It is abundantly clear that most women in the UK either actively want to breastfeed or are willing to breastfeed their newborn baby. Yet, the proportion who continue to do so drops off dramatically. Almost all of these women say that they would have liked to carry on breastfeeding (Bolling et al. 2007). This provides midwives and breastfeeding supporters with a practical challenge; one that we should work on together (Moran et al. 2005).

This article explores why breastfeeding matters, focusing on women’s breastfeeding experiences. It draws on a variety of academic disciplines and study designs. A search was carried out to identify qualitative studies of breastfeeding and we have included evidence of women’s experiences, taken from a study of parents who attended NCT (formerly known as the National Childbirth Trust) antenatal classes during 2009. This is the first part of a two part article for Essentially MIDIRS; the second article will focus on how breastfeeding support for new mothers should be developed.

support,
“Feeding my son has got to be one of my greatest achievements ever and the most fulfilling experience of my life”

Why breastfeeding matters

*Human contact, human meaning*

Breastfeeding matters to women and babies. When it goes well and women are able to comfort and nourish their baby easily, their sense of connection and fulfilment can be profound. Testimonies to this are surprisingly few and far between in qualitative studies. There is much greater emphasis on barriers to breastfeeding, difficulties, failure, pain and trauma. However, there is more acknowledgement of the contentment and the sense of achievement that breastfeeding can bring in the fields of art, anthropology, politics and individual women’s accounts. The anthropologist, Raphael, for example, referred to receiving ‘testimonials of joy’ from women in her study (1973: 91). Palmer quotes Lady Macbeth, ‘…and I have given suck and know how tender ’tis to love the babe that milks me’ (Macbeth, Act 1, Scene 4), and notes that

’a bit of plastic and silicon does not convey to the baby the primal contact that a soft warm breast can. Nor can bottle-feeding convey to the woman the warm sensual feelings that can be experienced through suckling a baby’ (2009: 81).

The NCT breastfeeding book is full of women’s breastfeeding stories, including positive accounts from women in all kinds of circumstances. It starts on a celebratory note: ‘Feeding my son has got to be one of my greatest achievements ever and the most fulfilling experience of my life’, and provides dozens of positive stories including accounts from disabled women who found they could adapt breastfeeding to their circumstances and enjoy it (Moody et al 1996: 181-186).

Kitzinger also celebrates the opportunities that breastfeeding provides for enhancing the mother-baby relationship: close physical touch and eye-to-eye contact; interaction in latching and feeding; a particular repertoire of touch, taste and smell; while emphasising that the quality of the communication between them is more important than ‘whether the milk comes in breast or a bottle’ (Kitzinger 1979: 182).

*Health impact*

Breastfeeding has a major role to play in improving public health and reducing health inequalities (Dyson et al 2006). Babies who are not breastfed are more at risk of gastroenteritis and severe respiratory infections, acute ear infections, atopic dermatitis, juvenile asthma, obesity, type 1 and 2 diabetes, childhood leukaemia, and sudden infant death syndrome (SIDS) (Ip et al 2007). A large UK study found that 53% of diarrhoea hospitalisations and 27% of lower respiratory tract infection hospitalisations could have been prevented each month by exclusive breastfeeding (Quigley et al 2007). Women who have not breastfed their children have an increased risk of type 2 diabetes, breast and ovarian cancers (Ip et al 2007).

Breastfeeding contributes to several government priorities, including:

- reduction of the infant mortality rate
- reduction of preventable infections and unnecessary paediatric admissions in infancy
- halting the rise in obesity in under 11s
- improving children’s life outcomes and general wellbeing, and breaking the cycle of deprivation.

(Dyson et al 2006)

Mothers’ experiences

For first time mothers, breastfeeding is often more of a challenge than they had anticipated, particularly for those who have not seen young babies and breastfeeding at first hand. Although in essence bringing breast and baby together may seem to be simplicity itself and something women have been doing since time began, in a world where birth usually takes place in hospital, support is hard to come by and where there are mainstream feeding alternatives, breastfeeding often goes horribly wrong.

Raphael said that in cultures where breastfeeding is almost universal and seen as natural ‘women are aware that breastfeeding is not automatic’ (1973:15). These societies relieve new mothers of household chores and more experienced mothers provide practical teaching on infant care. These practices, she said, ‘seem to help the new mother gear herself … to her new role and … give her a chance to establish her milk supply and [become] sensitized to her infant’s needs’ (1973: 22). Raphael emphasised that the process of becoming a mother, important enough to have a name, ‘matrescence’, ‘is a major life crisis’ involving physical and emotional change, a new identity and status (1973:19). She emphasised that ‘human mothers … who have some sort of “mothering” … do well at breastfeeding, but those who do not can almost certainly expect trouble’ (1973:15). If only this kind of insight was understood and acted upon in the UK.

Klaus and Kennell developed these ideas further (Klaus et al 1993). They highlighted how continuous social and emotional support of mothers by a female carer, and early and sustained close contact between mothers and their newborn infants increased affection and attention by mothers towards their babies, their responsiveness when their baby cried and more frequent and longer breastfeeds (Klaus et al 1993: 112). They state that ‘it is often difficult for a new mother to recognize her needs and feelings and give herself permission to
ask for help’ at a time when ‘meeting the never-ending demands of a young infant is a momentous change’ from having the freedom to live as an independent person (Klaus et al 1993: 113).


- daily home visits until mothers feel comfortable and confident in caring for their baby
- an increase in the health visitor workforce
- improved family support services, including breastfeeding ‘drop-in’ facilities
- all maternity services to be Baby Friendly accredited, offering access to trained breastfeeding supporters (NCT 2010).

Although the concept of ‘doula’ is gradually catching on, this comes at a time when universal home visits from community-based midwives are being cut to the bone (Healthcare Commission 2008). Neither government (Department of Health 2007, NHS Quality Improvement Scotland 2009) nor NICE (National Institute for Health and Clinical Excellence 2006) are prepared to commit to a minimum number of postnatal visits, yet only 16% of midwives feel they can provide sufficient help with infant feeding (Healthcare Commission 2008).

Following earlier NCT research highlighting the need for more consistent and sensitive postnatal support (Singh & Newburn 2000c, Singh & Newburn 2000b), a recent online postnatal survey of women who had attended an NCT antenatal course during 2009 shows that for many women the early weeks of motherhood are dominated by tiredness, the practical reality of feeding and baby care, and the need for reassurance (Muller & Newburn 2010).

In common with many previous studies (Hunter 2004, Graffy & Taylor 2005, Adewale 2006, Bolling et al 2007, Wambach & Cohen 2009) women reported difficulties with latching, settling their baby and worries about having enough milk:

- ‘I was engorged and my baby would not feed’
- ‘My baby (was) pulling on and off and screaming through feeds’
- ‘My baby was too sleepy to feed for two days after birth (as a result of pethidine)’

‘My baby continued to scream for food for first two weeks - I felt very stressed out.’

Pain was a recurring theme. In addition, simply knowing what ‘normal breastfeeding’ was like, what to expect and how to manage the changing nature of lactation, was a puzzle for some.

- ‘(I didn’t know) what to do when milk came in on day three’
- ‘I was concerned about how long it takes to feed and whether that’s normal’
- ‘Wasn’t sure about feeding on one side or both sides at each feed.’

When women experienced a period of difficulties, not surprisingly this left them feeling less confident.

- ‘I did not seem to be producing enough milk and my confidence dipped. I needed some advice and support that I could still breastfeed and that my baby was getting enough’
- ‘My baby wasn’t feeding properly … wouldn’t suck and had jaundice. I was very demoralised’

Traditionally, women have relied on other experienced women to learn about breastfeeding. Mother-to-mother support declined with the advent of formula feeding, smaller families and most women working outside the home. As these quotes demonstrate, women need considerably more supportive attention during matrescence – the period of becoming a new mother. They need the opportunity to talk about their fears, anxieties and emotional reactions, as well as practical nurturing, acknowledgement of their achievements, reassurance and practical information (Klaus et al 1993, Hunter 2004).

It is often difficult for a new mother to recognize her needs and feelings and give herself permission to ask for help.

It is strange and sad that something as fundamental to human life and the future of society itself - the needs of new mothers, their babies and their partners - should be so overlooked. We must not be complacent and accepting of the status quo but take active steps to raise awareness about families’ needs and improve support services. In an article to follow, we will look at the evidence on how support for new mothers can be developed with a focus on breastfeeding as a core value.
References


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Rosemary Dodds trained as a nutritionist and worked as a research dietitian at Kings College and Guy's Medical schools. The birth and breastfeeding of her son led her to train as a breastfeeding Counsellor with the NCT. Subsequently she joined the staff of the charity where she enjoys campaigning, gleaining research on all issues related to nutrition and feeding babies, informing opinion leaders and lobbying for policies to improve support for baby feeding. Rosie has two children and continues to volunteer as a breastfeeding counsellor in Essex.