How can antenatal education support a positive breastfeeding experience?

By Maxine Palmer

Young mothers show disproportionately low breastfeeding rates, despite a continuing drive to communicate the health benefits.¹ ² This literature-based study aimed to identify how young mothers can be supported in a positive breastfeeding experience, with possible applications for antenatal education.

Maxine Palmer is an infant feeding specialist and antenatal teacher working with young parents. In this article, Maxine summarises the findings of an independent literature-based study undertaken as part of a BA (Hons) Degree, Birth & Beyond Educator, at the University of Worcester, on a theme which evolved from issues encountered in her own practice.
Identifying antenatal opportunities for improving the breastfeeding experiences of young parents is pertinent because social, psychological, neurological and health research all suggest sensitive, responsive parenting is key to shaping infant attachment and security. Breastfeeding plays a crucial role in this.

The study considered primary research from the UK and other high-income countries from 2010 onwards, where the infant feeding experiences, attitudes and education of young mothers under 26 were explored. In practical terms, the aim was to identify which factors that support positive breastfeeding experiences could be applied to antenatal education. There were four clear emergent themes.

### Poor knowledge of breastfeeding and common difficulties

The strongest theme to emerge was that younger mothers from backgrounds where breastfeeding was not the cultural norm, frequently experienced difficulty due to their lack of breastfeeding knowledge and coping strategies. They consistently discussed information as a highly desirable component of antenatal breastfeeding education. Information giving by healthcare professionals was frequently reported as being of poor quality, impersonal and authoritarian, contrasting dramatically with the empathetic, non-judgemental support mothers desired. Positions in labour were commonly cited as well remembered from antenatal education, but few had the knowledge or skills to support themselves in ‘trouble shooting and taking control of their breastfeeding experience’, such as understanding early frequent feeding, engorgement and how to feed in public.

Young mothers desired breastfeeding information early in pregnancy with a concise, consistent, respectful approach, so that they could make informed choices. In a randomised controlled trial (RCT), Wambach et al. showed that improving breastfeeding initiation and duration rates is linked to breastfeeding antenatal education which focuses on benefits for the mother and baby, as well as the ‘how to’, including managing breastfeeding after a return to work or school.

Two studies portrayed the physical difficulties of breastfeeding, which participants felt unprepared for. Without an arsenal of strategies to cope with discomfort and difficulties, many mothers were inclined to give up. Fear of pain was reported as a significant antenatal factor in influencing decision making around infant feeding methods. However, another two studies reported early feeding as not being painful, regardless of anticipation.

---

**Summary of findings**

Infant feeding information focused on confidence building, sensitively facilitated from early pregnancy by trusted professionals offering continuity of care, is desirable and valued by young mothers. Professional, informal and innovative support networks are likely to prolong and enhance breastfeeding experiences. There are further benefits if these services are integrated and include the significant supporters of young mothers.
Young mothers were negatively influenced by a lack of knowledge of the benefits of exclusive breastfeeding, with many not appreciating the fundamental benefits of, and differences between, breastmilk and formula, which was often illustrated by the early introduction of formula.\(^8\)

### How it feels to be a young mother

Participants in the qualitative studies were acutely aware of the potential social stigma of being a young mother. In the RCT analysis of feeding intentions, only 30% of teens expected to initiate breastfeeding (prior to the intervention). All had experienced or anticipated negative attitudes or feeling judged, recognising that feeding their baby in public risked disapproval. These negative expectations appeared to influence health care professionals too, who in turn influenced young mothers’ feeding decisions, leading several participants to accept offers of infant formula instead of initiating breastfeeding.\(^6,7\)

The potential and actual social embarrassment of breastfeeding was a huge factor in influencing feeding methods,\(^7\) as many participants felt that breastfeeding was not widely accepted by society as the normal way to feed a baby.\(^5\)

A further significant factor in young mothers’ commitment and success with breastfeeding was whether the close circle of family and friends around them also had experience in breastfeeding and could offer practical and emotional support. This further illustrated the influence of social norms\(^7\) and the value of including ‘supporters’ in antenatal education. Social norms provided a real dilemma for young mothers, as they wanted to do the best for their baby but at the same time did not want to contravene their social norms. The need for peer approval was a particularly strong factor amongst adolescents.

### The who, what, when and where of breastfeeding support

This theme resonated throughout the qualitative studies. Mothers generally experienced more information about breastfeeding antenatally and immediately after birth. Condon et al highlight the stark reality of a rapid withdrawal of professional support once breastfeeding was judged to be established, often within days of the birth.\(^7\) Young mothers rarely solicited further support from professionals once existing support was withdrawn, relying instead on friends and family.\(^5,7\) The prevailing culture would then largely determine the outcome. Young mothers frequently reported that the lack of breastfeeding support and knowledge immediately around them was a strong contributory factor in cessation. Informal support networks, positive role models and social networking were important means of breastfeeding support.\(^5\) The study by Wambach et al showed that inclusion of supporters, and consistency of professional support (antenatally and postnatally) in the intervention group from a lactation consultant and peer counsellor, together improved initiation and duration rates.
Attitudes to breastfeeding

The majority of participants intended to breastfeed, their decisions largely being influenced by the health benefits to the baby, the cost implications of formula and the potential convenience to the mother. Strikingly though, most participants only anticipated breastfeeding for a few weeks and in one study their decisions to breastfeed were generally expressed as an intention only to ‘try’. Two studies identified statistically significant factors predicting breastfeeding initiation, including breastfeeding knowledge, antenatal intention and the timing of the decision to breastfeed (earlier decisions correlated with more likely initiation). However, they found no significant predictors of breastfeeding duration.

Feeding decisions made during pregnancy were not necessarily followed through when the baby was born, as a period existed postpartum when some mothers were willing to try breastfeeding despite their intention to formula feed. Conversely, mothers who had intended to breastfeed might offer their babies formula instead because of separation at birth or assumptions made by care givers.

It appears highly relevant that breastfeeding decision making was covered in antenatal education in the intervention group studied by Wambach et al, and that one rationale for supporters’ inclusion in classes was to support this.

Summary

This study found evidence that young mothers often lack adequate physiological knowledge of breastfeeding and have difficulty coping with common breastfeeding experiences. Their lack of understanding about the fundamental difference between breastmilk and formula was also a significant negative factor in the antenatal intentions of young mothers to breastfeed for short periods only, and in the generally low exclusive breastfeeding prevalence rates.

The social norms and judgments that discourage many younger mothers from breastfeeding might be addressed by the inclusion of their close supporters in antenatal education. Further encouragement to initiate and continue with breastfeeding is likely to result from antenatal facilitators, healthcare professionals and peer supporters building relationships with young mothers during their pregnancy, and the offer of through-support services.

The building of trusting, non-judgmental relationships from early in pregnancy appears to be a strong factor in building positive breastfeeding attitudes. It is a subtle but key finding of this study as antenatal intention and self-efficacy are linked to subsequent breastfeeding duration, and rates for both are currently disproportionately low for young mothers.

Wider research contextualised that some young women only want one-to-one antenatal education. My findings offered no results for how widely acceptable group-based antenatal education would be. Having only selected studies from high-income countries is another potential limitation, as not all findings are transferable to a local population in the UK; the evidence from all breastfeeding intervention trials is varied and depends on the context, culture and country.
The way forward

Young mothers need to be placed at the heart of any programme for antenatal education that seeks to redress the balance. My recommendations are drawn from the study’s findings.

The following are the key components of a programme that will better support the breastfeeding experience:

**Continuity of facilitator support** - beginning in early pregnancy, and part of a through-service offering continuous breastfeeding support.

**Group participation** - where friendships are actively fostered between young mothers, supporting the building of social capital.

**Peer support using a narrative approach** - so that young mothers and their supporters hear and observe 'real' experiences in order to 'normalise' perceptions of breastfeeding.

**Non-judgmental information** - personalised and engaging for participants.

**Easy-to-follow explanations** of the normal physiology of breastfeeding from initiation through to establishment.

**Spotlight** on the critical differences between breastmilk and formula.

**Coping strategies** for common breastfeeding experiences and difficulties.

**Emphasis on the role of breastfeeding** as more than infant nutrition: a critical part of the relationship between mother and child.

**Confidence-building** through participative experiential learning activities so that young mothers and their supporters perceive themselves as able to, and wanting to 'do it' for longer.

Conclusion

Supporting and improving breastfeeding prevalence in young mothers involves developing positive attitudes and expectations from early in pregnancy. This study shows that it can be done through continuity of supporters, normalising the experience and building support networks. Future research should focus on techniques for improving breastfeeding self-efficacy in young parents.

Mothers, their partners, family members and supporters can make transformational leaps to new ways of understanding and viewing breastfeeding, which will lead to more positive experiences.

References


