnaire</p>
<p>Getting you to nominate one of your friends or family to be a 'breastfeeding buddy', who will give you extra support with breastfeeding. This person would be able to visit you outside visiting times to support you and learn about breastfeeding with you.</p>	<p>Literature review</p>
<p>Give you lots of praise and tell you what a good job you're doing.</p>	<p>Literature review</p>
<p>Keep reassuring you that it can take a little while to learn how to breastfeed, but it gets easier with time.</p>	<p>Literature review</p>
<p>Talk to you about what to expect, what sort of problems you might come up against and how to cope with them, and how to tell whether your baby is getting enough milk.</p>	<p>Literature review</p>
<p>Encourage you to talk to yourself in a positive way when things aren't going well – for example, taking a deep breath and telling yourself 'I can do this' (apparently this is what sportspeople do to improve their performance!)</p>	<p>Reflection/discussion Literature review</p>
<p>Sit with you while you're feeding your baby, chatting to you, answering your questions and checking that all is well.</p>	<p>Literature review</p>
<p>Making sure there is a named Health Professional (a Midwife or MSW) looking after you each shift (They should introduce themselves to you and respond when you press the buzzer for help).</p>	<p>E-questionnaire Literature review</p>
<p>The named Midwife/MSW could carry a mobile so that you or your friends/family could text questions or requests for help to them during their shift.</p>	<p>Reflection/discussion</p>

Appendix 6.7

Invite other Mums who have breastfed to come and offer you advice and support in hospital	E-questionnaire
Receiving texts from other young women who have breastfed, offering advice and encouragement	Reflection/discussion
Use teaching aids such as dolls and rubber boobs to show you exactly how to latch your baby on to the breast.	Reflection/discussion E-questionnaire
With your permission, physically help you to latch the baby on if you are having problems and so that you can see what to do.	Reflection/discussion
Create designated beds for young women, so that you can be with people of a similar age to you.	E-questionnaire
Talk to you and your partner, or whoever is going to help you look after the baby, about ways they can be involved and help care for the baby while you're breastfeeding.	Literature review E-questionnaire

Appendix 6.8. Focus group participant information sheet



**Supporting Teenage Mothers
to Initiate Breastfeeding**

A research project

Focus Group Participant Information Sheet

Study Number: 09-H0606-114

Chief Investigator: Louise Hunter RM

Thank you for coming along to the Focus Group today. Before we start, we would like to collect a small amount of information about you, so that we know a little about the people who took part. None of the information you give will be linked back to you personally or used to identify you.

1. When was your baby born (day/month/year)?

2. How old were you when you gave birth?years,months

3. How would you define your ethnic group?

White British	
Black British	
British Asian	
Other European (please specify)	
Mixed origins	
Black African	
Asian	
Chinese	
Other (please specify)	

4. For how long did you breastfeed your baby?

I tried once or twice	
1-2 days	
3-7 days	
8 days – 2 weeks	
15 days-1 month	
Over a month but I've stopped completely now	
I am still breastfeeding	

5. While you were breastfeeding, did you, or anyone acting on your behalf, offer your baby any formula milk?

Yes

No

6. If yes, can you tell us how often?

Once or twice	
More than once or twice, but not every day	
Once a day	
More than once a day	

7. Are you still at school, or are you planning to return to school or college next September?

Yes

No

8. If no, how old were you when you left school?

9. Do you have any GCSE qualifications at grade C or above?

0	
1-2	
3-4	
5 or more	

Appendix 10.1 Initial Feeding Checklist

Appendix 10.1

Initial Feeding Consultation

To be completed as soon as possible after arrival on the ward

Name:

Hospital Number:

Date and time	
Form completed by	
Date and time of birth	
Mode of birth	
Birth weight and gestation	
Skin to skin contact since birth	Yes No
If yes, for how long?	
Has baby fed since birth?	Yes No
If yes, when?	
If fed, breast or formula?	
If fed, for how long/ how much?	
Does the baby require a managed feeding plan (e.g. small for dates, pre-term, mother has diabetes)	Yes No
Based on the above, does the next feed need to be scheduled, or can baby-led feeding be advised?	Scheduled feed advised by (time): Baby-led feeding advised:
How would the mother like to feed her baby?	
What options have you discussed for the next feed?	
What plan have you agreed with the Mother? Initially, this must include showing her how to latch her baby on and observing a feed, if she feels ready to breastfeed. If she is not ready, or the baby requires a managed approach, she should be shown how to hand express	

Appendix 10.2 Feeding review checklist

Feeding Review Sheet

To be completed at each feed/review until Mother feeding confidently and no longer requires help

Name:
Hosp number:

Date/Time	What did you do? (e.g offer help, observe feed, teach hand expression, show how to use pump)	If you observed a feed, were you able complete an observation checklist? (This only needs to be done once)	What advice did you give the mother?	What plan have you agreed with the mother?	Name and signature

Date/Time	What did you do? (e.g observe feed, teach hand expression, show how to use pump)	If you observed a feed, were you able complete an observation checklist? (This only needs to be done once)	What advice did you give the mother?	What plan have you agreed with the mother?	Name and signature

Appendix 10.3. By discharge checklist**By Discharge Checklist**

All the following topics should be discussed with breastfeeding mothers before they go home

Name:

Hosp number:

	Comment, Date and Sign
Positioning and attachment taught	
At least one feed observed and Observation Checklist completed	
Hand expression taught	
Benefits of ongoing skin to skin contact discussed	
Baby-led feeding and feeding cues discussed	
Mother aware no other food or drink needed for 6 months	
Discussed fat gradient of feed and importance of finishing 1 st breast before offering 2 nd .	
Signs that breastfeeding going well discussed (see Observation Checklist)	
Common difficulties such as engorgement discussed, including ways of dealing with discomfort	
Room and bed-sharing discussed	
Breastfeeding support details given and explained	
Mother's community support worker informed of discharge	
Mother has phone numbers for community midwives and support workers	
'Off to Best Start' leaflet and OUH 'orange booklet' given and discussed	
Ongoing feeding plan agreed with mother and documented in care plan	
Mother given opportunity to ask questions and discuss other issues (Please document any issues raised)	
Mother signed consent to take part in evaluation & asked to complete evaluation form	
Please record method of feeding at discharge	Exclusive bf Exclusive EBM Mixed bf/EBM Mixed EBM/formula Mixed bf/formula Exclusive formula

Appendix 10.4. Pre-course questionnaire

A realistic evaluation of a service intervention to improve breastfeeding support for teenage mothers on the postnatal ward.Ethics no. 12/NW/0627**Staff Training pre-course questionnaire**

Thank you for attending today's session and for your interest in this project. Before we start, please could you answer the questions below. There will be another short questionnaire/evaluation at the end of the session. Both are anonymous, and will not be seen by anyone outside the research team. There are no right or wrong answers – we are interested in your honest opinions, and whether they change at all over the course of today. If you have any questions before completing the questionnaire, please don't hesitate to raise them with the session facilitator.

1. What is your role?

Midwife

MSW

Nursery Nurse

Other (please specify)

2. Approximately how many years have you worked for the NHS?

3. Please list the 1st 3 words or phrases that you think of in connection with teenage mothers:

4. Please list 3 words or phrases that, in your opinion, describe the attitude of teenage mothers towards breastfeeding:

Please indicate whether you agree or disagree with the following statements by circling the answer that corresponds most closely with your view:

5. Teenage mothers do not generally want to breastfeed.

Strongly
agree

Agree

Disagree

Strongly
disagree

6. Teenage mothers are not mature enough to persist with breastfeeding.

Strongly
agree

Agree

Disagree

Strongly
disagree

7. Teenage mothers can breastfeed successfully, given the right support.

Strongly
agree

Agree

Disagree

Strongly
disagree

8. How comfortable do you feel about supporting young mothers postnatally?

Very
comfortable

Comfortable

A little
uncomfortable

Very
uncomfortable

9. How confident do you feel about supporting young mothers to breastfeed?

Very
confident

Confident

A little
unsure

Very
unsure

10. Please tell us what (if any) information and support you feel you need in order better to support young mothers to breastfeed.

Appendix 10.5. Post-course questionnaire

A realistic evaluation of a service intervention to improve breastfeeding support for teenage mothers on the postnatal ward.

Ethics no. 12/NW/0627

Staff Training post-course questionnaire

We hope you have enjoyed today's session. Thank you for your time and attention. Please take a few moments to answer the questions below.

1. What is your role?

Midwife MSW Nursery Nurse Other (please specify)

2. Approximately how many years have you worked for the NHS?

3. Has this session changed the way you think about young mothers? If so, how?

4. What, in your opinion, are the key components of breastfeeding support for young mothers?

5. How comfortable do you feel now about supporting young mothers postnatally?

Very comfortable

Comfortable

A little uncomfortable

Very uncomfortable

6. How confident do you feel now about supporting young mothers to breastfeed?

Very confident

Confident

A little unsure

Very unsure

7. Which aspects of this session did you find useful/interesting?

8. Which aspects did you find unhelpful/uninteresting?

9. Do you think this session would help other health professionals develop a more positive attitude towards teenage mothers wanting to breastfeed?

10. If not, what would you have done differently today?

A realistic evaluation of a service intervention to improve breastfeeding support for teenage mothers on the postnatal ward.

Ethics no. 12/NW/0627

Interview Topic Guide

What were your initial thoughts and views about the educational and support package?

Have these changed now that you have used the package in practice?

Discuss the positive/negative aspects of each of the different components:

Training

Checklist

Accessing Baby Café

Informing support workers

Warding young mothers together

How do you think any negative aspects could be overcome/addressed?

Have you adapted the package at all?

Are there any components that you have not delivered, or have found it very difficult to deliver? Why?

Has it changed the way you practice?

Do you think it has improved the care young mothers receive?

If so, how?

What do you think are the most important components of the intervention?

What would you change/do differently? Why?

Do you think the education and support package could be used in other hospitals? Why?

Is there anything else you would like to say?

A realistic evaluation of a service intervention to improve breastfeeding support for teenage mothers on the postnatal ward.

Evaluation Form

Thank you for completing this evaluation form, which asks for your views about the support you were given to feed and care for your baby while in hospital. Your views and experiences will help us improve the care we give to young mothers.

1. Before you gave birth, how did you intend to feed your baby?

Breastfeed	
Give expressed breast milk	
Bottle feed	
Mix of breast and bottle	

2. How are/were you feeding your baby on leaving hospital?

Breastfeeding only	
Breastfeeding and expressing	
Expressing only	
Breastfeeding/expressing and formula feeding	
Formula (bottle) feeding only	

3. How long did you spend in hospital after giving birth?

4-6 hours	
One day	
One day and one night	
Two days and one night	
Two days and two nights	
Longer (please specify)	

4. Which hospital ward were you on?

Level 5	
The Spires (Birth Centre)	

5. When you arrived on the ward, did someone ask you whether you wanted to breastfeed or bottle feed your baby?

Yes	
No	
Can't remember	

6. If you wanted to breastfeed, how often were you offered help with this on the ward? **(If you wanted to bottle feed only, please go straight to question 11)**

Never	
Once or twice	
Frequently	
Too often	
Only when I asked	

If you would like to make a comment about the number of times you were offered help with breastfeeding, please do so in the box below.

7. Which of the following words would you use to describe the help you were given to breastfeed (please tick all that apply, and add any words of your own in the blank boxes):

Excellent	
Unhelpful	
Quite helpful	
Confusing	
Rushed	
Friendly	
Unfriendly	
Clear	

8. What was the most helpful thing that was said or done to help you breastfeed?

9. What were the worst things about learning to breastfeed on the ward?

10. How could we improve the support we give to young mothers wanting to breastfeed?

11. If you wanted to bottle feed, or to mix breast and bottle feeding, did anyone show you how to make up a bottle while you were on the ward?

Yes	
No	
Not applicable	

12. Did you talk to any other new Mums while you were on the ward?

Yes	
No	

13. If you answered 'yes' above, did you find this helpful?

Yes	
No	

If you would like to make any other comments about how you interacted with the other women on your ward, please do so in the box below.

--

14. As you leave/left hospital, how confident do/did you feel about feeding your baby?

0 1 2 3 4 5 6 7 8 9 10

Not at all
confident

Quite
confident

Very
confident

15. We are trying to make bay 10 on level 5 more welcoming and comfortable for young mothers. If you stayed in this bay, can you tell us what you liked about it and what could be changed or added to make it a nicer place to stay?

16. If you would like to give us any more feedback about your hospital stay, please do so in the box below.

Thank you again for completing this evaluation. Please put it in the envelope provided and return it to your midwife, or post it back to us using the pre-paid envelope.

This evaluation is anonymous. Your answers and comments will be collated and cannot be traced back to you.

Appendix 10.8. Staff information leaflet

A realistic evaluation of a service intervention to improve breastfeeding support for teenage mothers on the postnatal ward.

Ethics no 12/NW/0627

An information leaflet and invitation to take part for health professionals

1. Introduction

We would like to invite you to take part in a research study to evaluate an education and support package designed to increase breastfeeding rates among teenage mothers on the postnatal ward. You are being asked because you work on Level 5 or The Spires and are involved in caring for young mothers. Your insights and experiences could help to ensure that young mothers who wish to breastfeed get appropriate support in hospital.

Before you decide whether to take part we would like you to understand why the research is being done and what it would involve for you. If after reading this leaflet you have any further questions, please feel free to e-mail or call the researcher, Louise Hunter, at any time at louise.hunter@uwl.ac.uk or on 07775501989.

2. What is the purpose of the study?

We want to evaluate a breastfeeding education and support package to establish whether it changes the attitudes of health professionals towards breastfeeding young mothers, whether it is workable in a busy ward environment, if it is acceptable to those delivering and receiving care, and whether it enables more young mothers to continue breastfeeding on and after discharge from the postnatal ward. We will then use that information to modify and improve the package. We know that many young mothers say that they want to breastfeed their babies, but give them formula milk soon after birth. We would like to be able to support them to breastfeed for longer, if this is what they want to do.

13. Who is organising the research?

The research is being organised by a Midwife as part of a PhD. It is being sponsored by the Oxford University Hospitals NHS Trust.

14. Who has reviewed the research?

All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given a favourable opinion by the Oxfordshire Research Ethics Committee.

15. Further information and contact details

Thank you for taking the time to read this information. If you would like to know more, or have any questions, please contact Louise Hunter, 07775501989 or louise.hunter@uwl.ac.uk.

4. Do I have to take part?

No, it is up to you whether you decide to join the study. We will describe exactly what you will be expected to do. If you agree to take part, you are free to change your mind at any time, without giving a reason. A decision not to take part will not affect your work in any way.

5. Would I be paid for taking part?

No, this study will take place during your normal working hours and you will not be paid any extra for taking part.

6. Are there any benefits to taking part?

We do not anticipate that you will benefit directly from taking part, although it is an opportunity to shape future care.

7. Are there any risks to taking part?

We do not anticipate that there are any risks to your taking part. If you feel upset or uncomfortable, or wish to raise any concerns about the study, you are welcome to discuss these with the research team or with your manager or supervisor.

8. What if I am harmed or suffer as a result of taking part?

In the event that something does go wrong and you are harmed during the research due to someone else's negligence, you may have grounds for a legal action for compensation against the Oxford University Hospitals NHS Trust. You may, however, have to pay your legal costs. The normal National Health Service complaints procedure will still be available to you.

9. Will my taking part in this study be kept confidential?

Any information which is collected about you during the study will be kept strictly confidential. A pseudonym (false name) will be used in any field notes collected during observations and when any contributions you make are used in written reports. We will not record your name on any interview tapes, and will only keep the tapes until the project is completed – they will be kept in a locked cabinet and destroyed securely when they are no longer needed. Other data from the study (which will not identify you) will be kept in a locked cabinet for 5 years before being shredded.

10. What will happen if I decide to take part and then change my mind?

You are free to withdraw from the study at any time. If you do choose to opt out, any identifiable material that you have contributed will be removed from the evaluation data.

11. What if there is a problem?

If you feel you have any reason to complain about the way you are treated while taking part in this study, please discuss your complaint with the research team, who will do their best to help you. If you would prefer, you can contact the research supervisor, Julia Magill-Cuerden, on 020 8209 4117.

12. What will happen to the results of the study?

The information from the evaluation will be used to modify the education and support package, to increase the likelihood of it being effective if implemented on a larger scale. We will also be collecting feedback from young mothers.

We would like to publish the findings from the evaluation in a professional journal so that other health professionals can read about them – we may use quotations from interviews in the report, but pseudonyms (false names) would be used so that no one taking part would be identified. We will also prepare a report of the evaluation for distribution within the Trust.

3. What would I have to do?

There are a number of different sections to this study, and it is up to you which ones you choose to participate in:

There will be a ½ day training session to explore the breastfeeding support needs of young mothers, revisit UNICEF guidance around breastfeeding support and introduce the elements of the education and support package. You will be asked to complete an anonymous questionnaire at the beginning and end of this session.

While the education and support package is being used on the ward, the researcher will observe practice during 3 separate shifts. You will be asked to sign a consent form before being observed. If you are observed, you should reassure the young women to whom you provide care that it is you, and not them, that is being watched.

During the 6 month trial period, a reflective diary will be kept in a locked drawer on the ward. You will be invited to access this diary to record your views and experiences implementing the education and support package.

You will be invited to take part in an hour long interview to discuss the implementation of the education and support package. This interview will be recorded, and you will be asked to sign a consent form before taking part.

Appendix 10.9. Staff observation consent form

Teenage Breastfeeding Research Project
 Level 5
 Women's Centre
 The John Radcliffe
 Headley Way
 Headington
 Oxford
 OX3 9DU

Tel: 0777 5501989

**A realistic evaluation of a service intervention to improve breastfeeding support for teenage mothers on the postnatal ward.
 Evaluation Participant Consent Form (Staff observations)**

Study Number: 12/NW/0627Chief Investigator: Louise Hunter RM

Please initial box

1. I confirm that I have read and understood the information leaflet dated 16/08/12 version 5 for the above study.
2. I confirm that I have had time to think about and discuss the information, ask questions and have had these answered satisfactorily.
3. I understand that my taking part is voluntary and that I am free to stop taking part at any time, without giving a reason and without my legal rights being affected.
4. I understand that my practice may be observed by responsible individuals from the research team. I give permission for these individuals to observe me at work.
5. I understand that anything I say while being observed may be quoted in any written reports of the study, but pseudonyms will be used to identify individuals. I consent to my words being used in this way.
6. I understand that the comments I write in training session questionnaires and in a communal reflective diary may be quoted directly in any written reports of the study, but pseudonyms will be used to identify individuals. I consent to my words being used in this way.
7. I agree to take part in the above study.

Name of participant_____
Signature_____
Date_____
Name of consent taker_____
Signature_____
Date

Appendix 10.10. Staff interview consent form



**Teenage Breastfeeding Research Project
Level 5
Women's Centre
The John Radcliffe**
Headley Way
Headington
Oxford
OX3 9DU

Tel: 0777 5501989

**A realistic evaluation of a service intervention to improve breastfeeding support for teenage mothers on the postnatal ward.
Evaluation Participant Consent Form (Staff interviews)**

Study Number: 12/NW/0627

Chief Investigator: Louise Hunter RM
box

Please initial

7. I confirm that I have read and understood the information leaflet dated 16/08/12 version 5 for the above study.

8. I confirm that I have had time to think about and discuss the information, ask questions and have had these answered satisfactorily.

9. I understand that my taking part is voluntary and that I am free to stop taking part at any time, without giving a reason and without my legal rights being affected.

10. I understand that the interview will be recorded, and that the recording will be transcribed, and I consent to this.

11. I understand that data collected during the study, may be looked at by individuals from the research team, from the regulatory authority or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals for these individuals to have access this information.

12. I understand that parts of the interview may be quoted directly in any written reports of the study, but pseudonyms will be used to identify individuals. I consent to my words being used in this way.

7. I agree to take part in the above study.

Name of participant

Signature

Date

Name of person taking consent

Signature

Date

A realistic evaluation of a service intervention to improve breastfeeding support for teenage mothers on the postnatal ward.

Information for young women

Ethics no 12/NW/0627

This leaflet contains information about the evaluation of an education and support package for teenage mothers wanting to breastfeed.

At a glance:

What is the study about?

'Supporting Teenage Mothers to Initiate Breastfeeding' is a research study looking at the sort of support young mothers would value to help them breastfeed in hospital. Young mothers and health professionals have told us about the sorts of support they think would help, and we have used their suggestions to create a new care package for young mothers. This should mean that, when you come to hospital to have your baby, you will be given all the help you need after giving birth to get breastfeeding off to a good start (if that is what you want to do). We are now evaluating the support we are giving, to see if it is working well. You are being asked to be a part of this evaluation.

Why me?

You will be giving birth soon, and are thinking about breastfeeding your baby. Your experiences and opinions will help us find out whether the care we are giving is effective.

What would I have to do?

If you give birth in hospital and spend any time after birth on The Spires Birth Centre or on Level 5, you will be invited to fill out an evaluation form at the end of your stay.

What else is happening?

The staff looking after you will offer you help and support with breastfeeding, and will make a note of the support you receive on a care plan (this will be kept by your bed, so you can have a look at it). During your stay, we may watch them providing care. After you have left, we will look at your care plans. We will also look at your notes to see how you were feeding your baby after 10 days and after 6 weeks.

You are welcome to contact Louise Hunter and request a copy of the findings.

13. Who is organising the research?

The research is being organised by a Midwife as part of a PhD. It is being sponsored by the Oxford University Hospitals NHS Trust.

14. Who has reviewed the research?

All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given a favourable opinion by the Oxfordshire Research Ethics Committee.

15. Further information and contact details

Thank you for taking the time to read this information. If you would like to know more, or have any questions, please contact Louise Hunter, 07775501989 or louise.hunter@uwl.ac.uk

3. What would I have to do?

Towards the end of your stay in hospital after giving birth, you will be given an evaluation form, which will ask your opinion on the care you have received. You can choose whether to fill the form in straight away, and hand it back to your midwife in a sealed envelope; or to fill it in at home and send it back in a stamped, addressed envelope which we will give you. The evaluation forms are anonymous – we will not know who has filled them in. You do not have to return the form at all – we will not chase you for it.

At the end of your postnatal stay, you will be invited to join a secure Facebook group. This will enable you to post further feedback about your hospital stay, or let us know how you got on after leaving hospital. Again, you do not have to participate in this part of the study if you don't want to. If you don't have a Facebook account or access to a computer, you are welcome to send any further comments to Louise Hunter by e-mail or text (contact details at the end of this leaflet)

We would like to look at the care plans that were filled in during your stay, access your maternity notes to find out how you were feeding your baby 10 days after giving birth, and contact your health visitor to find out how you were feeding your baby at 6 weeks.

While you are in hospital, a researcher may watch the midwife or maternity support worker who is looking after you, to observe the care they are providing. If this happens, it is the health professional, and not you, who is being studied.

4. Do I have to take part?

No, it is up to you whether you decide to take part in the study. We will describe exactly what you will be expected to do. If you

agree to take part, we will ask you to sign a consent form to allow us to access your records. However, you are free to change your mind at any time, without giving a reason. A decision not to take part will not affect your future care in any way.

5. Would I be paid for taking part?

You would not be paid for taking part in this study.

6. Are there any benefits to taking part?

We do not anticipate that you will benefit directly from taking part, although sometimes people find it helpful to discuss their experiences. You would be helping us work out what kind of support would benefit future young mothers.

7. Are there any risks to taking part?

We do not anticipate that taking part in this study will place you at any risk or distress you in any way. However, you are welcome to contact the research team at any time to discuss your experiences. You could also contact your Health Visitor or GP for help or advice.

8. Will my taking part in this study be kept confidential?

Any information which is collected about you during the study will be kept strictly confidential. Also, only data that is strictly relevant to the evaluation will be retrieved from your records. Once retrieved, any data will not be identifiable to you. Once we have retrieved all the information we need, your name and identifying details will be shredded and disposed of as confidential waste. A pseudonym (false name) will be used when any contributions you make are used in written reports. Data from the study (which will not identify you) will be kept in a locked cabinet for 5 years before being shredded.

9. What will happen if I decide to take part and then change my mind?

You are free to opt out of the evaluation process at any time, simply by not returning your evaluation form or not posting on the facebook page. If you give us permission to look at your care plans and access your notes but then change your mind, we will respect your wishes and remove any data that was identifiably yours from the study.

10. What if there is a problem?

If you feel you have any reason to complain about the way you are treated while taking part in this study, please discuss your complaint with the research team, who will do their best to help you. If you would prefer, you can contact the research supervisor, Julia Magill-Cuerden, on 020 8209 4117.

11. What if I am harmed or suffer as a result of taking part?

In the event that something does go wrong and you are harmed during the research due to someone else's negligence, you may have grounds for a legal action for compensation against the Oxford Radcliffe Hospitals NHS Trust. You may, however, have to pay your legal costs. The normal National Health Service complaints procedure will still be available to you.

12. What will happen to the results of the study?

The information from the evaluation will be used to modify the education and support package, to increase the likelihood of it being effective if implemented on a larger scale. We will also be collecting feedback from health professionals.

We would like to publish the findings from the evaluation in a professional journal so that other health professionals can read about them – we may use quotations from interviews in the report, but pseudonyms (false names) would be used so that no one taking part would be identified. We will also prepare a report of the evaluation for distribution within the Trust.

1. Introduction

We would like to invite you to take part in a research study to evaluate a care package to support teenage mothers to breastfeed. You are being asked because you will be giving birth soon, and your insights and experiences could help to ensure that young mothers who wish to breastfeed get appropriate support in hospital.

Before you decide whether to take part we would like you to understand why the research is being done and what it would involve for you. Your support worker, midwife or a member of the research team will go through this information sheet with you and answer any questions you have. If you have any further questions, please feel free to text or call the researcher, Louise Hunter, at any time on 07775501989, or e-mail her at louise.hunter@uwl.ac.uk. Please also consider discussing the research with those close to you – your partner, parents or friends. We can give you extra copies of this information leaflet to give to them.

2. What is the purpose of the study?

We know that many young mothers say that they want to breastfeed their babies, but give them formula milk soon after birth. After talking to young mothers and health professionals, we have developed a support package to help young mothers to breastfeed for longer, if this is what they want to do. We are now evaluating the support package to see whether or not it is effective, and whether it can be improved.

Appendix 10.12. Evaluation consent form – young mothers



Teenage Breastfeeding Research Project
 Level 5
 Women's Centre
 The John Radcliffe
 Headley Way
 Headington
 Oxford
 OX3 9DU

Tel: 0777 5501989

**A realistic evaluation of a service intervention to improve breastfeeding support for teenage mothers on the postnatal ward.
 Participant Consent Form**

Study Number: 12/NW/0627

Chief Investigator: Louise Hunter RM

Please initial box

13. I confirm that I have read and understood the information leaflet dated 16/08/12 version 5 for the above study.
14. I confirm that I have had time to think about and discuss the information, ask questions and have had these answered satisfactorily.
15. I understand that my taking part is voluntary and that I am free to stop taking part at any time, without giving a reason and without my medical care or legal rights being affected.
16. I understand that relevant sections of my medical notes and data collected during the study, may be looked at by individuals from the research team, from the regulatory authority or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals for these individuals to have access to my records.
17. I understand that data about the way I am feeding my baby at 10 days and 6 weeks will be retrieved from my records and that my health visitor may be contacted in respect of this. I consent to this information being accessed in this way.
18. I understand that the comments I write on an evaluation form may be quoted directly in any written reports of the study, but pseudonyms will be used to identify individuals. I consent to my words being used in this way.
7. I agree to take part in the above study.

 Name of participant Signature Date

 Name of person taking consent Signature Date

