

‘But is it a normal thing?’ Teenage mothers’ experiences of breastfeeding promotion and support.

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Abstract

Background

Exclusive breastfeeding is recommended for the first six months of life. In the United Kingdom breastfeeding incidence falls far short of this recommendation, with teenage mothers least likely to initiate or continue breastfeeding. There has been little research on young mothers’ experiences of breastfeeding promotion and support.

Methods

A social marketing approach was taken to explore teenage mothers’ experiences of breastfeeding promotion and support. Participants were pregnant and teenage mothers who were less than 18 years old when they conceived their first child (n = 29). In-depth semi-structured interviews and focus groups were conducted between March and July 2009.

Results

Teenage mothers experience an array of conflicting norms which influence their infant feeding choices and behaviours. Breastfeeding is presented by health professionals as incontrovertibly the best choice of feeding method, but teenage mothers encounter many obstacles in initiating and continuing breastfeeding.

Conclusions

The social barriers to continuing breastfeeding are insufficiently recognised and addressed by health professionals. It is likely that teenage mothers would breastfeed for longer if they perceived that breastfeeding was a normal way to feed baby in their social milieu.

Introduction

Breastfeeding rates in the United Kingdom are among the lowest in Europe despite evidence that increased breastfeeding has the potential to improve child and maternal health in both the short and long term^{1,2}. Encouraging breastfeeding is a key part of the Healthy Child Programme³, which recommends exclusive breastfeeding for around six months. It is recognised that the benefits of breastfeeding to mother and baby increase with longer duration of feeding, and the UK Department of Health recommends continuing breastfeeding beyond the first year of life⁴ while the World Health recommends breastfeeding beyond two years⁵. However, these recommendations do not automatically translate into optimum feeding behaviour. The 2005 Infant Feeding Survey showed that only 25% of UK mothers breastfeed their baby at six months of age, and less than 1% of mothers exclusively breastfeed at this age¹.

Mothers aged under 20 years are least likely to initiate and continue breastfeeding, and only 7% of UK mothers aged under 20 years breastfeed to six months¹. This represents a major health inequality for teenage mothers and their children, additional to the existing risks of social exclusion and deprivation⁶. Inequalities in breastfeeding have been the subject of health professional and governmental concern, leading to policy measures directed at raising breastfeeding rates among disadvantaged groups such as teenage mothers^{7,8}. Recent research has focused on young mothers' experiences of breastfeeding⁹ and the reasons why teenagers choose to breast or bottle feed^{10,11}. Studies have found that young mothers are often well informed about the health benefits of breastfeeding^{10,12} but other factors, such as dominant social norms and embarrassment about feeding in public, are influential in leading teenage mothers' to formula feed¹¹. Few mothers aged under 20 years breastfeed outside the home¹.

Although teenage mothers are recognised as a priority group for the promotion of breastfeeding³, there has been less research into their experiences of breastfeeding promotion and support. Lindenberger and Bryant used a social marketing model to explore the views of low-income women in the United States, and found that women considered that potential costs to themselves, such as pain, embarrassment and anxiety

about producing enough milk, often outweighed the health benefits of breastfeeding¹³. This study uses a social marketing approach to explore pregnant teenagers and teenage mothers' experiences of breastfeeding promotion and support. Social marketing focuses on the influence of socio-cultural forces on health behaviours and seeks to understand the issue from the perspective of the target audience, looking at the tangible benefits for the person from whom the behaviour change is sought¹⁴. This formative research can provide the basis from which to derive a targeted pilot intervention and subsequent health promotion programme^{15, 16}.

Methods

Participants and recruitment

Participants were recruited from organisations and groups specifically for young parents, such as children's centres, housing units, and a school. Snowball sampling was then used to identify and recruit further eligible participants, and some door-to-door recruitment was carried out in areas with high rates of teenage pregnancy. Included in the study were pregnant teenagers aged 18 years or younger, and teenage mothers whose baby was aged two years or younger. Data collection took place between March and July 2009.

Interview and focus group procedure

Following consultation with key stakeholders (such as specialist teenage pregnancy midwives and two teenage mothers), a topic guide was developed for use at both interviews and focus groups. Visual prompts were used to promote discussion, including pictures of young mothers feeding. Focus groups were carried out with friendship groups; two of these included pregnant teenagers as well as teenage mothers, but one was solely composed of pregnant teenagers. Semi-structured interviews were carried out with participants who were not part of a pre-existing friendship group or who preferred to be interviewed individually.

Ethics

Ethical approval was obtained from the relevant University of the West of England faculty ethics committee. Written consent was obtained before all interviews and focus

groups. A parent or head teacher gave additional consent for participants aged under 16 years.

Data analysis

Each interview and focus group was audio-taped and assigned a unique identifying number (all names assigned in this paper are pseudonyms). Transcribed text was entered into NVivo, a qualitative data analysis software package, and coded using inductive thematic analysis to reveal the main themes. After initial coding the data was then further examined in order to detect exceptions and contractions, and confirm patterns. This allowed distinctions to emerge and ensured that the analytic potential was maximised, rather than solely relying on the codes suggested by the topic guide¹⁷.

Results

Participants were teenage mothers and pregnant teenagers (n = 29), of whom details are given in table 1. Interviews lasted between 20 minutes and one hour, and focus groups between 45 minutes and one hour. All names have been changed in reporting the findings. Participants are not described as either breast or formula feeding, because these categories overlapped, with the majority having started breastfeeding, and mixed feeding being common. Findings are presented in three sequential categories; experiences of breastfeeding promotion in pregnancy, at birth and continuing breastfeeding support.

Experiences of breastfeeding promotion in pregnancy

Teenagers' first experience of breastfeeding promotion was generally at an ante-natal appointment with a midwife, and few participants had considered the subject of infant feeding prior to this. While family preferences about feeding method were known to participants, most described themselves as wishing to be informed about breastfeeding so they could then make a choice for themselves about how to feed their baby. Health benefits were cited as the primary reason for intending to breastfeed. A wide variety of benefits of breastfeeding could be recited by pregnant teenagers and teenage mothers, irrespective of their feeding intention or how they subsequently fed their baby:

'Apparently for the baby they have straighter teeth and it helps like their gum formation to make their teeth straighter and it helps prevent eczema and...they are five times less likely to end up in hospital with infections...[it] helps you get back to your normal size quicker and it helps protect you against ovarian and breast cancer.'

Focus group 1

Participants considered midwives to be 'pro-breastfeeding' but accepted this as inevitable, only expressing resentment if they felt undue pressure was being put on them to breastfeed. However, participants were aware that the health promotion messages of health professionals were not necessarily shared by the communities in which they lived. Some teenagers feared that to choose to breastfeed would transgress their own social norms:

'Midwives and doctors they try and persuade you to do it because it is classed as a normal thing...but I don't know.'

Hester, 17 years, pregnant.

The potential social embarrassment of breastfeeding loomed large in the mind of pregnant teenagers, and was a factor influencing choice of feeding method. Feeding in public was often feared by participants who thought they might be stared at, mocked or even told to stop breastfeeding. Many participants, even if they themselves had breastfed, said that it was very embarrassing to see someone breastfeeding as this was not usual behaviour for young mothers:

'Young girls my age, you just see them with their bottles really...I don't think I've seen any girls breastfeeding when I've been out anywhere.'

Anya, 20 years, baby aged 7 months'.

The decision to breastfeed was generally expressed as an intention to 'try', with formula feeding seen as a reliable fall-back option. Only one participant (a Black mother with a

strong family history of breastfeeding) intended to exclusively breastfeed for around six months, with the majority setting a time limit in pregnancy on breastfeeding duration, generally a few weeks. Both pregnant teenagers and mothers considered breastfeeding was potentially easier than formula feeding, which was seen as expensive and labour intensive; the idea of getting out of bed at night to prepare bottles was much disliked.

Experiences of breastfeeding promotion and support at birth

Feeding decisions made in pregnancy were not necessarily followed through when the baby was born. There seemed a period after birth when some mothers were willing to try to breastfeed even when they had categorically stated they intended to formula feed. Conversely mothers who had decided to breastfeed could subsequently formula feed, either because the mother and baby were separated due to health problems, or because an assumption was about the mother's feeding choice. In such cases mothers appeared accepting of what had happened:

'Well when she was first born, I actually wanted to breastfeed but...like everyone was like, oh this is where the bottle things are, like where the little stashes of bottles were, but I didn't see anything wrong with bottle-feeding so I didn't really care. At first I did want to breastfeed but as soon as I got the bottle out and fed her, it was fine.'

Marianne, 18 years, baby aged 11 months

Most mothers who initiated breastfeeding found the first feed was not painful, and described the midwives as helpful in showing them how to position the baby. There was some criticism of hospital staff for offering insufficient help with subsequent feeds, for instance leaving the mother to manage alone once the baby was fixed on the breast. Mothers who described themselves as coping well with the early days of breastfeeding had often been told by family or health professionals that there might be early difficulties, but that these would then resolve.

'I didn't want to breastfeed, my partner wanted me to, so I tried it and my midwife said, the first few days are going to be the worst but after the three days then it would be fine and ever since I've just breast fed. It's fine, it's brilliant.'

Tara, 17 years, children aged 3 months and 18 months

When a baby was born prematurely, some mothers described being categorically told by health professionals they should breastfeed in order to give the baby a better chance of survival. Participants in this situation were willing to attempt breastfeeding, not resenting the direct instruction. One mother, despite not planning to breastfeed, expressed breast milk to ensure that her baby was exclusively breastfed for eight weeks.

Experiences of continuing breastfeeding support

Satisfaction with the support given by health professionals decreased rapidly. Most mothers described the midwife or health visitor speedily 'signing off' if breastfeeding was going well, congratulating the mother on her success. After the first two weeks few mothers had continuing support from health professionals with breastfeeding. If difficulties subsequently arose then most mothers turned to their families for advice, with a minority requesting help from a health professional. Commercial products, such as specialist formula milks, often offered a solution to the problems mothers experienced, such as the baby wishing to feed frequently or being wakeful. An extended example gives an indication of the factors which typically led mothers to give up breastfeeding:

'When I was pregnant, I had all the talk, I'm going to breastfeed him and then it come down to it, I did, I persevered for about five or six weeks ... as soon as I got home, because I was on my own and it seemed more harder...he was just on my breast 24/7 ...and I couldn't do nothing what I wanted to do... so I went to my health visitor and I said, "What would you say was the best option?" because... I didn't want to like give up altogether and she said to me to start trying to express so I tried to express it, I couldn't express...so then I started a bottle through the day and breastfeeding at night and then I stopped that...and just went straight to

bottle because he was so hungry, I needed to put him up onto a hungry baby milk.'

Nancy, 17 years, baby aged 6 months

Introducing bottle feeds (whether expressed milk or formula) appeared to be the solution for many to reconciling the demands of breastfeeding with maintaining the mother's autonomy. Mothers knew that 'mixed feeding' contravened health promotion messages, but were otherwise unaware of the benefits of exclusive breastfeeding for several months, commonly believing that most benefits were derived from the early feeds. Several mothers described asking health professionals for advice about feeding outside the home, but the advice commonly given (to express milk or to find a private place to feed) rarely seemed to enable or encourage mothers to continue breastfeeding. Even mothers who were committed to breastfeeding and had family support, found feeding in public a highly challenging experience:

'I went to a party on Saturday and I didn't really want to do it... I was a bit scared because there were people watching me... I still breastfed her but my sister was there with me and she will breastfeed anywhere, she doesn't care, and I had to because [the baby] was crying and I just covered up. There are some times when I go somewhere when I think that I wish I'd brought a bottle, express milk though.'

Emily, 17 years, baby aged one month

Young mothers found it very difficult to juggle the pressures of wanting to breastfeed because it was 'best' but also not wanting to flout social norms. Additionally there was a conflict between the mother's personal freedom and the needs of the baby. This conflict was identified by both pregnant teenagers and young mothers who feared that breastfeeding would lead to the baby becoming too 'clingy', further limiting their own personal freedom. However, many who had stopped breastfeeding stated that they wished they could have fed for longer, and a few described themselves as missing a uniquely enjoyable experience for mother and baby which strengthened the bond between them.

Discussion

Main finding of this study

While health professionals were successful in promoting breastfeeding ante-natally they were less successful in supporting breastfeeding post-natally. This was partly because midwives and health visitors routinely withdrew from proactive contact with the mother once feeding was established, leaving the mother to seek help if problems arose. Teenage mothers were then likely to rely upon family solutions based upon local behavioural norms which predicated bottle feeding as the normal way to feed a baby. Participants were not opposed to breastfeeding *per se* and most were successful in initiating. Problems arose when mothers returned home and experienced difficulties in fitting breastfeeding into their daily lives. Frequent feeding presented a problem, which could be resolved by giving formula milk, which was believed to ensure longer sleep with fewer feeds.

Limitations of this study

Rates of breastfeeding initiation and continuation were much higher among the study sample than nationally. Rates of breastfeeding in the South West of England are higher than many parts of the UK, but additionally in the city in which this research took place midwifery and health visiting teams had recently received training to UNICEF Baby Friendly standards¹⁸, which meant that participants may have received an unusually high standard of breastfeeding support. There are defined limits on the generalisability of findings from qualitative studies¹⁹ but in this case the breastfeeding promotion and support experienced by participants could be very different from what teenage mothers experience elsewhere. This starkly highlights that teenage mothers do not receive adequate help and support from health professionals in order to support them to breastfeed, even when maternity and community services have reached an accredited standard. Despite the high needs of teenage mothers it did not appear that they were targeted for increased support post-natally as suggested in the Healthy Child programme³.

What is already known on this topic

In the UK teenage mothers are among the least likely to breastfeed¹. Studies have been carried out into the reasons why those from disadvantaged groups do not initiate and continue breastfeeding, many of which are linked to the theory of planned behaviour^{10, 11, 20}. Such studies conclude that family influences and concerns about breastfeeding in public significantly influence infant feeding behaviour²⁰ and that breastfeeding can be seen as a ‘morally inappropriate’ behaviour by teenagers¹¹. Giles et al²¹ showed that young people have limited exposure to breastfeeding, are unclear about the benefits of breastfeeding and find breastfeeding in public embarrassing. Knowledge about the benefits of breastfeeding increases in pregnancy^{10,11} but breastfeeding in public continues to be viewed highly negatively^{9,22--24}. It appears easier to educate mothers about the benefits of breastfeeding than to alter perceptions of the public acceptability of breastfeeding.

What this study adds

Information about the benefits of breastfeeding was appreciated ante-natally and was a strong factor influencing teenage mothers’ feeding choices. However, mothers were unaware of the benefits of continuing breastfeeding and there was little understanding of the recommendation to exclusively breastfeed for six months. The predominantly social barriers to continuing breastfeeding appear insufficiently recognised and addressed by health professionals. Many mothers in this study described themselves as experiencing a virtual ban on breastfeeding in public. This contrasts with the smoking ban which restricts an unhealthy activity in public places; for breastfeeding the healthy activity is restricted by public attitude, especially in areas with the lowest breastfeeding rates. Issues around breastfeeding outside the home, coupled with insufficient support from health professionals, create obstacles to long term exclusive breastfeeding. These obstacles are keenly experienced by teenage mothers, who are highly sensitive to public disapproval.

Conclusion

The social marketing approach gave insights into how to promote breastfeeding to teenagers by exploring experiences of breastfeeding within the context of young mothers’ everyday lives. Breastfeeding promotion must take into account how the desired

behaviour fits within the context of individuals' lives. Teenage mothers require additional support in continuing breastfeeding; this includes giving full information about the benefits of exclusive breastfeeding but also reducing obstacles to breastfeeding in public. A starting point for health professionals is to implement the Unicef Baby Friendly Initiative recommendations to discuss breastfeeding in public with mothers and to create a environment in community and health facilities in which breastfeeding is welcome.

Table 1: Demographic details of participants (n=29)

Number of teenage mothers	23
Number of pregnant teenagers	6
Number of interviews	17
Number of focus groups	3 (12 participants)
Ethnicity of participants	23 x White British 4 x Black British 1 x British Asian 1 x White European
Mean age at first pregnancy	16 (range 13-18 years)
Mean age at interview/focus group	17 (range 14-20 years)
Number (%) of mothers initiating breastfeeding*	16 (70%)
Number (%) of mothers continuing breastfeeding*	5 (22%)

*Classification of initiation is offering breast milk at least once (Bolling 2007)

*Classification of continuation is offering some breast milk at 6-8 weeks (Bolling 2007)

2972 words

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