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Thesis submitted on the 28th February 2014 in part fulfilment of the requirements of a Ph.D. in Health Professional Studies

WHAT ARE MOTHERS' AND HEALTHCARE PROFESSIONALS'
EXPERIENCES OF INFANT FEEDING WITHIN THE CURRENT POLICY
CONTEXT AND CULTURE OF HEALTHCARE IN ENGLAND?

Abstract

Background: Increasing breastfeeding rates is a longstanding goal of health policy in England. Rationale for this is premised upon the health benefits to both mother and child conferred by exclusive breastfeeding.

Current UK Infant Feeding Policy (IFP) derives from international guidelines incorporating the Baby Friendly Initiative (BFI) that promote exclusive breastfeeding. Such 'evidence informed policy formation' is emblematic of the current context of health policymaking. However, the impact of current IFP upon women and healthcare professionals is under researched.

Aim: This study explores the impact of IFP upon Women, Midwives and Heads of Midwifery services in England and considers the implications for maternity services.

Methodology: A qualitative design used semi-structured interviews to determine the experiences and views of IFP with eight Heads of Midwifery and eight Midwives. Six women underwent three interviews exploring their infant feeding journeys at: 8 months pregnant, 1 month and 6 months' post-partum. Data were analysed using Colaizzi's phenomenological method.

Findings: Three key themes arose contributing towards understanding the context of IFP: Being with IFP, Discourses of Self-Determination and The Emotion work of Compliance.

For Midwives: The socio-political context of health and health-care system policy is multifarious but contains identifiable spheres relating to current IFP. Midwives do not appear to actively engage in the political process of this type of policy generation. For Mothers: Infant feeding remains emotionally fraught territory. Three key themes arose from the first interview: Adopting a Stance, Formulating a Vision and Processing the Dialogues of Infant Feeding. The second interview engendered three more key themes termed: Being with the Reality of Infant Feeding, Regaining Selfhood and Seeking Companions.

Discussion and Conclusion: Foucault's analyses of power and governmentality were used to explore the 'Art of Midwifery' vs the 'Art of Governance'. Lack of holism and neoliberal agendas dominating current IFP may be detrimental to maternity service provision as they compromise decisional autonomy for women and clinical autonomy for midwives.

ACKNOWLEDGEMENTS

This thesis is dedicated to the mothers and midwives who participated in this study. Listening to their voices enabled me to find my own.

My heartfelt thanks to everyone who supported me on my research journey I am especially grateful to Professor Julie Jomeen.

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Introduction

Breastfeeding has been actively promoted in England by the Government, midwives and related healthcare professionals (HCPs) for three decades. This promotion is ostensibly premised upon physical and to some extent psychological, health benefits of breastfeeding for mothers and infants. These benefits are numerous, largely unchallenged, and have especially been presented as ‘evidence based’ during the last decade by international organisations, healthcare academia and professions (Dyson L, Renfrew M et al. 2006, NICE 2006, Bernardo, Bahl et al. 2007). It is unclear why, despite this lengthy promotion of breastfeeding, the standardised breastfeeding initiation rates have remained relatively static in England over the same period, with a median average of 36% of women never initiating breastfeeding (Bolling, Grant et al. 2005). More recent statistics up to 2012 suggest that of the three quarters of mothers who commence breastfeeding after birth, less than half are undertaking any breastfeeding at 6-8 weeks and less than a third are exclusively breastfeeding at this time (DH 2012).

Evidently, effective promotion of breastfeeding is a complex issue and the UK Government is presently committed to an active pro-breastfeeding campaign. This current policy influence upon contemporary infant feeding culture naturally inclines infant feeding research towards women who initiate breastfeeding, but do not maintain their breastfeeding intention. It also results in Infant Feeding Policy (IFP) focussing upon a technical and prescriptive approach (UNICEF BFHI UK 2010), which may be construed as a reductionist, oversimplified strategy for social issues (Beresford 2010). Reductionism is a feature of a contemporary UK infant feeding research culture that is largely conducted and interpreted ‘through the lens’ of IFP that seeks to ‘enable breastfeeding’ (Dyson, Renfrew et al. 2010, Thomson and Dykes 2010). This interpretive approach to policy results in an emphasis upon promoting breastfeeding and finding solutions to the reasons women

articulate (insufficient milk supply, pain, discomfort), when asked what made them **“give up breastfeeding”** (Bolling, Grant et al. 2005:12).

This research intends to holistically explore the impact of contemporary infant feeding discourse and practice on maternity service providers and women’s infant feeding experiences and decisions. It incorporates a qualitative study about infant feeding that seeks to understand how healthcare practitioners experience infant feeding and related policy in England and aims to represent mothers’ experiences of infant feeding. The present era is characterised by an increasingly professionalised approach in society towards the conduct of private and domestic lives; what Lasch refers to as ‘The Common Life’ (Lasch and Lasch-Quinn 1997). HCPs including midwives are a part of this evolution, conducting their roles within the National Health Service (NHS), a state institution governed by health policies that direct service provision and apply government health objectives. Infant feeding is inherently grounded in domesticity and also rising in public health policy profile owing to the perceived maternal and infant health benefits conferred by exclusive breastfeeding.

This holistic macro-exploration provides a contemporary account of the impact of IFP and discourses on HCPs and women who access maternity services. It integrates their perspectives, articulating the environment and thereby evaluating the efficacy of current IFP. The research approach is unique because the central aim of this study is to embody the research subjects’ views on infant feeding and IFP by qualitatively identifying their dominant discourses and representing them authentically in order to inform the infant feeding debate in England and future related policy.

The literature review for the study is located in chapters 1 and 2. It is extremely broad in order to identify the key influences behind contemporary IFP in England. Chapter 1 explores general healthcare system and health policy including the matter of public health to

present an extensive contextual, overarching perspective of present policy which will enhance interpretation of the research data. This position is justified owing to the unique culture of healthcare in the UK which has been dominated by the NHS since 1948 (Klein 2006, Hunter 2008, Ham 2009, Hill 2009). The chapter concludes with a critique of political ideology and health policy.

Chapter 2 incorporates the literature review relating to maternity policy and IFP with particular reference to public health, the BFI and the evidence base relating to promoting, initiating and sustaining breastfeeding. The role of the midwife in health promotion, the effect of IFP on women and sociological perspectives on 'health' and 'risk' are also summarised. Chapter 1 combines with the content of chapter 2 to create a literature review that attempts to create a 'macro-contextual' perspective of where current IFP is located in England.

Research methods are situated in chapter 3 and include the origins and purpose of the study, philosophical and theoretical foundations of social research, methodology and method of the study. Analyses of interviews with HCPs (midwives and heads of midwifery) are located in chapter 4. The study findings exploring women's infant feeding journeys are found in chapter 5 and the discussion and conclusion to the thesis in chapters 6 and 7 respectively.

Chapter 1: The Political Health Policy Context

1.1 Introduction

Exploring general UK health policy helps to inform the overarching operation underpinning the context of current IFP. This exercise in essence assists this chapter's attempt to answer the following questions:

...how do we make sense of these constant shifts in health policy? Should the public pronouncements of health ministers be accepted at face value? Or should health policy be seen as a pragmatic response by government to changing political demands without any long-term strategic plan? Can a broader set of social, political and organisational processes which have shaped policy be identified? (Crinson 2009:1)

The chapter commences with an overview of the political ideology impacting upon general health policy that was generated during the 'New Labour' Government administration (1997 to 2010). It will outline general UK¹ health policy in relation to healthcare system provision, commencing with the structure of the NHS followed by contemplation of the political agendas driving health policy and NHS reform. These analyses inform the subsequent appraisal of the statutory framework of the NHS.

Public health policy is then explored with specific consideration of the issues of obesity and inequalities in health as they relate directly to aspects of IFP. Political critiques of the ideology driving New Labour's approach to general health policy and health care systems development is then appraised. The chapter ends with a summary of the key issues.

¹ Political administrative power was actually decentralised between 1998 and 2006 therefore UK as a term in this thesis refers to England post- devolution. However, for simplicity UK is retained throughout the text.
<https://www.gov.uk/devolution-of-powers-to-scotland-wales-and-northern-ireland>

A universal and unequivocal theme, to be considered alongside all aspects of healthcare provision and associated policy, is the fact that society, particularly during the past two decades, has been subjected to an enormous degree of change. Increasing reliance upon technology, shifting international demographics (developed countries are aging whilst developing countries are youth dominant), the supremacy of capitalism with concomitant notions of individualism as the overriding political economic ideology and the hegemony of 'globalisation' are the key seminal influences today. Inevitably, these cultural and sociological influences are reflected in the evolution of healthcare systems serving any given society, at any point in time. They are interwoven within the fabric of our present structures (Hunt and Symonds 1996, Culpitt 1999, Hill 2009).

All governments within developed countries face similar, complicated issues with regard to germane development of health policy. As Hunter notes (2008a) they struggle to deal with the pressures of modern medicine that include ethical and financial resource distribution and the requirement to balance treatment of ill-health with strategies that promote health.

Public health is somewhat difficult to define and as a concept has changed much over the 21st Century. It first became a significant political issue in 1903 when 40% of the applicants for active service in the Boer war were rejected on medical grounds. These applicants were predominantly poor and suffering from rickets (Fatchett 1994). This statistical fact was of embarrassment to the government of the day and became a feature of the 1906 election campaign.

A century ago, the principle functions of UK government were the protection of the population from war and the malign behaviour of citizens. However, the landslide defeat of the Conservative party and incoming Liberal Government altered this position. A legislative social program, the 'Liberal Reforms', were implemented during 1906-1911,

thereby radically shifting the political perspective from a 'laissez-faire' to a more collectivist approach (Szreter 2002). It is often claimed that this period constitutes the commencement of the welfare state in Britain and subsequently influenced the creation of the NHS; an institution conceived within a framework of public welfare and the nationalisation of health services that were perceived as better managed by government than private enterprise (Freeman 2008).

As the following analysis suggests, the founding NHS concepts appear to oppose key aspects of all political parties' ideological approaches towards the NHS. However, prior to exploration of the subject of policy and political ideology, an appraisal of present health policy and system provision follows to facilitate understanding of the contemporary organisation of services. Owing to the complexity of issues surrounding devolution of parliament, precise health policy analysis is confined to that in England, unless stated otherwise.

1.2 General Health Policy and Healthcare System Provision

The population of England is uniquely privileged in having access to free healthcare services provided by the NHS. Consequently, the NHS as a healthcare system has dominated the provision of healthcare services since it was founded in 1948 leading to government policy NHS and health policy being inextricably linked. In the past decade, the NHS has been extensively reformed by a series of radical government policy initiatives. The next section outlines the structure of the NHS and then considers the political agendas driving health policy and the NHS reforms of 1997 to 2010 under the New Labour administration before exploring the approach adopted by the current Coalition (Liberal/Conservative) Government.

1.2.1 The Structure of the NHS

The NHS is by far the largest UK employer with an excess of 1.3 million employees (ONS 2010). It is not surprising therefore, that the structure and operation of the NHS is a leading political issue in the UK, firstly because it is highly regarded by the UK population and secondly as it provides the principle mechanism through which government accomplishes health policy (Walt 1994). The NHS is:

...one of the world's largest publicly funded health service. It is also one of the most efficient, most egalitarian and most comprehensive. (NHS 2009).

The NHS is principally controlled by, and directly accountable to, the Department of Health (DH). It is predominantly funded through direct taxation, legislated by the NHS Act 2006 (as amended by the Health and Social Care Act 2012) and monitored by the Care Quality Commission (NHS 2009a, DH 2010). Of relevance to maternity services and the interview data generated in this thesis, is the structure of the DH under the New Labour Administration and previous policy concepts of 'Health Improvement', 'Health Inequalities' and 'Choosing Health' (DH 2010a). Under New Labour, the DH viewed policy generation and implementation as a 'key strand' of the DH's role.

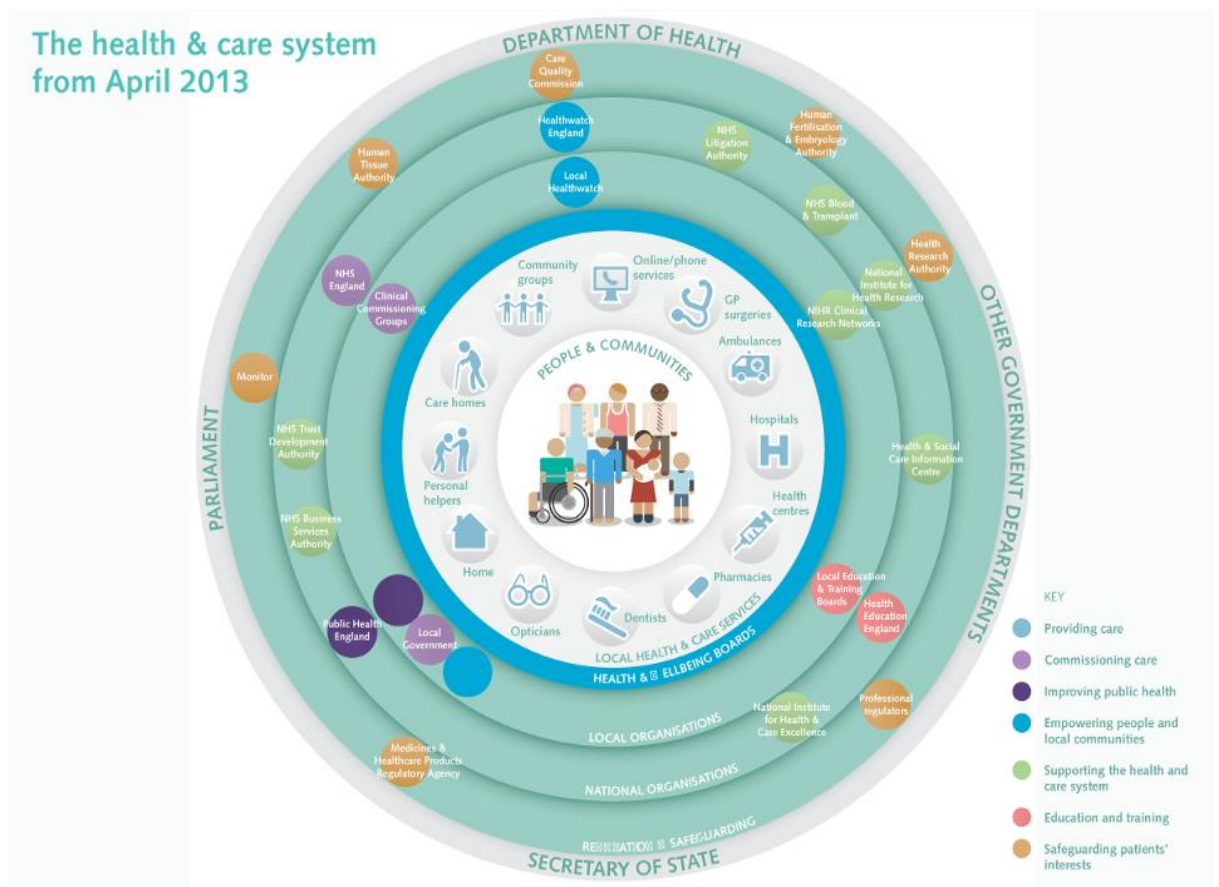
DH policies are designed to improve on existing arrangements in health and social care, and turn political vision into actions that should benefit staff, patients and the public. They aim to ensure services funded or supported by the Department are delivered in the most responsive, flexible and patient-centred way (DH 2010a).

Since 1st April 2013, the Coalition Government implemented the most radical reform to the UK's healthcare system to date, arising from the Health and Social Care Act 2012. The contemporary DH now structures itself as a 'health and care system' to fulfil the remit of the new Act with

responsibility for: Social Care, Public Health, The National Health Service and Public Safety.

The Department of Health's purpose is to help people live better for longer. We lead, shape and fund health and care in England, making sure people have the support, care and treatment they need, with the compassion, respect and dignity they deserve. The new and changing health and care organisations work together with the Department to achieve this common purpose (DH 2013).

Figure 1: The Health and Care System 2013



The present structure of the NHS and associated DH policy result from significant revisions since their institutional inceptions in 1948 (Rivett 1998). The structure is informed by contemporary political ideology underpinning health policy which is explored below. This ideology is of relevance to IFP as it forms the bedrock of all present UK policy direction.

1.2.2 Political Agendas Driving Health Policy and the NHS Reforms 1997-2010

The huge election victory in 1997 of New Labour under Tony Blair heralded a new era in administrative government reform with the promise to 'save and modernise' the NHS. Moreover, abandonment of Clause 4 in 1995 from the Labour Party's constitution committed the party to the 'ends' as opposed to 'means' principle, thereby reducing Labour's ideological commitment to the principle of nationalisation (Labour 1997).

Contemporary NHS structure and operation is especially based upon the political milieu influencing NHS reform throughout the noughties. However, the years from 1997 to 2000 are significant too and merit consideration being referred to by political commentators as the first wave of NHS reform (Baggott 2004, Klein 2006, Lister 2008, Ham 2009, Hill 2009, Hunter 2009). Upon election, New Labour actively disassociated itself from technocratic paternalism and central planning (Klein 2006) having inherited an NHS with an internal market system that effectively split the 'purchaser' from the 'provider' of healthcare services. This market was the tentative manifestation of a health strategy engendered by the outgoing Conservative government (Baggott 2004).

The concept of 'The Third Way' dominated Labour politics providing an appealing perspective that was reflected in a power shift from collectivist trade unions towards individuals. This reflected technological advances that had created social and economic change in society as work became increasingly service industry based. The 'New Way' was a political strategy driven by analysis of what was required to win elections and govern successfully in 'modern Britain' (Finlayson 1999). It was characterised by the drive towards 'modernisation of public services' through transcendence and reconciliation of concepts previously considered incompatible. For example: **“rights and**

responsibilities... patriotism and internationalism...the promotion of private enterprise and the attack on poverty and discrimination...” (Klein 2006:188) and ‘responsibility and opportunity’ (Le Grand 2003).

Third Way rhetoric is a source of recurring tension with regard to NHS Policy between the themes of ‘decentralisation’ and ‘democratic self-governance’. This is illustrated in the epithet **“The truth is that freedom for the many requires strong government.”** (Tony Blair in Klein 2006: 188) and rationalised by Tony Blair’s maxim **“What counts is what works”** (Labour 1997).

During the first wave of NHS reform, health policy was controlled using Third Way strategy tightly controlling spending on public services, retaining low taxation and supporting private enterprise. The concept of ‘permanent revisionism’ entered the healthcare policy arena and the government expanded upon a previous approach of co-ordinated policies to address specific issues, for example, inequalities in health and social exclusion. These policies incorporated a fundamental shift in perspective towards a provision of quality services that were responsive to ‘services users’ expectations and needs, as opposed to a care service structured and designed to suit the ‘service providers’ (Cm 4310 1999).

The philosophy of decentralisation however, as mentioned above, contained certain contradictions. One principal manifestation of this tension occurred when central government instigated, via the Treasury Department (Cm 4181 1998), a target culture in government policy through the introduction in 1998 of public service agreements (PSAs). PSAs set performance requirements for government agencies and a timetable for their (theoretical) implementation. In effect, they were the principal tool used by central government to control agencies and overtly evidence that control to the public. PSAs fundamentally affected the development of the NHS over the next decade, exerting pressure on both NHS managers and politicians to ensure they were accomplished.

Control and accountability of public sector performance became so politicised that a special unit was established to report to the Prime Minister upon progress of targets in government departments, including the NHS (Hunter 2008).

In 2000 New Labour embarked upon the second wave of NHS modernisation, with a substantial commitment to increase funding almost certainly in response to negative media press relating to the functioning of the NHS. This included criticism of idiosyncratic features within the healthcare system typified by 'postcode lottery' aspects of the NHS and disparate standards between NHS Trusts (Klein 2006). Government perennially remained vulnerable to public opinion on the subject of the NHS (Seldon 2005) and fiscal policy was retrospectively justified because it brought UK healthcare spending in line with that of European counterparts from 7% Gross Domestic Product (GDP) to 8% (Wanless 2002). This was recommended by Derek Wanless, in a report for the Chancellor of the Exchequer, that sought to ascertain what resources were required to provide an inclusive and quality public service based upon need, as opposed to ability to pay (Wanless 2001, Wanless 2002).

The Wanless report was significant because it assessed healthcare 'outcomes' (survival rates for cancer etc.) and 'inputs' (number of consultants), comparing these with European Union countries thereby demonstrating that the NHS had indeed been underfunded for years. This suggested that increasing demand, driven by rising public expectations, would create a costing gap between actual provision and expectations. National Service Frameworks (NSFs) were introduced (DH 1999) as the tool designed to 'reduce the gap', providing an objective assessment of the financial costs of implementing a quality service based upon clinical consensus. The NSF assessment also factored costs associated with clinical governance, demographic issues and technological developments in health care (Klein 2006).

Returning to the subject of modernisation, during the second wave of reform, the Government principally effected this transformation by shifting from general policy goals towards a wholesale redesigning of the healthcare service. The political impetus to this restructure was in effect a direct response to the changes in social and economic structures that had characterised the preceding decade of UK society. As Klein writes **“consumer politics were replacing producer politics”** (2006:188).

This reshaping endorsed an international neoliberal cultural perspective -a stance derived from neoliberal economic theory² that implements a paradigm where the language of markets³ dominate society’s social, cultural, and political discourses. One consequence of this paradigm is that it forms the basis upon which governments and corporations shift the concept of risk onto individuals in society, away from any notion of state responsibility (Hunter 2008, Crinson 2009). Ultimately, this type of market philosophy becomes imposed onto all aspects of an individual’s social relationships (Ong 2006, Brown 2008).

The third wave of NHS reform under New Labour (2008 to 2010) expanded upon the second with an increased commitment towards the private sector supplying services. The coalition government from 2010 greatly extended these NHS reform processes in a manner unprecedented in the history of the NHS. This drastic new approach to healthcare service policy was not introduced in either the Conservative nor Liberal Democrat party manifestos prior to their election. Moreover, whilst the proposed policy was much debated by both the public and associated healthcare professionals, it was scarcely questioned by the media (Hunter 2013). As such, it somewhat effortlessly culminated in the Health and Social Care Act 2012. This Act sets the current agenda of the NHS firmly as open to ‘market competition’, a process that almost certainly will lead ultimately to the privatisation of much of the service

² This theory describes Governments who base their political and economic agendas upon an ideological commitment towards the private sector role.

³ For example: ‘efficiency’ ‘consumer choice’ ‘individual autonomy’.

(Hunter 2013a).

The summative effect of the reform processes under New Labour, upon the professional balance of power in the NHS, was a shift from a centralised hierarchical model of healthcare, with hospital medical committees directed by the medical profession (Freeman 2008), towards a locally accountable consumer driven service. This reduced the overt power of the medical profession and thereby the profession's influence upon the NHS. Whilst transparency, greater accountability and the associated inextricable element of comparison is welcome as a general policy initiative, the methods were criticised widely as 'perhaps adopting tools that are too simplistic for purpose' (Klein 2006).

Arguably the goal of comparison is now the dominant factor governing healthcare provision at a national and intra-national level. UK health care policies are designed to be measureable on a quality, outcome and cost basis. Notwithstanding the criticisms of the statistical data (Bowker and Star 1999) incorporated into the mechanisms of measurement (Freeman 2008) the Organisation for Economic Co-operation and Development (OECD 2010) and the World Health Organisation (WHO 2010) both reflect and perpetuate this perspective, providing a 'globalised legitimacy' to this model of healthcare provision with the establishment of 'composite indicators' (OECD 2010a) for health. As a result, this emergent 'governance by comparison' culture is now highly significant for all professions who work within the NHS. Indeed, as chapter 2 demonstrates, IFP is governed by (historical) public service agreement targets and contemporary statistical comparison. The next section of this chapter will explore the statutory and chronological detail of the colossal program of investment and radical reform of the NHS during the noughties, through consideration of the Statutory Framework of the NHS.

1.2.3 The Statutory Framework of the NHS

The statutory framework of the NHS from 2000-2012 originated in 2000 when the Department of Health published *The NHS Plan* (DH 2000), an investment and reform strategy document that also established PSA targets for Health and Social Care services through associated documents (DH 2001a, DH 2001b, DH 2001c, DH 2001d, DH 2001e). *The NHS Plan* (DH 2000) was subsequently ratified by *The NHS Improvement Plan* (DH 2002), *Delivering the NHS Plan* (DH 2002a) and *Creating a Patient-Led NHS –Delivering the NHS Improvement Plan* (DH 2005). In essence, the plan focused upon creating an NHS that was patient centred with measurable, national standards of care (targets).

The NHS Plan (DH 2000) also stipulated regular inspection of all local health bodies by an independent inspectorate known as the Commission for Health Improvement (now the Care Quality Commission). The status of the National Institute for Clinical Excellence⁴ (NICE) as a primary source of practice guidance was confirmed within the policy document. *The NHS Plan* and associated documentation included incentives (financial and self-governing inducements) for trusts to perform well and a commitment to deal quickly with NHS trusts that were failing to deliver adequate services. Of note for the midwifery (and nursing) profession was first mention of government proposals to extend their roles (DH 2002a).

The third wave New Labour vision for the NHS is located in the report by Lord Darzi, *High quality care for all: NHS Next Stage Review Final Report* (DH 2008a). Within the preface Gordon Brown, the then Prime Minister, neatly summarised the evolution in the philosophy of the NHS over the past decade when he stated:

We need a more personalised NHS, responsive to each of us as individuals, focused on prevention... giving us real choices

⁴ Now the National Institute for Health and Care Excellence

over our care and our lives (DH 2008:2).

The concept of ‘world class commissioning’ also entered the policy arena at this point with emphasis upon transformation of the commissioning component of health services. It was designed to advance commissioning with a ‘long-term approach’ and ‘clear focus’ upon health improvement (DH 2008).

The ousting of New Labour by the new Conservative/Liberal-Democrat Alliance Government (the Coalition Government) in the May 2010 elections clearly signalled health policy to undergo further fundamental reform. A White Paper⁵ titled *Equity and Excellence: Liberating the NHS* (Secretary of State for Health 2010) extended radically the application of neoliberal principles to the operation of the NHS. A commitment to reduce a number of ‘unjustified targets’ present within the NHS under New Labour⁶ and to reduce the DH’s ‘NHS functions’ was also expressed (Cameron and Clegg 2010). The target culture in the NHS was diminished in favour of indicator assessments that incorporated measurement of planning, accountability and quality (DH 2011). The breastfeeding rates at 6-8 weeks remain a Key Performance Indicator (CF001) for health visitors to statistically collect.

To return to New Labour policy, the ratification of NICE within *The NHS Plan* effectively established this institution as a key functioning component of the statutory framework of the NHS. NICE is an independent government agency, established in 1999 as part of the NHS. In 2005, following the abolition of the Health Development Agency, NICE became responsible for public health. It kept the acronym NICE but became the National Institute for Health and Clinical Excellence. The contemporary remit of NICE is to produce NHS guidance upon three areas of health care: public health (promoting health and preventing ill health), use of innovative technologies

⁵ Published 12/07/2010

⁶ At 2010 there were 100 targets with over 260,000 annual, separate data returns to the DH.

(medicines, procedures, treatments) and clinical practice (for specific diseases and conditions). NICE endorses the promotion of breastfeeding in the UK but is yet to produce clinical guidance dedicated solely to the issue of evidence based breastfeeding promotion.

The ‘independence’ of NICE may perhaps be questioned given the contiguous position it occupies with respect to the NHS. Indeed the NHS described NICE as an **“agency controlled by the NHS”** (NHS 2009). Government Ministers also have the power to advise the NHS to ignore NICE guidelines through the use of Statutory Instrument 1999 No. 220; *The National Institute for Clinical Excellence (Establishment and Constitution) Order*. To date this right has not been exercised although various patient interest groups and pharmaceutical companies have attempted to challenge NICE decisions through the UK courts. These legal challenges resulted in ambiguous success in one instance only, with the appellant claiming partial victory and NICE counterclaiming that the court judgement merely clarified NICE’s role towards General Practitioners (Dyer 2007).

Prima facie a lack of ministerial interference is significant because it suggests that NICE’s ostensibly independent status translates faithfully into self-determining practice. In reality, it would perhaps appear that complex interplay more accurately describes the concept of independent status with regard to UK health policy. This view is supported by a recent example reported in the UK broadsheets and the British Medical Journal concerning a NICE ruling that newly developed biotechnology drugs were not cost effective for the treatment of Multiple Sclerosis (NICE 2002). In the face of stiff opposition from the pharmaceutical industry and patient groups, the DH established a huge trial through a ‘patient access scheme’ designed using NICE clinical study guidelines. It was to run over ten years, with two yearly price setting reviews that aimed to reduce drug prices if they were less effective than predicted. The trial was principally funded by the NHS with the DH and pharmaceutical industry funding the patient monitoring mechanisms.

The Independent newspaper reported the British Medical Journal's (BMJ) overall verdict on the trial with the following pronouncement.

The most expensive publicly funded drug trial in history is condemned today as a 'fiasco' which has wasted hundreds of millions of NHS cash and raised fresh concerns about the influence of the pharmaceutical industry (Laurance 2010).

On balance, there were clear arguments to both support and discredit the trial (Compston 2010, Ebers 2010, McCabe, Chilcott et al. 2010, Raftery 2010, Scolding 2010). However, of key concern and relevance for the issue of independent status, was the fact that it took until 2009 to report patient outcomes as 'most probably worse than the control group' (Boggild, Palace et al. 2009). Additionally, despite the evidently poor results, the report **"judged that it was premature to reduce prices"** (Raftery 2010:340). This is appreciably contrary to the original study remit.

It is highly significant that this report (Boggild, Palace et al. 2009) was produced after representations from a scientific advisory group whose panel members included: four pharmaceutical industry employees, two people from MS patient groups and neurologists treating the patient trial group. All these panel members had lobbied government for continued use of the MS drugs. Clearly, the balance of power in health policy generation is more complex than first consideration suggests, with multifaceted aspects of influence that require careful monitoring to ensure the goal of independent assessment is achieved. Conflict of interest is a straightforward concept, yet tardily applied to matters of government policy (Goldacre 2008). The issue of active lobbying of governments by powerful corporations or other vested interests such as NGOs extends from this principle too and is revisited below in the critique of political ideology.

To return specifically to the functioning of NICE, their guidance is produced after comprehensive review of relevant clinical research and

consideration of affordability (NICE, 2009). Pearson and Rawlins (2005: 2620) note that “...**not surprising for an organisation at the fulcrum of decisions...**” not all the attention that NICE and its guidance has received in the UK is favourable. However, the fact remains that NICE is unique as an institution fundamentally influencing a nation’s health care. It is admired globally, with governments in developed countries seeking to emulate the organisation in order to address the contemporary global challenges of improving quality, fostering innovation and ensuring value for money spent on health care (Pearson and Rawlins 2005).

The section above has outlined the contemporary legislation underpinning the structure of the contemporary NHS and listed Key health policy documents and related Acts of Parliament. The key points of relevance for this thesis are summarised below. The next section of this chapter will explore the concept of public health and policy.

Key Points: General Health Policy and System Provision

- Health (and social care) system policy dominates the political agendas driving health policy in the UK.
- The ‘target’ (comparison) and ‘quality’ (outcomes) cultures are significant features of present health system policy.
- Partisan politics no longer affect health and health system policy. An international, neoliberal economic philosophy forms the bedrock of such policy.
- Policy emphasis is upon ‘consumerism’ and ‘choice’ thereby shifting the notion of risk from the state onto individuals
- There is an inherent tension between decentralisation of healthcare services and government retention of control of services (through targets).
- Powerful bodies also exert influence upon UK health policy.

1.3 Public Health Policy

The term 'public health' is often used to describe generally the health of a community and the analysis of how to improve that health through education and practice (ASPH 2010). Yet as Szreter notes it also historically encompasses associations with social and scientific movements (Szreter 2002b). He also comments that public health is an evolving process, inextricably linked to the state that measures aspects of public health and the related disciplines of medicine, demography and epidemiology (Szreter 2002b).

Hunter et al (2010) highlight the longstanding difficulties surrounding a universal definition of public health. They consider that international initiatives derived from WHO publications during the 1970/80s have traditionally dominated concepts of public health. These include: *The Alma Ata Declaration* (WHO 1978), *The Ottawa Charter* (WHO 1986) and the *Health for all Strategy* (WHO 1981). Notably, significant components of these initiatives have resurfaced recently in another WHO publication by the Commission on Social Determinants of Health, *Closing the gap in a generation: Health equity through action on the social determinants of health* (WHO 2008). The reappearance of the initiatives highlights the general lack of progress made concerning public health internationally and not just in the UK.

'Public health' is additionally difficult to define because of the lack of boundaries attached to the concept. In part, these difficulties stem from the broad range of factors impacting upon notions of public health including social, political, environmental and economic issues. Any firm definition is further compounded by the fact that all these influencing factors are themselves subject to tangible fluctuations. Also, 'public health' is a concept that extends into the spheres of 'public health systems' (designed to deliver public health care/initiatives) (Chapman 2004) and to 'public health professionals' who undertake public health roles within such systems. Further complications concerning a

standard definition is the fact that the context of public health changes in conjunction with society (Hunter, Marks et al. 2010).

The problem surrounding a resolved definition of public health demonstrates that this subject matter is extremely complex. The consequence of this complexity is uncertainty in approach towards public health policy, yet optimising breastfeeding rates is a clear public health policy goal and given the complexity of the subject matter, the origins of that goal merit exploration. Understanding of how public health policy arises may be facilitated through an analysis of the processes engaged in by government to generate policy.

Regarding the development of government policy generally, whilst politicians are often elected and proceed to dictate policy (and consider it a simple process to implement such policy that merely requires them to ‘pull the levers of power’), it is important to appreciate that the decision making and distribution of power in contemporary government policy is not easy to establish. Whereas Parliament retains control over legislation and budgets, government departments (including civil servants), The Prime Minister, Chancellor of the Exchequer and increasingly outside interests such as consumer pressure groups, the commercial sector and special advisors, all influence actual policy (Buse, Mays et al. 2005, Klein 2006, Ham 2009, Pollock, Godden et al. 2009).

In practice, civil servants from Government departments share power with their respective Government Ministers. The extent to which they do so is dependent upon the relationship between them. Departmentalism facilitates the establishment of policy communities and allows participation of client pressure groups (Ham 1999). During the noughties, the DH was the central Government department concerned with generation of health policy, containing six chief professional officers: medical, nursing, dental, health professions, pharmaceutical and scientific. However, during the second wave of NHS reform,

managers were elevated to senior roles at the DH. Special advisors (notably McKinsey & Company) who were orientated towards a managerial ideological perspective (Hunter 2013a) were accorded the status of the Government's attention (Ham 2009). This established previously unknown tensions at the DH with allegations that **“the executive faces in two directions”** with diminishing civil service representation at the top (Greer and Jarman 2007:31). These events may partially explain the common perception that ‘managerialism’ has encroached upon the territory of professionals, possibly distorting certain important and distinctive characteristics about health care professions (Hunter 2008a).

Public health and associated policy is one of the principal functions of the DH. New Labour viewed such policy with sufficient seriousness to appoint the first UK Minister for Public Health in 1997 (DH 2010a). Public health measures are now unequivocally considered to be a key contributing factor towards increasing the health of the UK's population. This is in marked contrast to the 20th century when key resources were predominantly focused upon the development of hospitals and medical services, as developments in the field of medicine advanced diagnoses and treatment of disease (Ham 2009). Hence the hitherto traditional dominance of the medical model approach to public health (Hunter, Marks et al. 2010).

The concepts of public health and disease prevention were revived by government, following publication of lucid historical and socio-political analyses by Lalonde (1974), Illich (1976) and McKeown (1976). The UK government responded to these publications by devising a public health policy strategy, commencing with the publication of the consultative document *Prevention and Health: Everybody's Business* (DHSS 1976) and culminating to date with the white paper *Healthy Lives, Healthy People: Our strategy for public health in England* (Cm 7985 2010).

The Public health programme has always focused upon identification of 'risk factors' that were detrimental to health and in the 1970s smoking was the dominant public health issue. Today it is the issue of obesity and the strongly associated diseases of cancer, diabetes and cardiovascular disorders (DH 2010) that dominate public health discourse. Obesity is linked to contemporary IFP (see chapter 2) and statistics demonstrate there is much evidence to support this public health concern. The rapid rise of obesity in the past decade suggests that in 2008, 24% of men and 25% of women (aged 16 or over) in England were classified as obese (BMI 30kg/m² or over) (NHS 2010). The DH views on obesity remain unchanged from those under New Labour:

Obesity is one of the biggest health challenges we face. The Government is committed to taking action to prevent more serious illness and much bigger costs to the health service and the country in years to come (DH 2010).

Health issues aside, of primary concern for the government is the actual and potential cost of the obesity epidemic with the annual cost to the NHS of overweight and obesity estimated at £2 billion in 2001 with the subsequent suggested impact on employment **“as much as £10 billion”** (Butland, Jebb et al. 2007:39). Moreover, by 2050 the estimated cost of obesity for the NHS is £9.7 billion and the wider cost to society suggested, at today's prices, as being £49.9 billion (Butland, Jebb et al. 2007).

A concept that has advanced in conjunction with the discourses on public health is the notion of inequalities in health. These were demonstrated to persist thirty years ago between differing socioeconomic groups (Black 1980) and are strongly associated with personal economic circumstances. With regard to general health policy, even before the first wave of NHS reform commenced, the issue of social inequality was at the forefront of the minds behind New Labour. Social inequality is indisputably associated with inequalities in health and

poverty (Black 1980, Marmot, Atkinson et al. 2010) and the government was acutely aware that in 2000 poverty and social inequality affected 25% of the UK's children (Szreter 2002). Addressing health inequality was (DH 1999a) and remains, a top priority for the UK Government (NICE 2012b, Buck and Gregory 2013) although there is a suggestion that this issue may recently be diminishing in priority for the Coalition Government (Scally 2013).

The first half of this chapter has provided an overview of the political ideology impacting upon health policy generally under the 'New Labour' Government. Present political health agendas towards health policy and health care system provision have been outlined with particular consideration of the issues relating to obesity and inequalities in health. The key points relating to public health are summarised below. The topics are pertinent to IFP as chapter 2 illustrates. A summary of the political critiques of the political ideology driving New Labour's approach to general health policy and health care systems development follows -these underpin the foundation of current IFP.

Key Points: Public Health

- Public health is very difficult to define and is a significantly complex subject due to social, political, environmental and economic impacting factors.
- Optimising breastfeeding rates is an ongoing part of public health policy.
- Developing public health policy is a key function of the DH which has experienced erosion of departmentalism and increased managerialism.
- Public health policy is influenced by powerful lobbying bodies.
- Public health is linked to social and health inequality.
- Public health policy focus changes with society. Present tactics relate to attempts to improve the health of children.
- Rising obesity levels are of huge concern for UK Government, in particular the potential cost of the health implications of obesity.

1.4 Critique of Political Ideology and Health Policy

Public policy is an extraordinarily diverse and complicated aspect of government. It is evident from the above that health and health systems policy has been fundamentally overhauled since 1997. One perception of this phase in the NHS's recent history is effectively encapsulated by Professor Michael Hill when he states:

... as far as the National Health Service is concerned very many people have become bewildered by the pace of change and increasingly doubt whether the changes will have any positive benefit for them (Hill in Hunter 2008:a p.x.).

Hill considers that the Tony Blair's attempt to 'save and modernise' the NHS has resulted in health policy **"lacking in any effort to engineer change in a slow and methodical way"** (Hill in Hunter 2008:a: x) suggesting that the dominant, supposedly progressive political view is **"to support relentless, often almost mindless, change driven by an ideological attack on state provision"** (Hill in Hunter 2008:a p.x.). These views are echoed by an eminent sociologist, Professor Richard Sennett, who suggests the noughties constituted a period when the government became an 'over-consumer' of policy, falling victim to its own consumerist approach to new management ideas that were simply thrown into the NHS without proper assessment (Sennett 2006). In this way, New Labour became addicted to 'fad surfing' (Shapiro 1998) **"which was lucrative for consultancies but disastrous for NHS organisations"** (Hunter 2011:343).

Political commentators acknowledge the problems facing all health systems including the NHS; as well as the pressing requirement for responses to them. Nevertheless, there is a collective recognition that the historical professional dominance (mostly by the medical profession) of healthcare services has been replaced by the alternative dominance of government policy. Criticisms of the 'dominant policy' approach can be summarised by a practically undisputed perception that classical economic based theory now pervades all thought relating to health care systems policy. This has been described as the 'cult of neo-liberalism' (Hunter 2009) and utterly dominates current direction for NHS provision under the Health and Social Care Act 2012.

The commencement of the second wave of NHS reform demonstrates 'public choice theory' has intruded into, and remains embedded within, political and administrative behaviour regarding the NHS. This has occurred with, according to Hunter (2009) **"little systematic thinking...nor effective testing of policy impact"**. As Hill states:

Hyperactive politics, not rational decision making, has driven

the system. Market models, or indeed rampant commercialism, without consideration of whether these deliver the ‘choice’ they are believed to promise, have dominated so-called ‘reform’ ” (Hill in Hunter:2008a:xi).

Whilst it is not within the remit of this thesis to explore critiques of neo liberal economic theory (for a concise account see Buse, Mays et al. 2005), it is important to appreciate that the neoliberal economic perspective is internationally dominant, despite the unique nature of the NHS. This had resulted in a common, yet unsubstantiated perception that private sector practice is superior as a model compared to **“allegedly underperforming, low-quality public services, and weak public sector management”** (Hunter 2009:10). This economic ideological paradigm directly influences contemporary UK health policy and healthcare system management.

This is additionally significant because the overarching context of capitalism confers additional powerful influences upon the UK Government by powerful corporations (q.v. NICE above). The private sector is a ‘powerful actor’ with regard to development of health policy and this industry is characterised by a market orientation that aligns it towards the principle goal of obtaining profit (Harrison and McDonald 2008). Even NGOs and charities -not for profit organisations traditionally viewed as supportively lobbying government on public health issues (Hunter, Marks et al. 2010) may be established to support commercial interests or trade federations. This concern also applies to a broad range of industry funded ‘think tanks’ or scientific organisations that produce reports on public health issues (Buse, Mays et al. 2005).

To return to New Labour’s NHS reforms, political commentators are broadly agreed that the general verdict upon the first wave of NHS reform was positive. As Ham notes (2009), four credible reports by ‘independent’ think-tanks and statutory agencies were published in 2003 offering an affirmative and even perspective on the Government’s

efforts at NHS reform. The Nuffield Trust's report (Leatherman and Sutherland 2003), as an independent and comprehensive observer, was especially valuable. It was largely supported by the views within the Commission for Health Improvement (CHI 2003), Audit Commission (AC 2003) and The Kings Fund (Kings Fund 2005).

However, five years later (Ham 2009) the verdict on the second wave of NHS reform was more cautious. The Kings Fund reported positively (Thorlby and Maybin 2007) noting increased staff and infrastructure, reduced waiting times for hospital and primary care. This was balanced against healthcare associated infection rising and management deficits in one third of sectors. In conclusion, structural changes to the NHS had conferred little benefits to overall operation. In addition, the Kings fund review of NHS performance and funding (Wanless 2007) highlighted that the high cost of new GP and consultant contracts resulted in no commensurate increase in NHS productivity. These calculations were supported by the Office for National Statistics (ONS 2008). The King's Fund review also discussed public health as an issue where the government was not succeeding in certain areas, especially in relation to rising inequalities and obesity. The Wanless (2007) review findings were supported by the Nuffield Trust (Leatherman and Sutherland 2003) but some findings have been vehemently contested by certain members of the medical profession (Barer 2010).

Reasons suggested by these reports for the lack of NHS productivity were: ideological rifts existing between central control 'retainers' and supporters of NHS devolution, structural changes that lead to low staff morale, new policies being interpreted at grass roots level as 'flavour of the month', the existence of co-ordination of care/duplication of effort/territorialism (these are recurrent problems for policy reformers), that public policy conceptualisation standards were higher than implementation competence and finally a lack of data existing to assist in quality improvement. The report authors suggested creation of an English National Quality Program for the purposes of refining the

reform agenda and coherently integrating the approach. These reports are significant because they highlight issues indirectly affecting the implementation of IFP.

The Audit Commission and Healthcare Commission (AC 2008) also reported on the progress of government reforms with respect to: patient choice, payment by results, NHS foundation trusts, greater NHS use of the private sector, and development of commissioning. Like other bodies, it acknowledged some improvement in NHS performance through reduced waiting times, but thought these arose as a result of increased funding and target setting as opposed to the market-orientated reforms introduced by Blair. The Audit Commission found that ‘patient choice’ had no demonstrable influence, foundation trusts were not conspicuously different and commissioning remained a weak link in the reform program. Acknowledging the ‘early days’ component of efficacious assessment, the report concluded there were barriers to progress mainly, the need to engage frontline staff more in the **“process of change”** (Ham 2009:74) an issue that was addressed by Lord Darzi in the Next Stage Review (Darzi 2008).

All these reform processes generated under New Labour were greatly extrapolated by the Coalition Government in the latest NHS reform initiative (Cm 7881 2010) that was enacted on the 27th March 2012 in the Health and Social Care Act 2012 (HSCA 2012). It is unclear what impact these reforms will have on the NHS yet section 75 of the HSCA 2012 *Requirements as to procurement, patient choice and competition* firmly enshrines the privatisation agenda for the future NHS, despite this radical reform being undertaken in the absence of public consultation. Privatised health services in the USA have been subjected to much analyses over the years and critiques of that model consistently suggest it is less efficacious than the ideology presumes (Woolhandler and Himmelstein 2007, Hunter 2013a).

The analysis above raises important concerns for frontline professions

in the NHS. It is regrettable that there lacks much contemporary critique of government healthcare policy amongst the midwifery and nursing professions. The medical profession are more productive in this domain with frequent comment and analysis within the British Medical Journal and by the British Medical Association (see also Pollock 2005, Talbot-Smith and Pollock 2006). Some political commentators have suggested that the lack of critique from the medical profession is attributable to the claim that the government effectively 'bought off the medical profession' when doctors (especially GPs) were awarded significant pay rises out of the budget that increased NHS investment in 2002 (Baggott 2004, Pollock 2005, Klein 2006, Hunter 2009). The medical profession has traditionally always attempted to exert professional dominance with regard to health policy, motivated by protectionism and evidenced by a history of collective and co-ordinated self-interest promoting activity, apparent since the inception of the NHS (Hunter 2009).

Lack of political critique by Nurses and Midwives may be attributed to the complexity of issues relating to the subject of health policy and a perceived distinction between political science and healthcare professions. Nonetheless, healthcare practitioners are always in a potential position to contribute to health policy making (Hunter 2009) and political awareness is crucial for clinical professionals. These professions are at the fore-front of healthcare services with specific, considerable expertise and associated comprehension of issues that could significantly inform government health policy. Moreover, every health policy or strategy implemented by any government directly affects the population receiving health care services and by extension it affects the professionals providing such services (Antrobus 2004).

Another potential explanation for the diminishing influence of the medical profession upon government health and health system policy may also be attributed to neoliberalism. As previously mentioned, New Labour drastically extended policy changes concerning health care

services, commenced initially under Conservative rule. A tandem process of ‘quiet reform’ towards the medical civil service effectively reduced the Chief Medical Officer’s power. This reform was achieved principally through the application of similar ‘new public management reform methods’ adopted by New Labour for NHS reform. In keeping with Tony Blair’s penchant for the use of ‘specialist’ temporary advisers or ‘tsars’, an approach was adopted that dismantled medical civil service hierarchies and replaced them with an influx of managerial influences, sourced from the NHS (Hunter 2008, Ham 2009).

This strategy effectively usurped the traditional power of the Department of Health’s Standing Medical Advisory Committee (SMAC) and the Standing Nursing and Midwifery Advisory Committee (SNMAC). The SMAC and SNMAC were statutory advisory Non-Departmental Public Bodies (NDPB) established in 1949 by legislation (as one of nine separate bodies) to advise the Minister (the then Central Health Services Committee) on matters relating to services provided under the NHS Act 1946. They were abolished (SI, 2005:1100)⁷ in May 2005 following an ‘independent review’ of their role in Whitehall (DH 2010b). The implications of abolition are that the dismantling of traditional routes to inform the government has the potential to leave an ‘influence vacuum’. This may destabilise the somewhat tenuous position that nursing and midwifery professions occupy with regard to professional status (Davies 2004) and their related influence upon government health policy. This consideration is especially important in the UK due to the existence and present structure of the NHS. The vast majority of healthcare practitioners are NHS employees. Accordingly, their clinical practice is profoundly influenced by government health policy and healthcare systems decisions. A greater awareness of contemporary political critiques might lead some clinical practitioners to agree with Sheard who writes:

The government needs to acknowledge that some of its tasks,

⁷ The National Health Service (Standing Advisory Committees) Amendment Order 2005. Number 1100.

such as protecting the public's health, do not easily fit into fashionable Public Service Agreements or the ethos of New Public Management (Sheard 2008:2).

To return to the introduction to this chapter and the concept that health policy in the UK needs to shift focus away from costly dependence upon healthcare services, towards that of health promotion, another consideration suggests that the underlying issue may not solely be fiscal. As Hunter acknowledges, of principal concern is effectiveness, not just the cost of acute service provision (Hunter 2008a). He cites Rose (1989) when he states:

The so called diseases of comfort –the primary cause of death in the 21st century and the next -demand a different approach (Hunter 2008b:217).

He asserts that current methods employed to tackle such diseases are unlikely to be successful because they are rooted in the medical model approach and consumerist/free market principles.

Hunter's call for a 'new paradigm' suggests focussing upon creating the right conditions for health and holistically conceiving of health. He proposes building upon positive aspects of health, identifying health assets as opposed to deficits and 'public-health leaders' working in conjunction with people to identify **"tipping points for change"** (2008b:217). He points to the fact that much evidence exists to suggest that people generally understand about diseases of comfort, yet poor health is rising and the health gap between social groups is widening. He considers that too much emphasis is placed upon changing individuals' behaviour and on mechanisms to repair damage once it has occurred, in contrast to policy that prevents it in the first place. The end result, he describes, is a **"weak and inadequate"** government response to society's complex public-policy requirements (2008b:217).

Key Points: Political Critiques of Health Policy

- Pressing need for change is acknowledged but the intrusion of neoliberalism and public choice theory into all political and administrative behaviour imposes an unevaluated healthcare system model.
- The influence of new public management reform methods has led to the erosion of statutory advisory non-departmental bodies.
- The radical overhaul of health policy and investment in healthcare systems fell short of reform expectations but increased funding and the target culture are effective at achieving prescriptive results.
- Reform aspiration may have been frustrated due to problems surrounding the implementation of new policy agendas at grass roots level.
- The dominance of neoliberalism confers weight upon the influence of corporate bodies upon health policy generation by government.
- There exists disparity between the concept and execution of choice at systems level functioning.
- Lack of health care professional critique of related government policy is potentially detrimental to the quality of policy generation.
- To date, health policy has been ineffective at reducing social inequality and lifestyle diseases.

This thesis explores current IFP in the UK. In order to inform the debate driving government UK health policy this chapter has provided an overview of: general health policy and system provision, public health

policy and political critiques of health policy. The key points in each section of this chapter demonstrate that, as the chapter introduction suggested, a broader set of political and organisational processes can indeed be identified. These processes drive government agendas and form the macro context of present IFP.

Fundamentally, New Labour and Coalition Governments policy towards health and health care systems is characterised by a political ideology that has moved “... **away from social democratic corporatism towards a greater emphasis upon free market economies**” (Bartley et al 1998:1). This is in contrast to the NHS being conceived within a framework of public welfare creating the nationalisation of health services that were perceived to be better managed by government than private enterprise. To some extent, history may be at risk of repeating itself and the consequences of this are presently unknown. In summary:

New Labour demonstrated political commitment towards improving public health and health inequalities through policy agendas. This was achieved by:

- Appointing the first UK Minister for Public Health
- Developing specific policy to address public health
- Changing the structure of the NHS to facilitate the policy agenda
- Ideologically subscribing to neoliberalism and the concepts of markets and choice in the provision of health and healthcare services
- These stances have been largely maintained by the present coalition government.

The next chapter will commence with an overview of maternity services policy and IFP. It will explore this policy, and the role of the midwife, in the context of public health promotion. The impact of current IFP upon women and midwives will then be considered. The chapter will conclude with a sociological analysis of public health.

Chapter 2: Maternity Services and Midwifery

2.1 Introduction

The preceding chapter explored the context of UK health policy from a political perspective, concluding that an internationally dominant economic structure has an overarching effect upon UK health policy and healthcare systems (the NHS). This analysis was important to appreciate that the UK's political orientation and attendant homogenous economic structure forms the bedrock of present UK society. In essence, the chapter concluded that it is the 'macro' political influence that has set the neoliberal idioms and culture that permeates contemporary UK (and similarly 'economically developed') societies. These idioms include the notions of 'risk', 'choice' and 'consumerism' and these concepts have effectively shifted the notion of state responsibility for health onto individuals (Crimson 2009).

However, this neoliberal representation is at odds with the UK Government's dualistic aim of successfully implementing public health policy, which has similarly developed alongside health systems policy. Public health initiatives formed an intrinsic component of health systems policy, as evidenced by the existence of public health orientated public service agreements (PSAs) or targets under New Labour and the public health focus of the reorganised Department of Health under the Coalition (DH 2013). During the course of the data collection for this thesis, increasing breastfeeding rates was a requirement of PSA 12 (2008-2011). It remains a government public health policy aim and has been extended in terms of statistical collection under the Public Health Outcomes Framework⁸ with attendant Performance Indicator status and remains located in multiple policy streams (DH 2009).

⁸ <http://www.phoutcomes.info/>

This thesis seeks to contribute to an understanding of the outcomes and consequences of the Government's pro-breastfeeding agenda. Having evaluated the origin of government health policy in chapter one, this chapter will commence with an overview of UK current maternity services and IFP in the context of health promotion. It will then appraise the role of the midwife with regard to public health promotion and IFP, before exploring the effect of this policy from a qualitative perspective, upon women and midwives' experiences of infant feeding. The sociological perspectives of 'health' and 'risks' will also be summarised in this chapter to contribute to the debate.

2.2 An Outline of Maternity Policy

Maternity policy and policies for children have only relatively recently sustained attention by policy makers (Hunter 2008, Ham 2009). In the UK today, maternity services policy is linked to policy relating to services for children, because of government response to a key recommendation within Lord Laming's formal report of the inquiry into the death of Victoria Climbié (Laming 2003). This recommendation was for the government to provide a distinct ministerial department for children and families. The government acted upon this report initially with the simultaneous publication of a Green Paper *Every Child Matters* (Cm 5860 2003), which subsequently led to the separation of children's services from adult social care. Whilst the essential remit of the Green paper was to expand and fortify preventative services for children, it marked the origin of a focus towards the 'well-being' of children that was unprecedented. The Government simultaneously launched a website⁹ to co-ordinate the multifaceted aspects of their policy towards children, within which maternity service policy became subsumed.

⁹ <http://www.dcsf.gov.uk/everychildmatters>

The Government rapidly followed on from the Green paper, with a publication by the Department for Education and Skills¹⁰ entitled *Every Child Matters: Change for Children* (DfES 2004). This was a broad policy agenda document that incorporated explanation of the concurrent, associated legislative foundation to the reform, to be found within the Children Act 2004. *Every Child Matters: Change for Children* was radical new government policy, conceptually ambitious and including an outline of statutory duties with clarification of accountabilities for issues affecting young people in the UK up to the age of 19. The document was signed by sixteen associated Ministers and Secretaries of State and proposed a cross government departmental approach with the aim of enabling children to **“fulfil their full potential”** (DfES 2004:2).

Every Child Matters: Change for Children established the National Service Framework (NSF) for Children, Young People and Maternity Services. The NSF for children is essentially a ten year programme with the purpose of achieving improvement in the ‘health and well-being’ of children and young people by setting standards for any organisation that provides services to children or young people. The Government’s primary policy goal is identified in the first standard which seeks to promote the health and ‘well-being’ in all children **“through a co-ordinated programme of action, including prevention”** (DfES 2004:8). The NSF incorporates a series of policy documents, published since 2004, which are cross referenced with *The Children’s Plan* (DCSF 2007) –another key policy subsequently developed in 2007.

The NSF for Children, Young People and Maternity Services included 11 standards for improving services for children, young people and maternity services and set a ten year plan for policy implementation. Maternity services policy is specifically addressed by standard 11 of the NSF and consists of a best practice guidance document, *Maternity Services, National Service Framework for Children, Young People and*

¹⁰ A then subsidiary of the Department of Health between 2001 and 2007 now subsumed since 2010 by the Coalition’s Department for Education.

Maternity Services (DH 2004). The standard aimed for stipulates that maternity services for women are accessible, supportive, of high quality and **“designed around their individual needs and those of their babies”** (DH 2004a:4). The ‘vision’ of future services includes an emphasis upon a non-medicalised model of care, and of meeting **“the needs of vulnerable and disadvantaged women”** (DH 2004a:4). Of particular relevance to this thesis is the strategic vision that directs:

Midwifery and obstetric care being based on providing good clinical and psychological outcomes for the woman and baby, while putting equal emphasis on helping new parents prepare for parenthood (DH 2004a:4).

In 2006 the views of healthcare service provision were sought from public following an unprecedented consultation process. The subsequent White Paper, *Our health, our care, our say: a new direction for community services* served as a direct response. This set out Government commitment to a **“new era where the service is designed around the patient”** (DH 2006:10). This policy was significant because it implemented many of the public’s suggestions relating to health service provision. In doing so, it further supported the culture of choice and autonomy for users of health services in the UK. It also reiterated the rising obesity issue as a prime public health objective, and acknowledged **“health inequalities remain much too stark – across social class and income groups”** (DH 2006:10). Notably, it linked the emphasis upon health promotion as a means to **“close the health gap”** (DH 2006:10). In relation to maternity services, the policy restated previous policy aims (DH 1993) promoting an ‘individualised’ approach to care to enable women to retain ‘control’ throughout their:

...pregnancy, birth and post-birth. It will mean midwives ensuring that women have all the information they need about this life event. This will include information about the choices available (DH 2006c:97).

To strategically implement the Every Child Matters objectives a crucial component of government policy was the establishment of Sure Start Children's Centres (SSCCs). The remit of SSCCs is the provision of integrated support services, joined up through partnership working, between statutory and voluntary agencies with the overarching aim of:- improving the health of children and families, reducing crime rates, child poverty and facilitating education/work opportunities (DCSF 2010). SSCCs serve the most disadvantaged areas of the UK, linking child-minder networks, Jobcentre Plus, primary care trusts, local authorities, education providers, social services, and community/voluntary agencies who **“work together to deliver seamless holistic services in partnership”** (DCSF 2010). They are an essential tool for the health promotion agenda, providing the forum for delivery of services. This agenda is set out in *Choosing Health: Making Healthy Choices Easier* (DH 2004a). In relation to maternity services, *Choosing Health* highlights the **“important health promotion role”** (2004b:52) that midwives will undertake in the provision of **“good”** (*ibid.*) maternity services, much of which will be conducted through the SSCCs. This role includes:

...helping pregnant women to stop smoking, improving nutrition and rates of breastfeeding, promoting mental health and building social support (2004b:52).

Choosing Health and *Our Health, Our care, Our say* provided the background for maternity services policy, which was subsequently addressed in the document *Maternity Matters: Choice, Access and Continuity of Care in a Safe Service* by the Department of Health (DH 2007). This document set out commitments to increase choices for women in the ante, intra and postnatal care stages of their maternity care, with a deadline of implementation of December 2009. *Maternity Matters* outlined a national framework for maternity services,

highlighting how commissioners, providers and maternity professionals could use the health reform agenda to shape provision and thereby meet the needs of women and their families. An NHS National Workforce Planning resource (NWP 2007) was concurrently published as a service provider's tool for workforce planning when implementing the *Maternity Matters* agenda. The NWP resource office also co-ordinated NHS Trust's statistical data. This enabled compliance with the statutory stipulations of *Maternity Matters* policy to be monitored by the commissioners of services. Lord Darzi's review of the NHS *High Quality Care for All: NHS Next Stage Review* (DH 2008) cemented the consumer focused philosophy pervading contemporary maternity services policy. Contemporary statistics relating to service provision and activity are published by NHS England and the Department of Health.

There have been two key Government evaluations of recent maternity policy in the past decade. *Children's Health, Our Future*, concluded there was much to be done to meet the ten year target (Shribman 2007). Acknowledging this, and the need for concerted, connected action to meet the child health and maternity services targets in PSAs for the period 2008-2011, the Government demerged the Department for Education and Skills in 2007 and immediately established the Department for Children, Schools and Families (DCSF). At the same time, the Department of Health established a Child Health and Wellbeing board to oversee the agreement delivery (Ham 2009). Since the general election in May 2010, the DCSF became the Department for Education and maternity service provision came under the revised *Healthy Child* program (DH 2009), an update to the National Service Framework for Children Young People and Maternity scheduled to end in 2014.

Maternity services were also comprehensively reviewed in 2007 by the Healthcare Commission in 2008 (now the CQC) and reported upon in *Towards better births: A review of maternity services in England* (HC 2008). Concordant with the philosophy of the NHS Plan, the review is

heavily focused upon what women want from their maternity services (DH 2005a). It incorporated information from an unprecedented 27,000 surveys of women, across all NHS trusts. This review was important because it was first time that the entire maternity service from first antenatal appointment to last postnatal visit was appraised. It led to the Healthcare Commission publishing 'scores' for every maternity unit in the UK. Of significance for this thesis was the finding that **“Women experienced poor communication, care and support after their babies were born”** (HC 2008:5). Additionally, was the recommendation that trusts monitor care pathways and **“ensure compliance with”** (HC 2008:8) NICE guidance.

The most recent maternity survey was conducted in 2013 by the CQC and was undertaken in the same manner as the Healthcare Commission 2010 survey reported above. The survey in relation to infant feeding is incorporated into the thesis discussion located in chapter 6. In general terms, the survey suggested that communication and emotional care had improved in maternity services since 2010. However, postnatal services remained poor and some women reported that they lacked the information to make informed choices about key aspects of their care (CQC 2013).

In summary, what the above analysis demonstrates, is that contemporary maternity policy is clearly modelled upon the government policy described in chapter one. Maternity policy is firmly established in a 'quasi consumer orientated and feedback driven model', with distinct government agendas providing the overall policy framework. This framework is also at the nexus of a number of different policy directives. The analysis additionally reveals that contemporary providers of maternity services are now required to 'evidence' their compliance with government policy, through statistical data collection methods. These government policy agendas also contain a strong public health agenda, which is particularly focussed upon reducing obesity as a priority. Public health initiatives are also perceived as an opportunity to reduce

the persistent inequalities in the population's health and midwives are key agents in the health promotion role. The efficacy of health promotion to reduce inequalities has been explored (see 1.3) and deemed to be of limited value given that the issue of poverty confers much more influence upon the choices people make to lead healthy lives. Nevertheless, the central vision of maternity services policy includes the concepts of: promoting dignity and choice, convenience and flexibility for the women and families accessing maternity services.

2.3 Infant Feeding Policy: Laying the Foundations for Public Health?

Infant Feeding Policy has developed alongside maternity service policy and may be summarised as follows. The UK Government views optimising breastfeeding rates in the UK as a method to:- reduce inequalities in health, reduce obesity in children and to promote the health of women and children. This is underpinned by the seemingly undisputed health benefits that breastfeeding confers over formula feeding infants (DH 2007a). However, this is additionally attractive to the Government owing to the estimated long-term financial benefits that increasing breastfeeding duration rates would bestow, through reduced costs to healthcare services (NICE 2006b).

Hence, a series of policy documents endorsing the pro-breastfeeding agenda coalesced with publication of *Commissioning local breastfeeding support services* (DH/DCSF 2009). This document consolidated previous guidance on infant feeding from *Healthy Lives, Brighter Futures – the strategy for children and young people's health* (DH 2009a). The *Healthy Child Programme: Pregnancy and the first five years of life* is also a key policy document relating to IFP (DH 2009). *Commissioning local breastfeeding support services* stated:

Prevalence of breastfeeding at 6–8 weeks is a key indicator of

child health and wellbeing and is included in PSA 12. The Government aims to increase breastfeeding rates so that they are as high as possible (DH 2009:5).

PSA 12, or Public Service Agreement 2008-2011 (HMT 2008), set a stipulation to increase breastfeeding rates in infants that are 6-8 weeks old (Indicator 1). As part of the delivery strategy for PSA 12, the government required GPs, Health Visitors, Midwives and Children's Centres to:

Actively promote breastfeeding to mothers and fathers, particularly in the antenatal period and influence decision making (HMT 2008 p.17).

Both PSA 12 and *Commissioning local breastfeeding support services* encouraged maternity units to promote breastfeeding by adopting UNICEF's Baby-Friendly Hospital Initiative' (the BFI).

2.3.1 The Baby Friendly Initiative

The BFI is a worldwide WHO/UNICEF initiative¹¹, first introduced in 1992, that is designed to improve support for breastfeeding during maternity care. It aims to achieve this goal methodologically through the utilisation of the evidence contained with the WHO 'scientific review' policy document, the *Evidence for the Ten Steps to Successful Breastfeeding* (WHO 1998). In practice the BFI is an evolving initiative with contemporary policy designed to work with health care systems to provide evidence based guidelines that promote breastfeeding. The benefits of breastfeeding are regularly reviewed (WHO 2007) and a fundamental tenet of the BFI is support for the WHO's adoption of *The International Code of Marketing of Breast-milk Substitutes, a World Health Assembly Resolution* (WHO 1981a). This code was developed

¹¹ The remit of UNICEF's BFI may be viewed at www.babyfriendly.org.uk .

primarily as a response to the inappropriate marketing of infant-formula in developing countries, which was resulting in infant deaths from a lack of sanitised facilities to prepare infant feeds. It advocates **“that babies be breastfed”** (WHO 2008a :2) and it prohibits the commercial marketing of infant-formula, feeding bottles and teats. The contemporary BFI is a costly (In excess of £8000 as at 2010) six-stages accreditation process for UK hospitals and community services (UNICEF BFHI UK 2010) that encompasses the education of key staff and the standards for the communal and hospital environments of maternity services.

The BFI is valued largely because of a large (over 17, 000 women & infants) cluster randomised control trial (RCT) conducted during 2001 in Belarus (the PROBIT trial) that was designed to explore the effects of breastfeeding promotion upon breastfeeding duration rates and degree (exclusivity) (Kramer, Chalmers et al. 2001). These findings were subsequently supported by smaller studies that are regularly cited as support for the BFI initiative (Broadfoot, Britten et al. 2005, Bartington, Griffiths et al. 2006).

However, whilst Broadfoot, Britten et al (2005) was a large study in Scotland, conducted between 1995 and 2002 upon the feeding practices of half a million infants, it was an observational study that linked a hospital’s BFI status to breastfeeding rates. The study concludes that hospital BFI accreditation raised breastfeeding rates at seven days postnatal from 41% to 52%, whilst hospitals lacking accreditation saw rises in rates from 39% to 47%. Bartington, Griffiths et al. (2006) was similarly of observational design, but conducted in England. It analysed **“maternally reported breastfeeding initiation and prevalence of any breastfeeding at 1 month for 17 359 singleton infants”** (2006:1178). The rates were correlated with BFI maternity unit status and concluded that women were more likely to initiate breastfeeding, but were not more likely to breastfeed at 1 month, if maternity units were BFI accredited. These two studies demonstrate the complexity of assessing

what interventions are required to demonstrably affect breastfeeding initiation and duration rates.

To return to PROBIT, because the data from this study has the most credible scientific value, this study also explored the relationship between breastfeeding and the risk of: respiratory tract infection, gastrointestinal tract infection and atopic eczema in the first year of life. It concluded that breastfeeding intervention packages modelled upon the BFI significantly increased the duration and degree of breastfeeding. It also found that whilst breastfeeding had no effect upon respiratory tract infection rates, it did decrease the risk of atopic eczema and gastrointestinal infections in the first year of life.

The PROBIT study is a classic example supporting the risk culture hypothesis discussed in chapter one. It provided the data (Kramer, Chalmers et al. 2001 p.413) for the **“twice as likely to have one or more gastrointestinal infections, or eczema in the first year”** representations that permeate contemporary advice presented to women, in order for them to make ‘informed’ infant feeding decisions (UNICEF BFHI UK 2010). These representations are (selective) accurate extractions of data but do not portray ‘risk’ in relative terms. For example, put another way, the PROBIT study found that if women do not breastfeed their babies they have a 1 in 11 chance of getting 1 or more gastrointestinal infections in the first year of life. This contrasts with a 1 in 8 chance of contracting gastrointestinal infection in babies who are breast fed. The relative risk is not nearly so alarming presented in this context, yet the data remains the same (Goldacre 2008).

With regard to gastrointestinal infections in children, the increased risk of formula fed infants vs breastfed infants was, and sometimes still is, portrayed as eleven-fold (or eleven times more) risk. This was due to the findings of a trial conducted in 1990 that was based on observational studies (Howie, Forsyth et al. 1990). This trial is perpetually referred to in contemporary breastfeeding promotional literature, WHO literature

and the NICE costing guidance (NICE 2006b). It is unclear why the trial's findings take precedence over the more recent RCT PROBIT trial (see below), and hence it may be reasonable to question the validity of this NICE guidance. This highlights lucidly the complexity of the issue of validity and the accurate interpretation of findings.

2.3.2 Appraising the Evidence: Breastfeeding Promotion

When evaluating the evidence base for the promotion of breastfeeding, it is important to appreciate that the PROBIT study was conducted because of the acknowledgement that the evidence base to date, upon which the premise that 'breast is best' was constructed, was actually based exclusively upon observational studies. These studies are methodologically limited (Elm, Altman et al. 2007, Goldacre 2009) because amongst other issues, they do not account for confounding variables within their design (selection bias etc.).

Observation studies remain an overwhelming feature of the promotional breastfeeding literature today because RCTs are difficult to implement for ethical reasons. A recent rigorous systematic review by the American Agency for Healthcare Research and Quality, *Breastfeeding and Maternal and Infant Health outcomes in developed countries* (Ip, Chung et al. 2007) highlights the lack of reliability in many breastfeeding studies due to observational status. Additionally, the review highlights the lack of reliability in many breastfeeding studies, in the main due to the lack of standardised definitions of breastfeeding that relate to duration of breastfeeding and failure to differentiate between exclusive and partial breastfeeding. Furthermore, there is a lack of reliable data collection strongly associated with breastfeeding studies that also impacts upon the overall reliability of findings. Reliable data collection has also been identified as a potential source of error by both NICE (2006b), WHO (1981) and the UK infant feeding survey team (Bolling,

Grant et al. 2005).

All establishments (government, academic etc.) require the collection of accurate data in order to assess the effectiveness of related policy and/or interventions. With the New Labour administration, statistical errors in relation to accurate infant feeding data collection from regional maternity services were discussed by central Government in 2003 (House of Commons 2003) and the National Audit Office¹². As a result, the Department of Health now requires PCTs to submit quarterly breastfeeding initiation figures and figures for any breastfeeding at 6-8 weeks (DH/HIAT 2010). This situation forces trusts to reveal their practices and allows their practices to be scrutinised and compared.

This system probably represents the most sophisticated collection of breastfeeding data in a developed country yet whilst data collection may have become more reliable over the past eight years it still remains problematic in the UK. One potential confounding factor is illuminated by the work of Lee and Furedi (2005), who explored the experiences of formula feeding teenagers, and suggest that women feel pressured to lie about their breastfeeding intentions or status. Anecdotal evidence also supports this finding. This phenomenon clearly requires further investigation but may partially explain the steep decline between the initiation (ever breastfed) and one week post-partum rates of breastfeeding (Bolling, Grant et al. 2005).

In summary, statistics and standardised definitions remain a relevant and important issue in the infant feeding debate. This fact, the issue of observational data and interpretation of the findings of the PROBIT study in the previous section, confer legitimate doubt upon some claims for advocating breastfeeding in the context of health promotion. It is unclear why the issue of evidence in relation to IFP has not been rationally debated by healthcare professionals, or why this has only been raised more recently by a sociologist in America (Wolf 2011) and

¹² http://www.nao.org.uk/wp-content/uploads/2010/06/MDA_PSA12.pdf June 2010

the press in the UK –see Heinig (2007) for a critique of Wolf’s articles that preceded her book. Nevertheless, as previously noted, the specific connection between breastfeeding and a reduction in obesity has gained momentum in recent public health policy agendas.

A report by *Foresight: Tackling Obesities: Future Choices -Project Report* (Butland, Jebb et al. 2007) produced by the UK Government Office for Science, made only one reference to breast-feeding, as an intervention to reduce obesity. This suggestion was to **“improve the quality and quantity of breastfeeding”** (p.134) and constituted part of a strategic plan containing multiple suggestions to address the obesity epidemic. This report is a multidisciplinary, rigorous analysis of this prime public health issue. It states:

An unhealthy weight is often seen as a result of individual choice on diet, exercise and lifestyle. However, this report maps the complex web of societal and biological factors that have, in recent decades, exposed our inherent human vulnerability to weight gain (p.3).

Moreover in another analysis on the epidemiology of obesity commissioned by Foresight the authors suggest:

Breastfeeding has been suggested to protect against obesity but findings are inconsistent. A meta-analysis concluded a small protective effect of breastfeeding, but there was significant evidence of publication bias. Although there are few reports on secular trends of breastfeeding, some studies show an increasing proportion of mothers breastfeeding since the 1970s (Canoy and Buchan 2007:4).

These scientific reports illuminate the sheer complexity of this public health matter. Such complex issues are sometimes referred to as ‘wicked issues’ because they hold no single, easily identifiable solution or ‘magic bullet’ (Hunter, Marks et al. 2010). In this context, it appears

that policy promotion of breastfeeding as an attempt to address the issue of obesity, probably overstates the benefits breastfeeding is likely to bestow. The next section of this chapter appraises the evidence for successfully initiating and sustaining breastfeeding.

2.3.3 Appraising the Evidence: Initiating and Sustaining Breastfeeding

With regard to the evidence base that applies to the successful promotion of breastfeeding initiation and duration, in 2006 the Health Development Agency (HDA) commissioned an 'Evidence into Practice' review¹³. Although not representative of NICE guidance, *Promotion of Breastfeeding Initiation and Duration* (Dyson L, Renfrew M et al. 2006) was comprehensively formulated from studies of effectiveness of interventions within four previous systematic reviews (Tedstone A, Duncie N et al. 1998, Fairbank, O'Meara et al. 2000, Protheroe L, Dyson L et al. 2003, Renfrew, Dyson et al. 2005). The first sentence of this review states **“Breastfeeding has a major role to play in public health”** (Dyson L, Renfrew M et al. 2006 p.7). The first 'evidence based action' (EBA) this review advocates is the implementation of the BFI in the maternity and community services. The other seven include:

Ante-natal breastfeeding education and support packages for women that include dealing with potential problems arising when breastfeeding. (EBA 2).

Changing hospital/community policy and practice to incorporate:- a hands off positioning and attachment approach, unrestricted baby-led feeding, supportive care and reassurance for women with 'perceived insufficient milk'. (EBA 3).

¹³ Subsequently published by NICE when the HDA's functions were transferred to NICE.

Changing hospital/community policy and practice to abandon:- the restriction of timing of feeds, reducing mother-baby contact, supplemental feeding of babies unless medically indicated, the separation of mother from babies that are jaundiced, the provision of material to mothers that contains information promoting formula feeds. (EBA 4).

Providing complementary telephone peer support to breastfeeding women in the early postnatal period. (EBA 5.)

Providing education and support from one professional to women on low incomes. (EBA 6)

Providing needs based one to one education and support to women on low incomes during the antenatal period and up to one year after birth. (EBA 7).

Developing local media programmes targeted towards teenagers to change their attitudes to breastfeeding. (EBA 8).

EBA 2, 3 and 4 are in fact similar to the BFI recommendations for maternity services, suggesting that the ‘evidence base’ for promoting initiation of and sustaining breastfeeding has not advanced particularly in the past decades. Whilst the potential issues with regard to the validity of the BFI have already been discussed, it is also worth noting that the BFI represents only ‘one piece of the puzzle’ necessary to encourage a breastfeeding culture in the UK. EBA 8 represents this requirement and the challenge that it presents is vast. A recent attempt to explore (Dyson, Green et al. 2010) why economically deprived teenagers are the lowest demographic group to initiate breastfeeding (Bolling, Grant et al. 2005), is illuminating. It demonstrates just how persistent and entrenched negative cultural attitudes are, towards breastfeeding in the UK. This study was supported by a flagship social

marketing start4life survey¹⁴.

There have been many other studies conducted that attempt to address the issue of why women cease to breastfeed. However, almost all of these studies have been conducted within the scope of attempting to understand how to 'enable' women to breastfeed (Chambers, McInnes et al. 2007, Hannula, Kaunonen et al. 2008, Hoddinott, Tappin et al. 2008, McInnes and Chambers 2008, Bartick, Stuebe et al. 2009, Bosnjak, Grguric et al. 2009, McMillan, Conner et al. 2009, Mandal, Roe et al. 2010). The most common reasons women cite for stopping breastfeeding include: 'perceived' insufficient milk, fatigue, sore nipples and latching problems (Spiby, McCormick et al. 2009, Dyson, Renfrew et al. 2010). Although more recent studies have made significant attempts to understand women's decision making processes more around breast feeding (Hargreaves and Crozier 2013, McInnes, Hoddinott et al. 2013). The BFI, with the exception of fatigue, presents 'evidence based' solutions to these problems, making it attractive to policy makers. However, it represents a narrow focus for public policy, given the cultural issues referred to above.

In summary, in the UK today, breastfeeding is actively promoted as being associated with multiple health improvements and reduced 'risks' for women and children. The vast majority of the data, from which these recommendations arise, is inferred from observational research studies which could be argued to be of more tenuous validity. Of key interest to government policy makers is the suggestion that breastfeeding confers a reduction in the risk of obesity. This however is a questionable claim on which to base clinical practice when the subject remains a matter of debate in the scientific literature.

The language of risk is a powerful coercive tool much employed in the medical vs midwifery model of antenatal and intrapartum care debates (Hunt and Symonds 1996, Symon 1998, Symon 2006, Jomeen 2010)

¹⁴ www.nhs.uk/start4life/Pages/healthcare-professionals.aspx

and infant feeding has many parallels with these discourses. As Van Esterik notes, to effectively promote breastfeeding, particularly within the media, healthcare professionals must continue to **“stress the risks associated with artificial breast milk substitutes and the risks of not breastfeeding”** (2004:43).

The next section of this chapter will appraise the role of the midwife in health promotion and explore that role in relation to IFP. The impact of that policy, upon midwives and women, will then be evaluated.

2.4 The Role of the Midwife in Health Promotion.

A midwife’s role is very diverse but categorically includes supporting women throughout the childbearing process and during their adjustment to the parenting role (NMC 2004¹⁵). This is undertaken through providing as much accurate information as is possible, to allow women to make their own informed choices, about the options available to them for their maternity care (RCM 2008). Pregnancy and birth are not simply clinical events, they are **“social and psychological transitions of tremendous significance”** (RCM 2006:1). Accordingly, the midwife’s role is inimitable in mother’s lives, providing care that is centred on women’s unique needs -ensuring that it is holistic, empowering, proactive and sensitive to the social context and changes in healthcare provision. To be ‘with woman’ the midwife must be the woman’s advocate, in true partnership with her care (Silverton 1993, Guilliland and Pairman 1995).

The acceptance of the value of autonomy in western democratic societies is ubiquitous as Di Stephano notes **“the concept of autonomy is central to the modern, Western, democratic political imaginary”** (1997:4). Feminist discourses have articulated the

¹⁵ The revised NMC Code, issued in 2012 notably mentions care during the childbearing process only, in relation to the role of a midwife. (<http://www.nmc-uk.org/Documents/NMC-publications/Midwives%20Rules%20and%20Standards%202012.pdf>).

importance that the notion of autonomy has for women (Hirschmann 2003, Oakley 2005). Autonomy confers a personal sense of control that has been identified by political scientists (Barry 2006) and applied psychologists (Ryff 1989, Deci and Ryan 2000) as an important feature of the emotional state of well-being.

The perception of choice is a feature of a sense of autonomy.

Government policy first supported choice for women in maternity service provision in 1993. *Changing Childbirth; the Report of the Expert Maternity Group* (DH 1993) was published by the Department of Health having been commissioned in response to the preceding two decades of 'medicalised' (Silverton 1993) childbirth that had culminated in widespread dissatisfaction with maternity services amongst women and midwives (Hunt and Symonds 1996).

Changing Childbirth was the first DH publication to state that the 'medical model' of care should no longer drive the service and that women should be given unbiased information and opportunity for choice, in the type of maternity care they receive (Maternity Services; HMSO 1992). Accordingly, the new focus of maternity care was to be 'women centred', conducted in partnership between professionals and women. Intrinsically, this approach requires that women receive unbiased information, thus enabling them to make 'truly informed choices' (DH 1993).

Choice is important to mothers (DH 2008) and can only be exercised by policy that places women at the centre of their maternity care. The concepts of choice and control have been indicated to be intimately linked (Jomeen 2010). Anderson and Jack (1991) suggest that women need the opportunity of choice to feel that they have control over their bodies, thereby enhancing their experience of childbirth and pregnancy. The role of the midwife within this framework therefore, includes that of empowerment through provision of information and health education. This philosophy is endorsed by the findings of Green et al. (1990) who

consider that informed choice is important because it allows women to feel in control of their decisions about their maternity care, thus allowing a more fulfilling experience of pregnancy and birth. A similar sense of control is also desirable for the antenatal period (Levy 1999).

It is significant that despite the importance of choice for women being endorsed by government policy and supported by academic literature, the reality of women's experiences in the UK maternity services is that choice remains an elusive notion (Kirkham 2004, Jomeen 2006, Jomeen 2010). This may be due to 'professional nervousness in a litigious climate', or the 'dominance of evidence based' care models which impact upon the information presented to women, thereby affecting their perceptions of choice (Jomeen 2010). It may also be as a result of the language of choice being presented to women in terms of the 'risks' associated with their 'choices' for care (Symon 2006). Such language, as already alluded to, dominates the information presented to women making their infant feeding choices.

In the light of the above, it is evident that whilst the role of the midwife also encompasses health education and promotion (historically NMC 2004, NMC 2008, NMC 2012), this is not a straightforward issue. Mander (2001) suggested that the information upon which choices are based will impact crucially upon the type of choices made by women. This further highlights the importance of the role of the midwife as education provider. It illustrates that, in order to provide unbiased information, midwives need not only evidence based knowledge but awareness of their own prejudices. The information midwives provide in this context should then allow women to make truly informed choices (Egan 1990, Steele 1995).

However, as Edwards highlights (2004), choice in maternity care might be construed as a fundamental right, but in reality it may be a potentially coercive cultural construction, based upon 'subjectivities'. Furthermore, the execution of choice is related to the extent to which a

woman's self-esteem 'enables' her to make a choice. In this regard, the execution of choice in maternity services seems an impossible ideal, despite the prevalence of policy supporting the 'informed choice' concept. Health promotion (and education) is an important aspect of the midwife's role (Sheridan 1997). However, if the concepts underlying health promotion are interpreted by midwives in a dogmatic way, or they constitute a 'cultural construction' perpetuated by midwives, the role and the autonomy of the midwife will be compromised and this will inevitably have detrimental effects upon autonomy for women.

Merits aside, a pro-breastfeeding government agenda based upon a prescriptive model that reduces infant feeding choices, is in conflict with the role of the midwife as the woman's advocate. Given that nearly one quarter of women never initiate breastfeeding in the UK (Bolling, Grant et al. 2005), this statistically significant group of women are implicitly marginalised by a pro-breastfeeding policy. The BFI is in danger of exerting what could be described as a 'corporate' authority or 'cultural construction' over the maternity services in the UK. Insensitive interpretation and adaptation of BFI standards within maternity services results in the implicit capitulation of choice for women over infant feeding. These statements are supported by the following quotation:

Bring the choice back for God's sake. When breastfeeding doesn't work bottle feeding is a good alternative, I didn't have a clue what I should be using (Thomson and Dykes 2010:6).

In summary, the restriction of choice for women accessing maternity services is antithetical to the fundamental ethos of contemporary government health policy. Moreover, in relation to infant feeding, such action may be unjustifiable in a health promotion/public health context, because the 'risks' associated with infant feeding choices in developed countries are debatable and incomparable with other 'lifestyle

behaviour choices' such as smoking. Delivering 'informed choice' creates a potential conflict in midwives' roles. To objectively present information to women, midwives need awareness of the multiple factors impacting upon how 'informed choice' is presented to women in the maternity services.

2.5 Infant Feeding Policy: The Effect on Midwives and Women

Infant-feeding is an emotive subject for many mothers and midwives, often invoking polarised views of the 'breast is best' construct (Crowther, Reynolds et al. 2009). In the light of this fact, it is important to appreciate that one quarter of women never initiate breastfeeding (q.v.) and worldwide less than 35% of infants are exclusively fed for even the first four months of life (WHO 2002). The majority of women in the UK (90%) are either partially or wholly feeding their babies infant formula milk (Bolling, Grant et al. 2005).

Most of the studies exploring the consequences of IFP on women and midwives derive from the 'breast is best' construct. A study produced from in depth interviews with ten midwives suggests

Influencing and supporting mothers' choice of infant feeding presents a dilemma for many midwives (Battersby 2008).

This study illuminated the tension midwives encounter when conflict arises **between "their health promotion role and supporting mothers' choices in infant feeding"** (Battersby 2008). Moreover, it implies that midwives do not feel empowered to provide mothers with information about formula feeding, in a manner that will enable women to make informed choices and safely formula feed their babies.

Given that the infant feeding survey (Bolling et al. 2005) demonstrated that half of women bottle feeding do not follow formula preparation

recommendations, this is a highly significant health issue for infants. Incorrect formula preparation may lead to overfeeding of infants and gastroenteritis (Renfrew, McLoughlin et al. 2008). Midwives perceive their 'lack of ability' as a direct result of them being **“bound by hospital policies and the current pro-breastfeeding stance”** (Battersby 2008). On a psychological level, some midwives are uncomfortable promoting breastfeeding because they consider that to do so may engender guilt in mothers who have chosen to formula feed. The strategies that midwives adopted to overcome these perceived conflicts with their health promotion role included furtive behaviour that contrary to hospital IFP, These findings are also supported by another study (Furber and Thomson 2006). There are parallels with this behaviour, and the behaviour of midwives in relation to their care of women during labour (Kirkham and Perkins 1997).

Given the above, it is perhaps understandable that the allegation has been made against some midwives that a bullying culture has arisen concerning matters of infant feeding (Battersby 2000). This view frequently arises in the UK media and some mothers perceive midwives as being less supportive than doctors or health visitors, and more likely to **“favour breastfeeding women”** (Cairney, Alder et al. 2006:694). These findings are further supported by Furber and Thomson (2008) who found that midwives often adopt an authoritative and directional stance towards mothers about breastfeeding and by the latest maternity services survey by the Care Quality Commission (CQC 2013).

In relation to women, it is the psychological consequences of the 'breast is best' policy that is of most concern. Women who choose to formula feed report feeling marginalised and often experience many negative emotions such as **“guilt, anger, uncertainty and a sense of failure”** (Lee and Furedi 2005, Lakshman, Ogilvie et al. 2009). Moreover, some women who 'fail' to fulfil their breastfeeding expectations experience acute psychological distress which may predispose them to post-natal depression (Lee and Furedi 2005, Larsen, Hall et al. 2008, McInnes and

Chambers 2008, Lakshman, Ogilvie et al. 2009, Burns, Schmied et al. 2010). In the literature, mothers have requested psychological support to cope with their 'moral collapse' (Lee 2008) when breastfeeding is unsuccessful (Graffy and Taylor 2005).

Mothers' views in relation to feeding choice are further illuminated in a recent qualitative study to evaluate how the BFI was being implemented in two North East England NHS Trusts. The researchers reported:

Mothers indicated that a 'dogmatic' approach to breastfeeding and disavowal of any alternatives was not necessarily what they needed. One woman wanted to supplement with a formula feed in order for her cracked nipples to heal. The health professionals advised against this decision in case it interfered with future breastfeeding. The mother considered this advice to be against her best interests...(Thomson and Dykes 2010 :6)

This study recruited fifteen women less than twelve months post-partum, regardless of their infant feeding intention, used purposive sampling that sought to include women with a diverse range of age and infant feeding experience. Despite findings such as those above, it is interesting that these mother's negative views of exclusive breastfeeding promotion were apparently interpreted by the researchers through the 'lens' of women misunderstanding IFP, as opposed to IFP simply not being 'right' for some women, because the rest of this paragraph states:

...but this may have reflected her lack of understanding of the importance of effective attachment to the breast as the most important way of preventing sore nipples (Thomson and Dykes 2010 :6)

In summary, despite decades of promoting 'breast is best' and subsequent pro-breastfeeding government policy, many women formula feed their infants at some point. The pro-breastfeeding culture in

healthcare services appears to affect midwives in several ways by: generating a dogmatic response to policy and creating a sense of conflict with their role as health promoters and as advocates for women. Midwifery researchers are primarily fixed upon conducting studies that are interpreted and designed with the present policy context that the BFI is an effective and valid 'evidence base' to promote the duration and initiation of breastfeeding. Non-exclusive breastfeeding women are marginalised by present IFP and some women appear to suffer psychological harm when their breastfeeding expectations do not match the reality of their experience.

Chapter 1 suggested that IFP arises because of the dominant economic paradigm. This theory and the 'breast is best' discourses in developed societies have been commented upon by sociologists. Their insights are explored below, as the concluding section to this chapter to provide a final insight into the context of contemporary IFP.

2.6 The Sociological Perspective

Sociological discourses have analysed the concept of risk in modern society. Crinson (2009) views the notion 'risk', individual behaviour and potential disease outcomes as a key feature of the debate relating to the relationship between individuals and the state. This suggests a cultural shift in perspective, from governance towards lifestyles and personal freedom. In essence, this view inherently rejects the concept that ill health is a result of social and environmental issues, and thereby out of the control of individuals. This contemporary association of health 'risks' with 'individual choices' in a 'consumerist model' of society neatly obviates the state's traditional role to mitigate what is **"euphemistically known as the 'externalities' of the capitalist market economy"** (Crinson 2009:181). As a result, some sociologists concur with political scientists regarding the perception that contemporary health policy has become too narrowly focused (Hunter 2008, Crinson 2009).

The political analysis in chapter 1 supports this sociological perspective and explains contemporary health policies that are orientated towards changing personal behaviour and that of 'at risk' social groups. With regard to the efficacy of such policy, Crinson (2009) and Hunter (2009) note that (debatably) excepting smoking, all such policies have been ineffective, because over the last thirty years childhood asthma, obesity and diabetes rates have soared (Marmot 2010). This reflects what Culpitt refers to as the **"conundrum of neoliberalism"** (1999: 15). This describes the tension between Government that seeks to diminish the interventionist role in the life of individuals, whilst acknowledging that the state requires engagement with the consequences that a risk society faces.

The sociological origins of this discourse arise from Foucault's theory of 'governmentality', a concept defined by Foucault as the 'art of government'. This refers to a range of control techniques that are not just limited to the politics of a particular state. This concept suggests a different understanding of power, one that is broader than traditional hierarchical conceptual models of the state. As a theory, governmentality also includes types of social control existing within disciplinary institutions such as hospitals and schools, in addition to types of knowledge. Power can become positively apparent through the production of knowledge, or discourses, that are subsequently internalised by individuals, thereby directing the behaviour of populations. This process results in a well-organized form of social control, because knowledge enables individuals to govern themselves (Foucault 2010).

Foucault also used the term 'neoliberal governmentality' to describe a type of governmentality epitomised by advanced liberal democracies. This concept refers to societies where the population are active agents of their own self-government and power is de-centered. This is the essence of neoliberalism, which could be described as an economic, social and moral philosophy characterised by a dominance of free-market

mechanisms with the resultant restriction of the action of the state (Hill 2009 q.v.Chapter 1). According to Foucault, owing to their agency, individuals require regulation 'from within' as opposed to by the state. Hence 'neoliberal governmentality' leads to discourses in society that legitimately construct 'auto-regulated' or 'auto-correcting' selves as the state increasingly eschews responsibility for the population (Foucault 2010).

The debate concerning public health policy requires objective scrutiny. However, empirical and sociological evidence strongly supports Crinson assertions (Furedi 1997, Culpitt 1999, Marmot, Atkinson et al. 2010) which cannot be dismissed as political posturing. Neoliberalism is likely to be ineffective when applied to public health issues as evidenced by the fact that social structure in contemporary Britain remains divided by persistent and systematic inequalities. Moreover, 60 years after the inception of the NHS, the differential health outcomes between social classes have grown wider (DH 2009b, Marmot, Atkinson et al. 2010) Yet until relatively recently, governments have failed to address social issues in health outcomes (Crinson 2009).

Sociologists contend that health promotion encroachment has multiplied potential areas for preventative action, generating the risk culture (Beck 1992) that has created an endless parade of 'at risk populations' and 'risky situations' (Petersen 1997, Culpitt 1999). The socio-cultural construct of 'breast is best' is an example of this process. It is affiliated with the sociological theory of 'intensive motherhood' which construes formula-feeding as risky for an infant's physical health and the mother-child relationship (Lee 2008). Furthermore, this construction is so dominant in contemporary society that women who formula feed experience responses to the 'risk' context of formula feeding. These responses include: moral collapse, expressions of defiance and defensiveness, and **"opting to go it alone in response to 'information overload' "** (Lee 2008:467).

Sociologists have also identified multiple complex factors impacting on breastfeeding. These include:- increased working practices of women, sexualisation of breasts, professional interventions into motherhood and class/race issues (Carter 1995). Whilst it is not within the remit of this thesis to explore these factors, it is important to appreciate their existence in order to restore a broad perspective on the reality of women's infant feeding choices which are dominated by a narrow public health orientated policy that pervades contemporary society.

Summary

Maternity services policy is premised upon 'quasi consumer orientated and feedback driven model' with government agendas at the nexus of various policy directives. These directives include a strong public health agenda that is particularly focused upon reducing obesity. Health promotion is viewed by the UK Government as an effective means of reducing health inequalities.

Government perceives increasing breastfeeding rates as a reliable method to reduce inequalities in health and obesity. It also believes that breastfeeding will improve the health of women and infants, resulting in a decrease in costs associated with healthcare expenditure. Raising breastfeeding rates was a component of PSA12 and *Commissioning Breastfeeding Support Services*. This drive has continued in associated Public Health Outcomes policy with initiation, 6-8 weeks and cessation of breastfeeding rates remaining a component of current NHS Trust statistical data collection¹⁶. Policy encourages maternity services to adopt the BFI to achieve this health initiative. The BFI is valued largely because of the PROBIT study (a large RCT) and an overwhelming body of supportive evidence based upon observational studies. This fact (observational studies) and the issues relating to statistical collection,

¹⁶ <https://www.gov.uk/government/collections/breastfeeding-quarterly-statistics-england>

suggest that the benefits of breastfeeding may be over interpreted.

The evidence base for promoting and sustaining breastfeeding has not advanced significantly. The BFI represents 'one piece of the puzzle' and a narrow focus upon 'effective' measures when considered within the cultural context of infant feeding in the UK. The measures prescribed in the BFI, which aim to reduce women's options to formula feed, create a conflict for midwives between their roles as health promoters and as advocates for women. This leads to some midwives practising deviant behaviour, which has parallels with the medical vs midwifery model of care debate. As a result, IFP appears to impact upon the autonomy of both women and midwives.

The restriction of choice for women accessing maternity services is antithetical to overarching government healthcare policy. From a public health perspective, due to the lack of unequivocal evidence relating to the benefits of breastfeeding in developed countries, current IFP may be misguided. Information presented to women about feeding their babies subscribes to the neo-liberal, risk focussed paradigm that characterises contemporary UK society. Current IFP marginalises women who feed their infants formula by presenting their choices as 'risky' and there is evidence to suggest that for some women, such policy is psychologically harmful. Pregnancy and birth are 'social and psychological transitions of tremendous significance'.

This thesis uniquely contributes to the debate on infant feeding by articulating the views of Women making their infant feeding journeys without presenting these views through the 'lens of present policy' that seeks to promote breastfeeding. It also presents the impact of present IFP on Midwives and Heads of Maternity services, from a similarly unique perspective by exploring their views and perceptions of IFP in current English maternity services.

Chapter 3 Methods

3.1 Introduction

This thesis will at times ‘without apology’ (Battersby 2006) employ the first person narrative to describe my research journey. This stance resonates with Silverman’s view (2000) that adoption of a ‘natural history approach’ is appropriate, as it enables the researcher to explore the realms of subjective insight and their methodological decision making in a similar manner.

Prior to stating the research question, aims and objectives this chapter will open with an account of my background in relation to my current role as a researcher. The subject of infant feeding and what this means to me reflexively, both in the personal and professional realms of my life, is then explored. What I hope to achieve in these sections is a sincere investigation into my motivations for the study, a sense of ‘who I am’ by thoughtfully interpreting ‘where I come from’. Such activity illuminates the personal influences upon the origins and purpose of the study and research question.

The chapter then continues with an exploration of the philosophical and theoretical foundations of social research including consideration of the ontological and epistemological foundations underpinning the research methodology that follows. The study method constitutes the latter section of the chapter.

3.2 The Origins and Purpose of the Study

To understand the personal influences behind the origins and purpose of the study reflexive analyses follow. This is useful because the practice of evolving reflexivity enhances understanding of the research thought processes undertaken throughout the course of a study and thereby increases reliability of the study design (Guba and Lincoln 1981).

Additionally, reflexivity is especially considered important because the study involves qualitative research techniques and self-questioning 'reflexive acts' constitute a major component of *doing* qualitative research (Mason 2002). Whilst placing oneself in the research method has been viewed in the past as egotistical and to some extent conceited (Coffey 1999), contemporary approaches to this method support such reflexivity. Margaret Chesney thoughtfully evaluates the personal reflective position by acknowledging:

The 'me' in the research influenced the choice and focus of the topic, the relationships in the field, and the content and analysis of the data and finally writing up the research
(Chesney 2001:128).

Her view was that for the reader of any qualitatively orientated research report to accept a study as valid, they needed to analyse the attitudes and integrity of the architect of the study. She drew support for her position from the work of Oakley and Callaway (1992) who encouraged honesty and openness throughout the evolving research process.

My work has parallels with Chesney who studied women in Pakistan's birth experiences. Infant feeding experience, regardless of the social and political context, is a similarly emotive topic (Crowther, Reynolds et al. 2009). I share her view, in effect that my 'curriculum vitae' does not confer credibility to the lay and professional 'audience' in the public domain. Instead, I believe that the experiences and dilemmas I dealt with as a woman, a mother and a midwife advocating for other women, encroach upon my motivation and method chosen for this study. They require inspection for they tint the lens through which I view the voices that I analysed during this research.

Another reason for reflexive investigation as a researcher applies particularly to my chosen method of qualitative research analysis, namely phenomenological descriptive analysis using Colaizzi's method. This method particularly requires that I have insight of my prejudices

relating to the research design and outcomes. The insight enables a type of analysis to be undertaken that claims research phenomena under investigation are most likely to be authentically represented, which fulfils a central aim of this study.

3.2.1 About the Researcher

The research proposal submitted for this thesis described me as a 'Registered Midwife and graduate of both Midwifery and Law with a keen interest in midwifery, physiology, maternal & infant health issues, political science, health and maternity services policy'. My professional midwifery experience consisted of work experience as both an independent and a community midwife within a small midwifery group practice in the United Kingdom. I also declared that I breastfed my two children for two years each yet asserted that I was ideologically committed to the concept of maternal 'decisional autonomy' (Lee 2008). I greatly value breastfeeding, believing that **“women who choose to breastfeed their babies deserve comprehensive and effective support to enable them to do so”**¹⁷.

The above description does little to convey the fact that my experience of infant feeding, and my ensuing doctoral research journey, has been at times an intensely personal, highly stimulating and emotionally complex progression into territory concerning a subject matter of immense importance to me. The topic resonates with me as a woman, a mother and a midwife and the central thrust of my interest centres upon the question 'how do current political, social and cultural contexts in the UK relate to women's infant feeding experiences?'

Subjective reflection (Boud, Keogh et al. 1985) for this project begins fundamentally with contemplation of the origin of my research question as this informs my inspiration for conducting the research. However,

¹⁷ *Ibid* 1 above.

reflection does more than suggest my personal motivation for this study, it also assists me as a researcher to apply a sound methodological approach to the whole research design by attending to the reality of my initial motivation and subsequent personal influence upon all stages of the research process (Johns 2010). The following reflexive personal information about me as a researcher is an important initial stage of the reflexive process as it informs the professional and personal reflexive accounts of my infant feeding experience that follow. Those accounts enlighten more specifically the overall research design but the personal information I volunteer next describes a 'fundamental lens' through which I believe I view the world.

Although I was born in the East Riding of Yorkshire, and spent my childhood summers in that region, the first decade of my life took place in the Middle East during the 1970s before relocating to England where I was then based in the South East. The expatriate experience was for me a period of relative cultural isolation, occurring in the pre-globalisation era of recent international history. It was an altogether 'otherworldly' and somewhat surreal childhood, frequently finding myself 'split' between two vastly diverse cultures that both required culturally appropriate navigation to exist in. Yet each culture also contained two resonating social discords namely gender inequalities and poverty. I became acutely attuned to these fundamental social issues from an early age.

My eventual repatriation did little to ameliorate my sense of dislocation, of never quite feeling 'culturally embedded' in any locality. 'Reverse culture shock' (Wolfe 1968) aside, this feeling was probably intensified by my perception that Southern England was also intriguingly culturally distinct from the Northern England that I knew. My childhood experiences have left a legacy that in existentialist terms confers on me the role of 'interested outsider' (Bayer and Merleau-Ponty 1951). I believe this enables me to interpret at an academic level, the breadth of perspectives and realities that people experience.

My midwifery education commenced as a mature student enrolled on the 'extended pathway' B.Sc. program at a UK University. At this time, I had over a decade of experience in care of the elderly and had also obtained a degree in Law. I viewed myself then, and continue to do so now, as a 'balanced practitioner' possessing equal passion for both 'coal face care delivery' and the pursuit of scholastic endeavours relating to my health and social care interests. I entered the midwifery profession having consciously moved away from full time care of the elderly owing to the emotional impact upon me of providing prolonged end of life care. I made a positive, focussed decision to embark upon a new vocation which I also appreciated would be challenging. My midwifery experience and consequent exposure to the institution of the National Health Service (NHS) has developed the perception that UK maternity service provision remains entrenched within structures supporting patriarchy.

Despite reflexive acknowledgement above of my support for breastfeeding I also possess a fundamental passion that inevitably colours my perceptions in this study. This passion I have is for women, and I acquired it as I learned to midwife women. It is my unequivocal belief that I am both professionally and ideologically committed to fulfilling the role of being the woman's advocate in her mothering journey.

3.2.2 Personal Experience of Infant Feeding

My personal experience of breastfeeding began after the birth of my first baby in 2003. I anticipated mothering my infant girl with the clear expectation that I would breastfeed her, as it seemed to me to be the most 'natural' method of infant feeding and I had been breast fed as an infant. My belief was most certainly derived from my personal opinion of breastfeeding which was in turn influenced by the life I had lived to date, but it was also underpinned by the prevailing professional 'breast

is best' midwifery culture in which I was immersed professionally at that time.

Although I had seen multiple problems professionally associated with breastfeeding I did not particularly imagine that such issues might arise for me. However, I was totally unprepared for the reality of establishing breastfeeding with my first child. She drew immense comfort from sucking since the hour she was born and never seemed to want to stop unless she fell asleep. So, in accordance with my midwifery training and the 'demand feeding' prescription of the BFI policy, I let her breastfeed on demand.

Despite what I believed was a 'perfect latch' within two days my nipples became extremely sore, cracked and bleeding. This was an experience that I had encountered many times professionally, in other women establishing their breastfeeding. Moreover, three days after the birth, the 'overstimulation' caused by my demand feeding approach caused an over production of my milk supply that resulted in extremely engorged breasts. My baby never managed to 'strip' my breasts of milk fully at this point, such was the surfeit produced. All my attempts to express the excess milk, as per 'evidence based' advice, were unsuccessful. My milk supply failed completely at seven days post-partum, according to lactation consultant advice this was probably a result of the over engorgement of my breasts leading to damage of the milk producing glands lining my breast ducts.

With the use of infant formula, an electric breast milk expression pump, regular doses of paracetamol and considerable support from my midwifery colleagues and friends, I started a three week journey towards successfully re-establishing exclusive breastfeeding my baby.

The above description of my personal breastfeeding experiences does not capture the emotional horror of that time in my life. I did not initially realise that my milk supply had failed completely, being so professionally indoctrinated with the breastfeeding evidence base that

suggested ‘insufficient milk supply’ was a fallacy, merely a ‘perception’ that women held because they could not ‘see’ their breast milk . It was a creeping realisation, starting on a Sunday afternoon, that my baby was becoming progressively weaker that started to alert me to the fact that something was becoming seriously amiss. Willow smelt of ketosis and had not passed urine for over twelve hours -these clinical signs identified the reality of our situation.

Upon realising what had happened to my milk supply, I passed my baby to my partner in the early hours of Monday and drove to the local supermarket, to wait for it to open. I recall my mind racing as I waited with what I can only describe as a sense of ‘primal terror’ at the thought that my baby required feeding and I could not provide any nourishment through breastfeeding. My imagination reeled with morbid fantasies about what would have happened to her in the days before I could easily access infant formula. I envisaged desperately knocking on doors, seeking lactating women to provide the essential milk for my baby.

I recall an almost overwhelming feeling of anguish and of letting my baby down, of somehow not being good enough for the task of mothering when I fed her formula milk. I was also seized by an irrational idea that I was somehow harming my baby by not providing breast milk, that formula milk was somehow ‘toxic’. This feeling was so strong at times that I had to ask my partner to feed Willow on several occasions as I felt so inhibited by this task.

In summary, I would describe the ensuing three weeks that saw my return to exclusive breastfeeding as slowly crawling across cut glass and despite much reflection on my experience I still cannot reconcile why I felt compelled to put myself through that experience. Strangely, I hold no sense of achievement for finally reaching my goal, to me it was simply ‘a relief -driven by necessity’. However, I was ‘rewarded by nature’, approximately six weeks after the birth when I experienced several nights of ‘ecstatic states’ (Odent 2009) whilst tucked up in bed,

blissfully breastfeeding Willow. These feelings returned from time to time throughout my breastfeeding journey and were some of the most profound emotional experiences of my life.

Ruby was born twenty one months after Willow and breast fed straight away. I experienced none of the previous problems I had encountered establishing breastfeeding. I fed both children on demand including in public and never experienced any sense of embarrassment or negative public comments. I did realise I was a statistical aberration though, and thought I was probably not bothered by my public breastfeeding tasks owing to my expatriate childhood imbuing me with the sense of being somehow 'on the outside' of the culture I existed in.

The years I spent breastfeeding generated a tremendous amount of fulfilment and serenity in me, although not every breastfeeding occurrence felt 'special'. I remain open of course to the idea that any type of maternal-child dyad experience will invoke similar sensations in women to those that I experienced when breastfeeding my children.

3.2.3 Professional Experience of Infant Feeding

I trained as a midwife in the latter half of the 1990s, when the UNICEF BFI was ascending in priority in the maternity services. As a student, I embraced and welcomed the initiative, being especially drawn to the somewhat simplistic notion that evidence based breastfeeding promotion was all that was required to 'set to rights' the apparent complications relating to breastfeeding for women. Infant formula feeding was notably absent in the curricula to the extent that I was acculturated into eschewing the consideration that formula feeding might be a woman's autonomous choice of method. This is largely because my interpretation of the midwifery training I received at that time suggested that midwives had a duty to actively promote breastfeeding. Moreover, there was a significant amount of anti-formula

manufacturing company rhetoric at my University and I absorbed (understandably with horror) the historical campaign against Nestle infant formula and other products, by the International Baby Food Action Network and the UK based Baby Milk Action group (BMA 2014). This was premised upon claims of an association between the inappropriate promotion of infant feeding products (due to lack of sanitation) by Nestle in the developing world and subsequent infant malnutrition that sometimes resulted in the death of infants.

As a student midwife I became a member of the radical campaign group, Baby Milk Action whose purpose was to 'protect breastfeeding and babies fed on formula'. I believed that women chose not to breast feed because they did not realise how beneficial it was for them or their babies and that they were not 'enabled' to do so due to a lack of sufficient information about breastfeeding methods. Therefore in a clinical setting I embraced every opportunity to inform women of the benefits for themselves and their babies. On reflection, I believe that during my midwifery training I acquired an unbalanced perspective of infant feeding, becoming a breastfeeding zealot on a mission to convert women using the blunt instrument of the 'breastfeeding promoting' evidence base. I was aware of my zealousness however, and like to think that despite my personal preference for breastfeeding as a method I was unequivocally supportive of women who chose to bottle feed. I certainly never intended to make women who chose this method of infant feeding undermined, nor do I believe I ever did so. I sincerely regret if my reflections do not reflect women's perceptions of my midwifery practice at that time.

Upon qualifying and then working in a birth centre and after that as a community midwife in a semi-rural setting I was always struck by how emotive the subject of feeding babies was for mothers. I was also aware on many occasions that women lied to me about their method of feeding their babies. I knew this from my routine examination of babies' stools and from the feeding paraphernalia in the women's kitchens which I

noted when I went to wash my hands.

Eventually over time I developed significant skills as a midwife in facilitating breastfeeding and in my experience, the evidence base particularly in relation to UNICEF's BFI became incongruous with some aspects of the actuality of women's experiences when breastfeeding their infants. This was notably with regard to the use of dummies hindering breastfeeding and in particular the notion that 'insufficient milk supply' was a fallacy. I witnessed first-hand, and frequently, the phenomenon of 'insufficient milk supply' in women. There was no 'perception' about these experiences they were very much grounded in reality and supported by clinical observation. Hungry, unsettled 'ketotic' babies with diminished functioning excretion were the result. Moreover, my colleagues had similar experiences and we noted that they were particularly associated with women who were physically ill, or 'older primagravidas' and women that had undergone physically demanding labours.

The reflective accounts above reveal how my professional and personal experiences of breastfeeding engendered many questions about the subject of infant feeding. I wanted to understand more the conflicting nature of breastfeeding for women, midwives and particularly in relation to how health policy directs the culture of maternity services and women's infant feeding experiences. All these experiences and curiosities were the start of my thesis journey and lead me on a questioning course that is described below.

3.3 Research Question and Aims of the Study

This thesis aims to articulate a contemporary account of the impact of IFP and discourses on maternity service providers, midwives and women who access maternity services. It aims to integrate these perspectives, articulate the environment and thereby evaluate the

efficacy, of current IFP culture in England. The research approach is unique and valid because the aim of the study is to embody the research subjects' views on IFP by qualitatively identifying their dominant discourses and representing them authentically in order to inform the infant feeding debate in England and future related policy.

3.3.1 The Research Question

What are Mothers' and Healthcare Professionals' experiences of infant feeding within the current policy context and culture of healthcare in England?

3.3.2 The Research Aims

- 1) To explore the impact of contemporary infant feeding discourse and practice on the infant feeding experiences and decisions of women.
- 2) To use the results of this research to inform future health policy and maternity services about ways to optimise the experiences of women relating to infant feeding.

3.3.3 The Research Objectives

There are several objectives to fulfil the research aim:

- 1) To use qualitative research methods (interviews) to follow the infant feeding journeys of women and explore how their infant feeding decisions are made and maintained.
- 2) To use qualitative research methods (interviews) to examine how service providers interpret and implement IFP and guidelines.

3) To use 1 & 2 above to identify the dominant discourses relating to infant feeding dialogue within the research groups. Dissonance and concordance across the groups will be examined in order to provide contextual understanding of contemporary IFP and its impact on women.

4) To inform maternity service provision through making a contribution to the body of knowledge relating to infant feeding.

The following section discusses the approach taken to address the research question, aims and objectives. It commences with theoretical contemplations of social research and progresses to methodological considerations before describing the method.

3.4 Philosophical and Theoretical Foundations of Social Research

All research methodology requires scrutiny of the philosophical and theoretical foundations upon which the research methodological decisions are based. Philosophical considerations are fundamental when designing, conducting and interpreting social research because philosophy helps to sharpen our awareness of the broader context of research proposals and findings. In the first instance, it can provide a term of reference for the recognition of poor reasoning or inferences from data. More broadly, it can lead to assistance in the development of innovative agendas for further social research topics. In essence, 'Philosophical and Theoretical Foundations' provide the essential framework through which to conduct a piece of social research, but it is also important to grasp that the framework it provides should not be considered a rigid construct (Bryman 1996).

The evolution of the philosophy of social research, alongside the development of social theory, is convincingly argued as **“crucial”**

(Bryman 1996:ix) owing to the intertwining nature of philosophy with the rapidly developing social world. Philosophical questions can also inform research practice through critical discussion of key ontological and epistemological issues, in order to comprehend their impact upon different theoretical perspectives of research methodology (see below). As Williams and May state: **“Methodological decisions are implicitly ontological and epistemological”** (1996:11) .

Notwithstanding the above, it is important to appreciate that the relationship between the theory and the practice of research is not necessarily a straightforward issue. Bryman (1996) highlights the two separate approaches to the philosophy of social science as outlined by Rudner (1966) who considers the subject to be concerned with the rationale for social theorising. This position contrasts with Rosenberg’s (1988) view that the issue is broader, encompassing choices of research questions and methodology. Yet as Bryman states:

...far from being a device through which social scientists will be able to come to terms with the philosophical backcloth to their field, they will often find that the Philosophy of the Social Sciences is as uncertain about its domain as social scientists are about theirs (Bryman, 1996:ix).

In contrast to research conducted in the natural sciences, there exist very few examples of published research that address the issue of ‘philosophical speculation’ concerning social research practice. Instead, the philosophical issues in modern academic social research tend to focus upon discussions relating to the epistemological foundations of quantitative and qualitative research, citing the positivist/naturalist vs. interpretist/phenomenological/hermeneutic positions (Colaizzi 1978).

The former focuses upon the application of ‘scientific’ principles to social studies whereas the latter rejects any such application due to the ‘agency’ that people possess (Colaizzi 1978). What it is important to appreciate is the fact that these philosophical concerns have evolved

into a significant body of relatively narrowly focused research aimed at the critique of research *methods* that are evident in the postmodern position (Ashworth, Giorgi et al. 1986).

This next section of the methodology chapter will explore what is understood by the terms Ontology and Epistemology as these are core elements to appraise in the subject of philosophy and theoretical foundations of social research.

3.4.1 Ontology & Epistemology

Ontology may be described as the branch of philosophy concerned with existence and the nature of things that exist (Williams and May 1996), it concerns the theory of social entities (Bryman 2008). Ontological considerations centre upon contemplation of whether a social entity ought to be viewed as an objective entity with an existence that is external to social actors, or whether a social entity can be considered as a social construction, derived from the perceptions and actions of social actors. These two ontological perspectives are generally referred to as objectivism and constructionism and these concepts are allied to the two dominant central themes of social science, namely organisation and culture (Bryman 2008).

To expand upon these themes, objectivism as an ontological position implies that social phenomena, and our categorisations of such phenomena, exist independently from social actors. Therefore, they exist beyond 'our' influence. 'Organisation' or 'an organisation' has tangible qualities, with associated rules and procedures. A hierarchy exists within the organisation, with work divisible according to the structure and focus of that organisation. As Bryman states (2008:18) **"It exerts pressure on individuals to conform to the organisation"**.

Objectivism considers that the organisation is a reality separate to the

individuals that inhabit it, thereby exerting constraint upon its members. This concept applies to culture (and subcultures) which may be viewed as repositories of shared values and customs. People are socialised, and thereby constrained by, their culture or organisation which has a separate, objective reality. This objectivist view is considered to be a traditional approach towards conceptualising culture and organisation (Bryman 2008).

The alternative ontological position, constructionism, claims that social phenomena or categories (and their meanings) are produced through social interaction and are therefore in a constant state of revision. This directly challenges the objectivist perspective. Becker (1982) applied these principles to culture, viewing culture as a constant state of construction and reconstruction as opposed to an external reality that constrains people. However, Becker also accepted that the constructionist position could not exist in isolation, conceding that there must be some pre-existence of objective reality within culture and organisation. Not all constructionists share this view. Walsh writes (1972:19) that:

In contrast to the natural scientist, a pre-constituted world of natural phenomena cannot be determined it is the processes that construct the social world that need examining.

The issue described above relates directly to the aims and objectives of the study stated in section 3.3, hence constructionism is the appropriate ontological orientation of the research. Constructionism suggests categories that enable our understanding of the social world are themselves social constructs and not external to us. Through social interaction they become constituted and this tendency may be identified through evaluating discourse which is a method that may reveal social phenomena (Bryman 2008:20). Aiming to understand dominant discourses relating to healthcare professionals' and mothers' experiences inherently supports this perspective.

Epistemology is a branch of philosophy concerned with the theory of knowledge, in particular what constitutes 'acceptable' knowledge within an academic discipline (Hammer and Elby 2002). It seeks to address questions such as **“how and what do we know?”** and **“how is what we know justified”** (Williams and May 1996:2). Epistemology applies to theories in philosophy relating to positivism, realism and interpretivism (Bryman 2008).

Positivism asserts the epistemological position advocating the application of objective, natural science methodology to the study of social 'science'. That is, scientific research should be based on empirical observations that are 'value free'. Empirical observations are seen, felt, heard, they are acquired through our sensory perception. A positivist considers that phenomena perceived by peoples' senses is exclusively 'real' and therefore only such sensory knowledge constitutes 'real' knowledge. It encompasses a deductive rationale although inductivism may be employed by positivists to disprove previously held theories or hypotheses. Positivists seek explanation of human behaviour, as opposed to the hermeneutic philosophical approach to knowledge that posits human behaviour may only be understood (Bryman 2008:3).

The positivist epistemological perspective contrasts with interpretivism which refers to the epistemological position advocating that social science can only discern social knowledge through the subjective understanding of social action (Bryman 2008). Interpretists believe that their subject matter differs fundamentally with natural science subjects. Prioritising the meaning and action of agents is the dominant theme of the interpretist approach to social science (Williams and May 1996). It is this epistemological position that resonates with the orientation required for the research to fulfil the study aims.

Hermeneutics is a branch of philosophy that is applied in the social sciences to consider theories and methods that apply to interpretation of human behaviour. It is concordant with interpretivism because it

focuses upon the empathic understanding of human behaviour (as opposed to the positivist perspective that seeks to explain human behaviour). Similarly, phenomenology is a philosophy that questions how people make sense of their world and how the phenomenologist might exclude their own preconceptions about an individual's world. It requires a methodology that accesses people's thinking, thereby enabling an interpretation of people's actions and their social worlds from their perspective (Lavery 2003). Phenomenology is particularly suited to the aims and objectives of this study because it seeks to understand women and healthcare professionals' experiences of infant feeding. Phenomenological methodology for the study is explored in section 3.5.2 below.

3.4.2 Theoretical Underpinnings of the Study

Traditionally, methods of research employed by social researchers have been distinguished as either quantitative or qualitative although some critics now view these distinctions as misleading (Patton 1990, Bryman 1996, Mason 2002). One superficial distinction between quantitative and qualitative research is that the former utilises measurement and that the latter does not. However, these two methodological approaches appear to differ with regard to their epistemological foundations and ontological perspectives thereby forming **“two distinctive clusters of research strategy”** (Bryman 2008:22).

In summary quantitative research quantifies data, and analyses that data through employing a deductive approach to the connection between theory and research, with emphasis upon the testing of theory. It integrates practices associated with the natural science models of research, principally the epistemological orientation of positivism. It is ontologically orientated towards objectivism as the perspective of social reality (Fox 1993).

In contrast to quantitative approaches, qualitative research traditionally comprises of a strategy that accentuates words for the collection of data. It incorporates an inductive approach towards interpreting the relationship between theory and research, thereby generating theories. The epistemological orientation of qualitative research is interpretivism, a paradigm that inherently rejects positivism. The qualitative method of social research embodies the ontological position of constructionism to perceive social reality (Bryman 2008).

Qualitative research methodology is advocated in the research objectives of this thesis because it clearly facilitates the research aims, namely to elicit views and perspectives of current IFP. However, selecting the method of qualitative research does not confer simplicity upon the research design because qualitative research represents various philosophical approaches towards research that are premised upon diverse methodological, ontological and epistemological paradigms (Williams and May 1996, Bryman 2008).

This research proposal supports a qualitative methodological approach which resonates epistemologically with an inductive, interpretist method of enquiry that thoroughly explores phenomena in order to understand their characteristics. It is a technique particularly suited to social and anthropological forms of analysis that is conducted without supposition about the phenomenon under investigation (Crotty 1998, Hollway and Jefferson 2000, Silverman 2004). The next section of this chapter considers what methodology derives from an interpretist epistemological position that supports the research question, aims and objectives.

3.5 The Methodology of the Study

3.5.1 Qualitative Methodology

Qualitative methodological approaches towards conducting research are now firmly established in various social science disciplines as appropriate for understanding peoples' lives, experiences and perspectives in the context of their circumstances (Spencer, Ritchie et al. 2003). The qualitative approach is a valuable contribution to the holistic evaluation of a topic. However, given the variety of philosophical influences upon this relatively emergent field of research, it is not perhaps unexpected to appreciate that a variety of debate exists about qualitative research definition and methodology (Denzin 2010).

Without straying too far into the realms of philosophical debate and setting aside general philosophical considerations, there exists specific issues relating to research methodology that merit exploration. Much of the debate centres upon the fact that qualitative research is traditionally compared with the epistemological foundations of quantitative research.

Criticism of qualitative research, from the quantitative perspective, includes the suggestion that it is too subjective firstly because it relies upon what the researcher considers to be important and secondly owing to the close relationships that often strike up between researcher and participant. Qualitative research also implies that that it is not replicable by design, because it relies upon the researcher's "**ingenuity**", thus impeding the evolution of a "**standard process**" that applies to the research undertaken (Bryman, 2008:391).

It is thought that subjectivity results in theories that will not be applicable to other, general populations. However, it could be argued that if the research is conducted so as to generalise to theory rather than populations, this issue is negated. It is the "**cogency of theoretical reasoning**" (Mitchell 1983:207) as opposed to the statistical

criteria that determines the generalisability of research findings.

Whilst it may be coherently suggested that social science could be regarded as the offspring of natural science, perhaps the pursuit of ontological and epistemological legitimacy of social science has been an 'academic' distraction. One solution to end this nominal 'paradigm war' is posited by Oakley (2000) when she suggests that the terms quantitative and qualitative be 'dropped' from the language of research strategy.

One method advocated to justify and counter criticisms of the qualitative research is that a clear aim and purpose should be set out for any project and studies should not be instigated merely as an exercise in data gathering, that is then 'sifted' and 'ordered' (Polit-O'Hara and Hungler 1997). The aim of this thesis is clearly stated (section 3.3) to address this issue.

This thesis also has clear precedent methodologically in the work of sociologists Benney and Hughes (1970) and of Oakley (1981, 2005) who collectively established a shift towards qualitative methodology that is particularly suited towards research conducted with women. The qualitative methodological approach towards research with women has been developed further in studies that are similarly themed notably by Carter (1995), Barnes (1999), Madriz (2000), Borbasi et al (2005) and Jomeen (2006, 2010). However, as mentioned above, qualitative methodology is a diverse subject and therefore question arises as to exactly what type of qualitative methodology optimally addresses the aim of this research. Section 3.4.2 above identified that an interpretist, phenomenological approach towards the study method was appropriate. The next section of this chapter explores exactly what phenomenological method is appropriate to fulfil the study aims and objectives.

3.5.2 Phenomenological method

Phenomenological approaches to social research are both philosophical and methodological (Cohen 1987). The aim of phenomenological research is to accurately describe the phenomenon being studied, by accepting the life-world or views of the phenomena (Miles and Huberman 1994, Huberman and Miles 2002). To conduct this type of research, it requires that the researchers have no preconceived frameworks, notions or expectations of the results whilst they gather and analyse the study data. The concept of the phenomenological method originates from the philosophy of Husserl (Husserl 1970, Husserl 1980), Heidegger (Heidegger 1962), Satre and Merleau Ponty (Kaelin, Merleau-Ponty et al. 1962) and Van Manen (1990).

There are three schools of phenomenological methodology that have derived from these seminal works (Cohen and Omery 1983). The schools originate from the works of VanKaam (1966), Colaizzi (1978) and Giorgi (1970). The approach that this thesis used to analyse the qualitative data is that derived from the work of the existential psychologist Colaizzi (1978), commonly referred to as Colaizzi's method. Although grounded in psychology, it has a relevance and application to health and social care phenomenon, having previously been utilised in research conducted within this sphere of scholarly undertaking (query extra refs).

Psychology is an appropriate academic base for research enquiry in health and social care settings (Jomeen 2010), an academic field that has rapidly evolved without clear precedent for any particular research methodology. The subject of psychology, as the study of the behaviour and functioning of people, has relevance to this study whose participants include women accessing maternity services and the people who work for those services as midwives, managers and commissioners.

3.5.3 Colaizzi's method

Colaizzi's seminal method of data analysis was set out in a chapter entitled *Psychological Research as the Phenomenologist Views It* (1978). He crafted the method by exploring the juxtaposition of traditionally derived psychological theory with natural science research methodology. He then critiqued traditional psychological research methodology to forge a new approach which he termed phenomenological psychology, from which he developed his method of data analysis.

Colaizzi commenced his theory by describing existing psychological research from the perspective of phenomenologists. He achieved this in a step by step process by analysing the *approach of natural science* and then the *approach of psychology* in relation to how they provide an explanation for the world. He then summarised the *historical overview of natural science* and integrated it into his exploration of the concept of *objectivity in experimental psychology* and *phenomenological psychology*. He concluded his analysis of phenomenological perspectives of existing psychological research with a consideration of the *concept of experience* and how human experience might be objectively psychologically investigated in a section of the chapter subtitled *experimental descriptions*.

Colaizzi then addressed the matter of theory in phenomenological research by firstly regarding *anthropological assumptions in phenomenological psychology* before setting out the approach of *phenomenological psychology* in his work. His final theoretical analysis that precedes his hypothesis for a method built upon existing descriptive phenomenological perspectives Giorgi (1970), in light of the subject of *technology and traditional psychology*. The next section of this chapter will summarise how Colaizzi stepped away from traditional psychology to establish a new philosophical anthropological methodology that is phenomenologically orientated.

3.5.3.1 The Theoretical Origin for Colaizzi's method

Approaching Natural Science

Colaizzi identifies the 'normality' of human behaviour where people can sometimes appear paradoxical by **"both affirming and denying"** the same thing (1978:48). For example, one might tirade against the evils of the technological age whilst writing about them on a computer. He identifies that natural scientists however, are particularly adept at placing distance between their experiences and their theoretical perspectives of life, to the extent that to see any connection between the two is problematic. For example, the biological description of neural impulses and reactions in a human face and the emotional facial reaction of love when a mother views a child are essentially two very disconnected ways to describe the same phenomena. Natural scientists, when understanding facial gestures, view them in a manner that does not accord with people's experience of human faces (1978). This is significant because natural science dominates contemporary western culture. The 'gap' between what people actually experience, and the way their experience is scientifically described or rationalised to them, is indispensable to the natural scientist. This gap is primarily accepted by people, even if they do not particularly understand the natural scientist's **"developing scientific enterprise"** (1978:48).

Approaching Psychology

Colaizzi suggests that natural science theory tends to incite emotional responses in people such as **"wonder, amazement and excitement"** (1978:48) even if the results of that theory are not necessarily understood. However, he suggests people who initially do not understand results of scientific-psychological enquiry that seeks to explain behaviour or phenomenon, conversely tend to experience a sense of **"confusion"** or **"impatience"** (1978:48) with the psychological

paradigm. Natural scientific theory elicits scholarly approval whereas psychological theory the perception of insubstantiality. He speculates that such lack of acceptance of psychological theory arises as a result of our expectation that our own experiences should correlate more with psychological theories, more than with natural science theories. His assumptions draw him towards a fundamental question namely:

What does the proximity of psychological phenomena to human experience have to do with the methodology of psychological investigations?” (1978:48).

Colaizzi explored the origins of natural science knowledge in Western society to further inform his developing method. He applied his understanding to of how that knowledge had imbued an ‘objective’ approach towards experimental psychology, his academic discipline.

Objectivity in Experimental Psychology

Since 1879 ‘scientific’ psychology has been the model informing the psychological study of human existence in a depersonalised form. This focus upon experimental methodology is the common element of all branches of psychology, despite their relatively divergent backgrounds (Colaizzi 1973). As a result, the phenomena of human experience were eradicated from the methodology of psychology since its inception. This has been accomplished in the field of experimental psychology by adherence to the concept of objectivity and application of operational definitions to fulfil this aim. Operational definitions effectively disregard human experience and reduce phenomena to empirical entities. For example, the phenomenon of hunger could be described as nil food intake by a person of a specific gender, religion, social status, height etc. This stance in psychology is defensible because it strikes out people’s experiences of, or judgements about, the state of hunger. It also renders psychological experiments replicable through adoption of operational definitions producing a collectively understood, objective

definition of hunger that is devoid of regard for how people actually experience hunger. **“Objectivity resides wherever experience is not”** (Colaizzi 1978:51).

Objectivity in Phenomenological Psychology

Merleau-Ponty (1962) highlights the inconsistency of psychological validity that ascribes value to objective operational definitions thereby eradicating experience, the vital element of **“human psychological existence”** (1962:ix). The inconsistency centres upon the fact that however a phenomenon such as hunger is represented objectively, the phenomenon of hunger cannot actually be conveyed in any meaningful way unless it had actually been experienced at least once. Thus, psychological notions of objectivity disallow what exists as experience. These psychological methodological principles, if applied, constrain psychological theories by not conferring legitimacy upon the phenomenon of experience in the study of psychology. Moreover, the psychological method shapes the subject’s content (Giorgi 1970).

Colaizzi turns this conundrum around when he questions whether this ‘shaping’ can in fact be viewed as objective and indeed whether psychological methodology that is objective does actually require experience to be eliminated. He posits that if human experience is considered valid territory for psychological enquiry, then what methodology would fulfil the aim of objective investigation if human experience has been traditionally eliminated from psychological methodology on the basis of promoting objectivity? To address this question he reconsiders the definition of objectivity from a phenomenological perspective.

In this reconsideration, Colaizzi commences with the premise that a person’s objective statements should faithfully articulate phenomena. In essence, this amounts to a refusal to ascribe a judgement as to what

the phenomenon actually is, rather it amounts to hearing what the phenomenon reveals about itself. To illustrate this concept, he employs an example of himself eating a pen and him insisting that his pen is in fact a strand of spaghetti. Colaizzi suggests that he is not being objective if he denies the actuality of his experience. Furthermore, insisting one feels fine when one is in fact seized by anxiety constitutes a 'betrayal' of experience that similarly results in a 'corporeal' betrayal that manifests in symptoms of anxiety. Denial of experience therefore, is not an objective act, nor can one distinguish oneself from others. In summary, because one cannot essentially deny one's experience, by extension one cannot deny the experiences of others. Colaizzi concludes then that objectivity necessitates the recognition and affirmation of the experiences of self and others. In his words **"Experience is there, for all of us, and it cannot be objectively eliminated"** (1978:52).

The Concept of Experience

In an attempt to define experience, Colaizzi commences with the striking claim by Laing (1967) that the ordinary and seemingly widespread attitude towards experience might be one of the most **"dangerous events"** of our century (Colaizzi 1978:52). This 'ordinary' attitude is basically that people acknowledge that they have experiences but because they attribute these experiences as not existing outside of their own heads, their experience has no worth. Colaizzi applies his position on objectivity to suggest that experience is not actually within people but rather it is **"how we behave towards the world and act towards others"** (1978:52). In this sense, experience actually exists outside in the world because people are agents in the world. For example, the experience of feeling anger might manifest in the expression of frustration towards one's inability to tie one's shoes properly. **"Internal states"** are not experienced in isolation, existence **"thrusts itself in the world"** (Colaizzi 1978:52).

The fundamental objection to the 'ordinary attitude' towards experience is the belief that one's experience does not count, is tantamount to stating that one's existence cannot be counted, which is negated by the fact that one is living. In summary, Colaizzi argues that there are four key concepts to advance his theory of methodological enquiry. Firstly, experience has an objective reality for one's self and others. Secondly, experience does not exist internally it has a **"mode of presence in the world"** (Colaizzi 1978:52). Thirdly, the 'mode' has significance existentially and finally, this existential significance is required to understand human psychology.

Experimental Descriptions

Colaizzi concludes his general background for his developing methodological theory by considering the options for the objective psychological investigation of human experience in the light of his analysis. He dismisses traditional experimental psychology, predicated upon natural science methodology with notions of objectivity that transform experience into operational definitions to explore human experience and fails to acknowledge the existence of certain types of experience. He advocates a method that:

remains with human experience as it is experienced, one which tries to sustain contact with the experience as it is given (Colaizzi 1978:53).

The foundation for such an approach he argues arises from Heidegger's (1962) phenomenological philosophy epitomised in Heidegger's seminal work *Being and Time*.

...to let that which shows itself be seen from itself in the very way in which it shows itself from itself... (Heidegger 1962:58)

Colaizzi makes the important distinction that Heidegger's approach is in

fact a descriptive method and Colaizzi derives his phenomenological research methodology from this premise, eschewing the psychological conventions of conformity to experimental methodology. In his view, phenomenological research methodology uses descriptive methods that are not prescriptive, but rather are evoked in **“conjunction with the particular aims and objectives of a particular researcher”** (1978:53). Phenomenological methodology is best understood as consisting of several descriptive procedures that have bearing in their respective ways.

Anthropological Assumptions in Phenomenological Psychology

Traditional psychological methodologies base themselves upon a construct that underpins the epistemology of the natural sciences. In essence this is the premise that there are laws that govern nature and these laws control the entities in nature as *causes*. The causes have a determining effect upon psychological events. By way of illustration, Behaviour Therapists believe that peoples' behaviour is causally determined to the same extent that causal determinations affect the way a plant grows. This 'philosophical anthropology' is based upon a primary assumption that is reductionist i.e. nature may be 'reduced' to the conceptions of natural scientists. The secondary assumption is that people are ontologically identical, (if somewhat more complex) to all other entities that are subjected to the scrutiny of natural scientists. Thirdly, there is a strictly determined cause for all the facets comprising human existence. Finally, there must be an assumption that dualism exists between nature and human existence. According to Luijpen (1969) 'brute reality' is an accurate portrayal of the world.

The significance of the above is the light it sheds upon the foundations upon which traditional in psychology is based, as it reveals the philosophy behind the subsequently developed methodology. In the interests of conceptual clarity phenomenologically descriptive

methodology requires consideration of the physical anthropology that underpins it. The assertion of the phenomenological position that human experience exists not in isolation within people, but as an experience involving interaction with the world, describes a phenomena of intentionality, which is a phenomenological notion. Intentionality essentially conceives that the unity between the world and human existence is so fundamental that neither one is conceivable 'without the other'. Moreover, neither is the **"cause of the other"** they simply **"co-exist by reciprocal implication"** i.e. they are co-constitutional not 'created' or 'caused' by each other (Colaizzi 1977:58).

Strictly interpreted, this philosophy delegates 'causation' out of the realm of human existence, but because it cannot be similarly stated not to apply to other entities in the natural state then natural scientists must view human entities as separate from other entities. This suggests that a 'person-centred' world structure is not reducible for analysis from the perspective of natural science. With this in mind, it is clear that 'the philosophical anthropology of phenomenology' is fundamentally distinct from, if not the **"antithesis of"** traditional psychology (Colaizzi 1977:58).

It is difficult to assert value judgements on the merits or otherwise of different approaches to methodology. However, Colaizzi does suggest there can be some certainty relating to experimental methodology. It is that there is no way to prove, within philosophical anthropology, the underlying presumptions of causality/determinism because experimentation is based upon assumption of causality. The value of a philosophical anthropology can only be measured by the success or otherwise of the application of a particular experimental psychology. This of course applies to phenomenologically descriptive methodology too –it should not be judged by its philosophical anthropology which is 'unfamiliar' but more on whether or not the methodology fulfils its aims. This is the criterion by which to judge a methodology namely accomplishment, which generates the question of how might such

criteria be measured?

The Approach of Phenomenological Psychology

Approach in phenomenological language describes implicitly preconceived objectives and meanings that we bring to a research project and these inevitably influence our investigated topic. Contemporary society is inclined towards a natural science approach to research as this method supports the values of a technocratic society, which aims for knowledge to have a practical application. Natural science experimental methodology is also the foundation of traditional psychology. Giorgi (1971) labelled the application of experimental methodology in technically orientated research as the 'content-method-approach-unity'. The dominance of this methodology of choice to conduct meaningful research in a technically focussed society and the traditionally similar methodology rooted in psychology is probably collectively responsible for the lack of critique from the psychological discipline, of the experimental method for conducting psychological research. Question arises therefore as to how phenomenologists fulfil 'content-method-approach-unity' and this is investigated below.

Phenomenologists regard *what* they want to investigate and *how* they proceed methodologically to investigate phenomena is of utmost interest because their approach towards research influences the whole research process. So, the phenomenologist self-scrutinises his pre suppositions by asking **“why am I involved in this phenomenon?”** (Colaizzi 1978:55) and by asking what aspects of their unique personality affect the processing of the research conducted on the phenomenon under investigation, i.e. what effect will the phenomenological researcher's personal prejudices or predilections have on the research?

The phenomenologist questions the benefits for themselves as researcher, their moral, political and religious ideals. All these

considerations amount to a method to foster awareness of the researcher's approach to the study. Awareness of approach ultimately informs the phenomenological researcher that they cannot devoid themselves of disinterest, i.e. complete objectivity cannot be achieved. However, **“scrutiny, analysis and examination”** (Colaizzi 1977:58) informs the phenomenological researcher and facilitates their disengagement from natural science criteria for conducting research, enabling the formulation of alternative criteria by which to conduct research. This is illustrated by the following:

..understanding the investigated phenomenon qualifies exquisitely as a criterion for research knowledge, specifically, an understanding that does not set out to master, control or dominate the research (Colaizzi 1978:56).

In essence, as Colaizzi writes, phenomenological understanding could be viewed as **“..a man as bodily engaged, participating, being-in-the-world-with-others”** (Colaizzi 1973:132).

Technology and Traditional Psychology

As a consequence of eschewing traditional approaches to conducting research and exploring as a researcher one's approach to a particular piece of research, the orientation of the phenomenologist becomes clear. Phenomenological researchers implement the descriptive method in stark contrast to the technological experimental method of traditional psychology and science. Two questions arise from this state of knowledge. Firstly, how does the descriptive method facilitate understanding of phenomenon? Secondly, how can it be distinguished from the experimental method?

The phenomenologist Giorgi argued in 1970 that the existing psychological method did not investigate phenomena because it focused

upon the natural science method of determining how variables could be manipulated. He concluded that:

The traditional psychologist knows precisely and reliably how something which he doesn't know what it is influences something else which he doesn't know what it is (Colaizzi 1978:56).

Quintessentially, what is known by traditional psychological method is the relationship between two unknowns that is quantitative in character. From the perspective of phenomenological psychology, this position is **“methodologically absurd but understandable if the goal of research is to predict and control behaviour”** (Colaizzi 1977:56) as opposed to understand it. It requires adoption of Husserl's precept of 'returning to the things themselves' to understand phenomena. This requires a relinquishing of the desire to control and a commitment to identify descriptively each phenomenon. It is this identification that was hypothesised by Colaizzi as being central to a new form of psychological methodology. This approach fulfils Husserl's three fold criteria:

- Returning to the thing itself
- Investigating phenomena in a meaningful way
- Relinquishing the technological grip on research

With the above in mind, Colaizzi developed his method of data analysis by questioning 'How does understanding descriptive methodology identify psychological phenomena?' Essentially he concluded if **“human experience is an essential and indispensable constituent of human psychological phenomena”** (Colaizzi 1977:58) then describing experience identifies psychological phenomena. In other words, by viewing the phenomenon as people experience it, psychological phenomena can be identified.

Colaizzi's method is set out below and although this study does not seek to identify psychological phenomena, it does seek to know 'what are women's and healthcare professionals' experiences of infant feeding within the current policy context and culture of healthcare in England?' His method of phenomenologically orientated methodology is therefore entirely appropriate as it facilitates identification of phenomena experienced by women, midwives and heads of maternity services through application of a particular method of data analysis. Colaizzi's method also supports identification of discourse and practice enabling these phenomena to be integrated into experiences of infant feeding.

3.5.3.2 Colaizzi's Method: The steps (Colaizzi 1978:59).

- 1) Read the subjects descriptions (protocols)
- 2) Extract significant statements from the protocols
- 3) Spell out the meaning of each statement (formulating meanings). This stage entails the use of "Creative insight" by bridging the gap between what is said and what is meant. "The researcher must go beyond and stay with it" and "let that which shows itself be seen from itself in the very way it shows itself for itself".
- 4) Repeat 1-3 for each protocol then organise the "the aggregate formulated meanings into clusters of themes".
- 5) Refer the clusters of themes back to the original protocols to validate them.
- 6) Note discrepancies.
- 7) Integrate results into an "exhaustive description of the investigated topic".

8) Try to “formulate the exhaustive description of the investigated phenomenon in as unequivocal a statement of identification of its fundamental structure as possible”.

9) Consider validation of the processes above by returning to the participants with the analysis.

Colaizzi’s method has been explored extensively in relation to the method of data analysis selected for this study. The next section of this chapter will turn to how the data is best acquired to fulfil the study aims and objectives.

3.5.4 Interviews

Qualitative methodology supports a variety of data collection methods including ‘open’ interviewing, observation of phenomena and analysis of pertinent documentation (Patton 1990, Mason 2002). Data generated from this type of approach is considered ‘rich’ in detail and there are several distinctive qualitative methods, that have evolved within qualitative methodology, to acquire and analyse qualitative data (Patton 1990, Miles and Huberman 1994)

3.5.5 Interviewing Women

Qualitative research methodology is especially valuable as a strategy for this thesis as it situates women at the centre of the research process and facilitates a broader understanding of women’s experiences of the phenomenon of infant feeding. This is advocated by a significant number of feminist scholars who suggest the qualitative method reduces the potentially exploitative effect of ‘doing research to women’ by orientating the research agenda towards ‘doing research with women’ (Oakley 1981, Skeggs B. 2001, Bryman 2008).

To effectively address the research question, a specific approach to data acquisition from women was designed incorporating a semi-structured qualitative interview method of using an interview topic guide¹⁸. This adoption of an 'expectant state' towards data acquisition (Paget 1983) is believed to effectively facilitate qualitative interviews (Patton 1990). Such an approach is thought to be particularly effective at shedding prescriptive agendas by the researcher, thereby especially enabling narrators (women) to be heard (Shakespeare 1993). It also reduces the possibility that an interview 'script' may incline the researcher to dominate interview proceedings, a potential issue that feminists suggest may be due to issues of power manifesting in a **"desire to take control of proceedings"** (Oakley 2000:41). However, concern about this possibility also has to be balanced against a need for validity. Statements made by participants during interview might require exploration by the researcher in order to 'truly hear' what women have to say (Anderson and Jack 1991), this 'conversational approach' is best facilitated by an interview topic guide as opposed to the relatively rigid structured interview approach towards data acquisition. This supports the view that the process of qualitative research consists of joint construction of data between the researcher and the research participant. There exists a 'performance' element to the 'role' of researcher. As Shakespeare concluded: **"My research wasn't merely data to be gathered in but was derived from the stuff of people's lives"** (1993:105).

For the reasons discussed above, this 'conversational approach' using an interview guide to conduct qualitative research is a method justified for this proposal to effectively acquire data about women's infant feeding experiences. However, feminist philosophy underpinning this qualitative topic guide approach described above is also appropriate for the other participants in the research proposal namely Midwives and Heads/Commissioners of Maternity Services. Apart from the fact that

¹⁸ See interview topic guide attached as appendix one

the vast majority of these potential participants are likely to be women, the approach is more likely to generate data that will answer the research question and fulfil the aims and objectives of the proposed study.

3.5.6 Ethics of Social Research

Addressing the subject of ethics within qualitative research design in a social healthcare context is not as straightforward as dealing with the topic in medical research proposals. Medical research ethics have precedent in the *Guidelines for Human Experimentation 1931* (Ghooi 2011) and are substantially derived from the subsequent 1947 *Nuremberg Code* (Sebring 1949) written after the medical Doctors' trial that ensued from atrocities committed during the second world war. Biomedical research ethics are also informed by The World Medical Association's (1964-2008) *Helsinki Declaration* (WMA 2008) and whilst these two codes provide authoritative guidance for social science, research as Ryen (2011) notes, the social sciences comparatively lack specifically determining ethical codes and authorities.

Without straying too far into the realms of conflicting qualitative research paradigms and standpoints Hammersley (1999) suggests there are two opposing positions with respect to ethics and qualitative research. Firstly, he questions whether or not qualitative research can ever be viewed as ethically correct, as the research process itself invites ethical dilemmas with respect to recruitment, ownership of data etc. Secondly, he cautions against the application of medical ethical models as they may in fact generate 'moral panic' ((Hoonard 2002) in Ryen 2011:418) which works against the benefits of qualitative methodology.

There are cultural influences to appreciate too when appraising ethical issues arising in Western Research Ethical Guidelines. Ryen (2004) has identified three key topics which include firstly 'codes (or guides) and

consent', secondly 'confidentiality' and thirdly 'trust'. However, she notes that they perhaps generate **“more questions than answers”** (Ryen 2011:41).

The matter of consent requires attention as to whether or not participants are agreeing to undergo research. Any consent must be informed i.e. participants must understand the nature of the study they are consenting to and participants must be aware that they have the right to withdraw their consent at any stage during the research process. Convention dictates that participant consent must be recorded by the researcher in either a written or recorded format (Murphy and Dingwall 2007 Ryen 2004).

The topic of confidentiality relates to an obligation to protect participants' identity and their place or location. This subject is predicated heavily upon Western cultural values and raises the question 'What if participants do not desire anonymity?' Or, 'What if they want their names included in, or published as part of the study?'

Trust is a complex matter too. It relies heavily on 'good' relationships in the research field (Ryen 2011). Trust is clearly breached when questions arise as to whether or not research should be conducted alone? Or when is an appropriate time to stop gathering data, to turn off the recorder? How about moving the questioning on? Or even deciding to close the whole project? Or, what about trust with regards to interpretation of the data? Gubrium and Holstein (1997) refer to the process of constructing meaning from data as being equivalent to the meaning that is produced from the data. Feminist scholars rightly identify this as a complex process, interwoven with subjectivity (Oakley 1981, Anderson and Jack 1991, Barnes 1999).

Criticism of 'Western-centric' research ethical guidelines incorporating consent, confidentiality and trust include that it may be viewed as an **“External Policing”** mechanism (Ryen 2011:428) which lends itself towards a 'tick box mentality' that perhaps undermines the

fundamental nature of qualitative research. In addition, presupposition of static or clear ethical research topics equates with positivist informed epistemology. But, if qualitative research is constructionist in nature and this premise is accepted, then positivist informed topics are incongruous with qualitative research methodology.

Epistemological deliberations aside, qualitative research by its nature challenges the professional/private divide that characterises researcher/participant relationships. Good rapport is desirable between interviewer and participant yet it can create dilemmas in relation to the fine line that exists between friendship and deception, privacy and intrusion. Emotional stress may arise during the course of data collection. All these factors have a bearing upon the Western research ethical guidelines that incorporate consent, confidentiality and trust as ethical considerations when conducting research. Duncombe & Jessop write of 'doing rapport' and use the term 'faking friendship' (2003). Such 'emotion work' (Hochschild 1983) may have questionable authenticity because it could be viewed as the commercialisation of human feelings by simulating empathy. Duncombe and Jessop (2003) refer to a 'disturbing ethical naivety' to describe ignoring the dilemma posed by the idea that friendship is being faked.

These concerns are perhaps countered to some extent by Oakley's feminist perspective encouraging minimal distance between the researcher and (female) participants by engaging in **"an emotionally empathic, egalitarian and reciprocal rapport"** (1981:108). However, this could be viewed merely as an earnest appeal to imbue authenticity into the relationship between participants and researchers which although laudable, as Duncombe and Jessop note it nevertheless remains a 'naive' approach to the ethical dilemma of cultivating non-spontaneous friendship.

The issue of boundaries and friendship extends also to the question of whether or not qualitative researchers are 'intruders' into people's lives.

Yet, emotional distress is desirable because it **“cultivates connections”** (Ryen 2011:431). But, does the emotionalism inherent in some types of qualitative research cause harm?

All the questions and topics raised in this section do not exclusively inform the ethical strategy for the research design which is set out below (see sections 4.2.5 and 4.3). However, they do suggest it is important to appreciate that that ethics is a field socially constituted and situated (Ryen 2004), whose practice is informed by epistemology. The issue of power in social research is vast and has been touched upon in this chapter in relation to interviewing women, it is worthwhile to also appreciate how research ethics are also combined with notions of power (Ryen 2008) and these debates are complex and not readily resolved.

3.6 The Method

This section addresses how the study was conducted and the particular considerations that informed the research design.

3.6.1 Interviewing Pregnant Women/Mothers

Regarding women, to address the research question a series of interviews were thought necessary to capture their evolving infant feeding decision making processes. As a result, a longitudinal component for the data acquisition of these participants was incorporated into the study design (Patton 1990, Bryman 2008). The potential emotional consequences (Hearn 1998) of asking women to talk and disclose personal information about themselves, was also considered in relation to the ethics of the study.

Practically and ethically the psychological and emotional consequences for participants in research always needs to be anticipated when conducting social research (Ryen 2011). To some extent there is a need to 'expect the unexpected' and to theorise that participants might experience a disturbed emotional state under interview or that the interview process might engender particular insights that may disturb women (Oakley 1981).

Potential issues arising from the research for women were fully explored at the design stage of the research process. There was particular sensitivity towards the notion that Women who may have not yet fully come to terms with their decisions regarding infant feeding might feel perturbed especially as breastfeeding may viewed as a 'pressure' associated with social constructs of 'good mothering' (Lee and Furedi 2005). The intensely emotive feature of caring for babies makes women uniquely vulnerable to this topic of research. An approach adopted throughout the interviews was taken that sought to reassure women **“that neither they nor I should be embarrassed, and that I understood their difficulty in discussing such experiences”** (Taraborelli 1993:179). It was hoped that this stance reassured women participants experiencing strong emotions.

Another practical strategy thought useful to employ prior to undertaking potentially 'emotionally charged' research in the interviewer (or focus group setting –see section 3.3.2) is ensuring adaptation of a neutral stance (Holstein and Gubrium 2004). This approach was constantly applied throughout the entire interviewing process. All the literature inviting participation in the project was carefully designed to convey neutrality and promote a sense of personal agency in all participants.

Prior to conducting the interviews, basic counselling skills were revisited and use of language was carefully planned with consideration of sensitive replies to potentially emotive questions alongside thoughts

about appropriate responses to potential ethical dilemmas (Hearn 1998). Of reflexive note, the midwifery profession is full of language such as ‘failure to progress’ (in labour) with clear negative connotations. It is extremely important that such phrases are not employed in any type of research interviews (Bryman 2008) and all stages of the research design this imperative was considered. Reflexivity as a research tool first developed prior to the rise of postmodernist thinking in the late 1980s. The postmodernist concept of reflexivity suggests that the role of the researcher is an integral component of the construction of knowledge. How the researcher positions themselves with respect to who is being observed, and how those observations are reported, requires an understanding and acknowledgement of the connotations of a researcher’s approach to their practice (Johns 2010a).

3.6.2 Interviewing Midwives

Midwives exert a substantial, proximal influence upon women’s experiences of their infant feeding decisions and the implementation of current IFP. The study question and aims suggest that two distinctive qualitative approaches were warranted to best acquire data from midwife participants in the study. Firstly, for the reasons discussed above in relation to women, midwives are similarly likely to yield relevant data if they participate in semi-structured qualitative interviews using an interview topic guide¹⁹.

Secondly, the qualitative method of focus group discussion using a topic guide²⁰ was also deemed useful to fulfil the aims of the project. Provided any necessary intervention is undertaken by the researcher in order to keep the discussion ‘on track’ (Wilkinson 1999), focus groups are particularly effective at allowing sensitive issues to be discussed as group participants may feel more able to participate ‘honestly’ through

¹⁹ See interview topic guide attached as Appendix two.

²⁰ See interview topic guide attached as Appendix three.

their collective identity (Madriz 2000). This may have particular application for the 'deviant' midwives identified in the literature scoping review for the thesis.

Additionally, a diverse range of potential research themes may be generated in a focus group setting that can inform study design for further enquiry of more depth using qualitative approaches. Of note for feminist research, it is suggested that the issue of power is reduced in the focus group setting (Wilkinson 1999) because participants are able to direct the session away from the facilitator somewhat, sometimes with interesting results. Not surprisingly, focus group methodology is preferred by feminists who are suspicious of potentially exploitative methods of social research (Bryman 2008).

3.6.3 Interviewing Heads of Midwifery and Commissioners

As the literature review for this proposal suggests, Heads and Commissioners of Maternity Services occupy a distal, and poorly understood, role in the implementation of IFP in the NHS. Nevertheless they are directly influential upon the culture of maternity services and also responsible for associated policies. Therefore they influence clinical practices of midwives and indirectly the maternity care women receive. Given the complexity of the subject matter, the data acquisition methodological approach considered most likely to fulfil the research aims and objectives was also the use of semi-structured qualitative interviews with an interview topic guide. This was justified methodologically on the basis of the discussions above. Interview topic guides for Heads²¹ and Commissioners of Maternity Services²² were devised that linked together conceptually regarding exploration of topics so as to generate similarly themed data from the narratives (Spencer 2003).

²¹ See interview topic guide attached as Appendix four.

²² See interview topic guide attached as Appendix five.

The above considerations were applied to the study design which is set out in summary form below.

3.6.4 Summary Research Proposal for the Study

3.6.4.1 Justification

The literature review in chapter 2 suggests there is a lack of qualitative research relating to views of infant feeding as opposed to breastfeeding. Chapter 1 suggests the study is justified because healthcare practitioners are in a potential position to contribute to health policy making (Hunter 2009) and therefore current political awareness is always important for clinical professionals. These professions are at the fore-front of healthcare services with specific, considerable expertise and associated comprehension of issues that could significantly inform government generated health policy. Midwifery and health policy related research is a rapidly expanding field. Accordingly, IFP analysis that is situated within the midwifery profession is especially desirable to ensure a plurality of views of this topic is obtained. Midwives may hold distinctive policy insights, through their professional and unique experiences with women accessing maternity services.

Furthermore, whilst a health policy or strategy implemented by any government directly effects service provision of the target population (Antrobus 2004, Davies 2004), by extension it also affects the practice of professionals providing services associated with such policy. This research proposal is therefore justified since it also has the potential to contribute to health and/or IFP from the perspective of the midwifery profession, maternity service providers and commissioners of healthcare services.

Finally, this research proposal is justified conceptually and methodologically because it adheres to the qualitative research

framework derived from the study *Quality in Qualitative Evaluation: A Framework for Assessing Research Evidence* by NatCen -the National Centre for Social Research (Spencer, Ritchie et al. 2003).²³

3.6.4.2 Recruitment and Sample

There are no definitive criteria in qualitative research that relate to appropriate participant numbers for a qualitative study. However, many researchers suggest that interviews continue until the data acquired yields no further insights relating to the research question (Silverman 2004). Therefore, the decision to interview a set a number of candidates thought appropriate to the study aims was taken with a view that they might require revision at some point.

Women: The study aimed for twelve candidates, from two separate NHS trusts in England. The women were to be recruited for a series of three interviews when they were approximately twenty eight weeks pregnant, experiencing a ‘normal’ pregnancy. Their first interview was to be conducted when they were approximately thirty six weeks pregnant, the second at two months post-partum and the last at six months post-partum. The women were to be invited to participate in the study via a study information invitation²⁴ and leaflet²⁵.

Midwives: The study was designed to occur within the two separate NHS Trusts where the women were participating in the study. It aimed for six candidates recruited for a single personal interview and one focus group interview (consisting of six-eight midwives), per NHS Trust, recruited by use of a poster campaign²⁶ and study information leaflet²⁷.

²³ NatCen are Britain's leading Independent Social Research Unit and were commissioned by the Strategy Unit of Her Majesty's Government's Cabinet Office to produce this appraisal framework. This authoritative document was generated in consultation with thirty-four associated experts within the fields of academic and civil service departments following a comprehensive evaluation of existing commanding qualitative methodological literature.

²⁴ See appendix six.

²⁵ See appendix seven.

²⁶ See appendix eight.

Heads and Commissioners of Maternity Services: The study aimed for recruitment of five candidates each from any NHS Trust within England, via a written invitation²⁸ and study information leaflet²⁹, to undertake a single personal interview.

3.6.4.3 Data Collection

Data was designed to be collected from women and midwives in face to face interviews in their homes or elsewhere by negotiation. Interviews were recorded and anonymously transcribed for the purposes of data analysis. The study was designed to collect data from Heads of Midwifery in either face to face or telephone interviews that were similarly conducted and recorded before being anonymously transcribed.

3.6.4.4 Data Analysis

Data analysis was conducted using the qualitative method of existentially phenomenological analysis (see sections 3.5.2-3.5.3) developed by the psychologist Paul Colaizzi (1978).

3.6.4.5 Ethical Issues: Consent, Confidentiality, Anonymity, Refusal

Consent: Recruitment into the project was designed by written or orally recorded consent, on the understanding that the participant's consent may be withdrawn at any point during the study. Written or oral consent was obtained from all participants in the study i.e. the Women³⁰,

²⁷ See appendix nine.

²⁸ See appendix ten.

²⁹ See appendix nine.

³⁰ See appendix eleven.

Midwives³¹ and Heads of Midwifery³².

All participants were reassured that withdrawal of their consent to participate in the study would bear no personal or professional consequences for them. The study was designed to ensure that all data relating to any withdrawn participants would be destroyed.

Confidentiality: Participants were advised that their data would remain confidential to the researcher at all times. Recorded interviews were transcribed and anonymously coded to ensure confidentiality. Trust specific data was identified and either removed or rendered anonymous. All data was stored in a locked secure cabinet at the researcher's home address. The study was designed to destroy all personal data six months after the end of the study. Computer data was encrypted and stored on removable storage devices, with password code access, in the locked facility described above. Relevant Data Protection Act Legislation 1998 was adhered to. There was a caveat incorporated into the study for the researcher to breach confidentiality only in the case of public interest disclosure. This fact was communicated directly to all research participants. Examples of public interest disclosure included child protection issues and/or any reasonable belief that a participant might engage in a criminal act such as an intention to commit grievous bodily harm.

Confidentiality and analytical issues: The majority of the study i.e. that relating to midwives and women, was designed to take place in two geographically distant NHS trusts to ensure participant confidentiality, and that 'trust specific' discourses were appropriately identified during the data analysis stage. The study was designed for rigorous qualitative data analysis to be undertaken of all data generated by the study as per authoritative guidelines (Spencer, Ritchie et al. 2003, Walsh and Downe 2006).

³¹ See appendix twelve.

³² See appendix twelve.

Psychological distress: It was deemed unlikely that any research participant will experience prolonged psychological distress, although consideration was given to the possibility that they might become emotionally upset at various points throughout the data collection process. To some extent this issue is addressed in the methodological approach section of this chapter relating to sensitivity towards women being interviewed (section 3.3). A general list of potential support services was made available to all research participants³³.

3.6.4.6 Funding: Declaration of Interests

This Ph.D. was majority funded by the Faculty of Health and Social Care at the University of Hull and part funded by a Danone Nutrition *Learning Curve Education and Research Grant Programme* (<http://www.learningcurve.uk.net/>). Full intellectual property rights are retained by the author and the University of Hull. Danone Nutrition are the parent company of Aptamil and Cow & Gate, who manufacture infant formula milk. Danone view their financial support in the following manner:

These are educational grants. Receipt of them does not imply in any way that you endorse the products or activities of Danone Baby Nutrition (our parent company) or of Aptamil or Cow & Gate. However, we do ask all applicants if they will register on our database of potential speakers for future study days or authors for future educational articles. This means that our grants programme can benefit the wider healthcare community. Of course it also means that your work becomes known to a much bigger audience than it was before³⁴.

³³ See appendix 13.

³⁴ <http://www.learningcurve.uk.net/ResearchGrants/EducationResearchGrantProgramme/tabid/129/language/en-GB/Default.aspx>

The remit of this study for purposes of the grant includes the following broad areas of education and research:

- Pregnancy and childbirth
- Feeding, nutrition, development and health of infants and toddlers (from birth to 36 months of age)
- The specialist areas of pre-term and allergy
- Weaning and feeding in early years.

3.6.4.7 Reflexive Consideration of Bias

To reduce the potential for bias in the study, the issue of reflexivity was dealt with extensively at an early stage of the research design and discussed at length in section 3.2 of this chapter. In relation to the phenomenological method chosen (see section 3.5.2-3.5.3) reflexivity is also an important component of the study process.

The next section of this chapter describes the experience of applying the above research design to the study progression.

3.7 Gaining Ethical Approval –The Process.

Approval was necessary from both the Faculty of Health and Social Care at the University of Hull and NHS Integrated Research Application System. This process is summarised below.

3.7.1 Application for Ethical Approval –The University of Hull

Upon successfully undergoing an MPhil to PhD upgrade interview based

upon the contents of the literature review for the thesis, a research proposal was submitted to and approved by the Faculty of Health and Social Care (FHSC) at the University of Hull. An application was then made to the FHSC Research Ethics Committee (REC) for ethical approval for the study. Ethical approval for the study was granted³⁵ following fulfilment of several relatively minor requirements to amend the research design³⁶.

3.7.2 Application for Ethical Approval –The National Health Service

Following receipt of ethical approval from the chair of the Faculty of Health and Social Care’s Research Ethics Committee, an application was subsequently made for ethical approval for the study using the NHS Integrated Research Application System (IRAS) that provides a standardised application process for conducting research involving either people who access the services of the NHS or people who work for it. This process was necessary because recruitment for the study was designed to use the NHS through the intention to distribute leaflets to pregnant women through community midwives, and recruit midwives through a poster advertising campaign. Heads and Commissioners of maternity services were to be accessed by direct written communication. The IRAS application process was lengthy and required insurance support from the University of Hull.

Ethical approval was granted by the NHS IRAS Research Ethics Committee on the first application for the study³⁷ which did not confer immediate granting of access to the study areas because local NHS Trust Research & Development (R&D) approval was subsequently required for each of the two NHS trusts. Gaining R & D approval was a

³⁵ See appendix fourteen.

³⁶ See appendix fifteen.

³⁷ See appendix sixteen

more idiosyncratic process, with one NHS Trust requiring attendance at a meeting of the hospital research committee to explain the study and the second trust granting approval upon receipt of all documentation from the IRAS application.

The next section of this chapter addresses study recruitment design.

3.8 Recruitment

Women: The study was designed to recruit women over a one month period via a written invitation³⁸ and a study information leaflet³⁹ was distributed to all women who were twenty eight weeks pregnant in two separate NHS trusts in England. Invitations and leaflets were distributed by community midwives conducting antenatal examinations. Women were recruited who were experiencing a normal pregnancy⁴⁰ and had sticker confirmation placed on their handheld obstetric notes upon receipt of the study information.

Consent for the researcher to contact women interested in study participation was implied when women elect to establish contact with the researcher. This assumption was communicated to women within the written invitation. To allow for participant attrition, fourteen women were hoped to be purposively selected by the researcher. The selection criteria included women experiencing normal singleton pregnancies and who represented as diverse a socio-demographic as possible. Extra effort was anticipated to be expended by the researcher if necessary to recruit traditionally 'hard to reach' socio-demographic population groups of women. This was thought to be achievable if necessary by the researcher being available, in antenatal clinic waiting rooms situated within economically deprived areas, to discuss the proposed study if invited to do so by women already in receipt of the written invitation

³⁸ See appendix six.

³⁹ See appendix seven.

⁴⁰ See appendix twenty.

and study information leaflet. Information about the study was designed to be presented to potential candidates orally using the written invitation and study information leaflet as a guide.

Midwives: The study aimed for a total of six candidates for personal interview and one focus group consisting of six-eight midwives, per NHS Trust. If an insufficient number of midwives were willing to undertake focus group participation, the total number of candidates for personal interview would be increased to ten. Candidates were to be invited using a promotional poster⁴¹ displayed in maternity services within two NHS Trusts in England. Participants were to be selected to include midwives with a broad experience in providing infant feeding support to women. Further information about the study was designed to be provided to candidates and participants using the study information leaflet.⁴²

Heads and Commissioners of Maternity Services: The study aimed for five candidates each within England, by invitation through written communication⁴³ and the study information leaflet⁴⁴ distributed by post. One follow up telephone call inviting future contact for participation in the study was to be conducted in order to prompt recruitment of study participants if necessary. No study selection criteria were incorporated into the design for inclusion into the study.

The next section of this chapter explores what amendments were made to the original study design during the course of the research.

3.9 Adaptation of the Study Design

Adaptations to the original study design were made for all groups of participants and are summarised below.

⁴¹ See appendix eight.

⁴² See appendix nine.

⁴³ See appendix ten.

⁴⁴ See appendix nine.

3.9.1 Recruitment of Commissioners

The element of the study designed to recruit commissioners of services was withdrawn from the study for political reasons. During the course of the research, a change in parliament caused an administrative reconfiguration of public health services away from Primary Care Trusts (PCTs) to Local Authorities which resulted in a lack of clarity concerning who was responsible for commissioning services that promoted IFP.

3.9.2 Recruitment of Heads of Midwifery

There was a good response to requests for Heads of Midwifery to participate in the study and as a result of the above more women were recruited into the study than the original design intended.

3.9.3 Recruitment of Women

Recruitment of women into the study was slow for interesting reasons. It appeared, from anecdotal feedback from the midwives distributing invitations, that women were interpreting the study as an attempt to monitor their breastfeeding and therefore women not intending to breastfeed felt intimidated as a result. An application to amend recruitment of women into the study was sought from the FHSC REC⁴⁵ that sought to shift recruitment away from health care professional involvement. This was subsequently approved and incorporated into the study design⁴⁶. It included advertising for women participants in the local press, attending antenatal classes to explain the study and 'snowballing' to recruit extra women.

The next section of this chapter summarises what process the data collected underwent during the course of the study.

⁴⁵ See appendix seventeen.

⁴⁶ See appendix eighteen.

3.10 The Data

3.10.1 Data Collection

A total of sixteen healthcare professionals were interviewed, Eight midwives and one Head of Midwifery were interviewed face to face for the study and a further seven HoMs were interviewed via telephone.

Seven women were recruited into the study. One woman withdrew from the study because she tragically lost her baby from still birth shortly after her first interview for the study. Another woman became ill and had to stop breastfeeding, due to her medication consumption, shortly after her baby was born. She remains a component of the study for her first and second interviews only.

The decision was taken to not incorporate the one Focus Group interview in the analysis section of the results. It was difficult to incorporate this data due to the method of analysis employed for the other interviews and lack of focus group participants recruited from the other site.

All interviews were recorded and anonymously transcribed.

3.10.2 Data Analysis

Analysis of the data arising from this study lends itself to the qualitative research tradition of postmodernist, existential phenomenological descriptive analysis that was developed by Colaizzi (1978) and Giorgi (1970). This technique is sometimes described as an extension of 'reflective critical thinking' (Dewey 1933) which illustrates an approach that may be viewed as originating from the philosophers of ancient Greece (Gulley and Socrates 1968). This method is extensively discussed in sections 3.5.2-3.5.3 above.

Colaizzi's method was applied to the transcripts of the interviews with

the women, midwives and heads of midwifery. The final section of this chapter addresses the reliability of the data collected from the study method.

3.11 Credibility, Dependability, Confirmability, Transferability, Authenticity: Limitations of the Study.

Despite the multiplicity of approaches to, and lack of consensus in qualitative research discussed above, qualitative method has a defined set of principles that relate to the challenge of ensuring the integrity of the findings it generates (Silverman 2004). These principles acknowledge the unique orientation of qualitative methodology as not precluding the striving for ‘quality’ in the conduct of qualitative methods (Mason 2002, Spencer, Ritchie et al. 2003). This section concludes the chapter on methodology by considering how the issues of: credibility, dependability, confirmability, transferability, authenticity and limitations of the study applied to this particular research route.

3.11.1 Credibility

Credibility is sometimes referred to as the ‘truthfulness’ of a study. It is enhanced in qualitative methods when the researcher describes the experience of undertaking the research and checks with study participants with regards to their interpretation of the data (Polit and Beck 2010).

My research journey was most certainly a learning curve. Despite my best intentions and prior theoretical considerations I do consider that the first few interviews I conducted were less than optimal, as I probably spoke too much during them. However, I do believe that my conduct as an interviewer improved significantly and I quickly became more skilled at questioning participants to explain what they meant

during the course of the study. These steps enhanced the credibility of the study.

3.11.2 Dependability

Dependability refers to whether the data might be constantly presented under similar conditions (Koch 2006). The study findings discussed in chapters 6 and 7 do suggest the research met this criterion to a certain extent.

3.11.3 Confirmability

Confirmability relates to the extent that the findings can be attributed to the participants discourses and not the researcher's perceptions of the data (Cope 2014). To facilitate this criterion, a robust method of data analysis was chosen (see section 3.5.3). Additionally, large sections of the primary data are reproduced in the chapters containing the data analysis (chapters 4 and 5) because 'letting the participant's speak' enhances confirmability of the interpretation of the study findings.

3.11.4 Transferability and Authenticity

The criterion of transferability is met when research findings hold a meaning for people outside of the participant group. Authenticity is achieved if the data appears to represent the 'voice of the participant' (Cope 2014). The study findings represented in the data analysis and discussion also suggest the research met these criteria to a meaningful extent in part because they replicate other research findings as well as generating new ones.

3.11.5 Limitations of the Study

To a certain extent the limitations of the study are addressed considerably by all the above components of this chapter. The issue of reflexivity and researcher bias is particularly and extensively discussed in sections 3.2.1 and 4.4.2.7. My candid accounts leading up to this design study reveal where potential biases might lie in my representation of the data. However, the extent to which I undertook reflexive analysis also occurred in relation to my interview and data analysis techniques as well as my interpretation of the findings. I have maintained an identifiable 'audit trail' (Cope 2014) to further enhance veracity of the results. This consists of transcripts of all interviews containing theme coding and formulated meanings attached to significant statements, an example of which is included in as Table 2 and Table 4 in chapters 4 and 5 respectively.

Study strengths included the incorporation of the methodological considerations earlier in the chapter and open questions in the interview guides with a longitudinal component to the interviews with women. This enhanced the trust between myself and interviewees which improved the data and enabled comparison between expectations and experience. Analysis was presented in the context of existing knowledge and context, which further increases the trustworthiness of the study.

Limitations of the study not previously mentioned relate to that sample size. I felt that the concept of data saturation was not quite reached with all groups of participants and that new insights or further confirmation might be achieved by interviewing more participants which was not possible given the study resources.

3.11.6 Critique upon using Colaizzi's method of data analysis

In the interests of transparency, having extensively researched and then

applied Colaizzi's method of qualitative data analysis during the course of my study, I have a number of reflections upon this experience. In part these reflections reveal further insights into the actuality of my analysis, but they also result in reservations about the utility of this method for future research.

Colaizzi's method was initially attractive to me as a 'novice' analyser of qualitative research not least because the field of qualitative research is remarkably less defined than that of quantitative (see 3.4-5 above). This fact especially applies to the stage of data analysis in qualitative studies (Feldman 1995, Silverman 2000). As I sought clarity from the 'unwieldy' raw data I had obtained, the nine steps (3.5.3.2) proposed by Colaizzi were 'reassuringly prescriptive' at the start of my qualitative data analysis journey. However, on reflection they are perhaps unnecessarily laborious as at many times during the process of my deriving formulated meanings from the significant statements, this technique seemed to become superfluous to understanding the implicit meaning of participants' narratives.

I was additionally attracted by Colaizzi's view that his method conferred a rigour in the data analyses owing to such instructive methodology towards scrutinising the data. However, the analytic pathway involves conceptual and intellectual flow (NatCen 2014: 296) that especially lends itself at the early stages of data analysis to the creation of an initial thematic framework (NatCen 2014). Such a stage in my analysis would have been very useful for presenting the data, and could have been linked closely with the research objectives that were exemplified in the interview guides. Therefore in future, for a similar project I would employ a framework analysis approach, with or without the use of computer aided analysis software. This method enables a similarly 'creatively systematic approach' towards data analysis that has been developed extensively in the past decade (NatCen 2013).

Colaizzis method is also unsatisfactory because analysing data in

practice often reveals a 'Global Theme' that links discrete 'Organising Themes' together (Attride-Stirling 2001). Two themes (or 'Organising Themes') generated in this study, namely the 'Discourses of Self-Determination' and 'The Emotion Work of Compliance' (Attride-Stirling 2001: 139) may have been interpreted as linked to what could be termed a 'Global Theme' that related to notions of Power.

Notwithstanding the above I would like to acknowledge that the 'researcher reflexivity' component of Colaizzi's theoretical analysis (see 3.2.1-3 above) really clarified to me the importance of understanding this element of potential bias when analysing qualitative data. In that regard, I believed the method to be extremely useful although I only identified this component in the seminal chapter of his method, *Psychological Research as the Phenomenologist Views It* (Colaizzi 1978). Indeed it was notably lacking from all studies that I read which reported using his method of data analysis.

The next chapter explores the results relating to the analysis of the data obtained from the healthcare practitioner participants in the study.

Chapter 4: Analysis of the Heads of Midwifery and Midwives

4.1 Introduction

This study was designed with the aim to answer the overarching research question:

What are Mothers' and Healthcare Professionals' experiences of infant feeding within the current policy context and culture of healthcare in England?

One key objective of the study was:

To use qualitative research methods to examine how service providers interpret and implement IFP and guidelines.

An associated objective of the study was:

To ...identify the dominant discourses relating to infant feeding dialogue within the research groups ... To inform maternity service provision through making a contribution to the body of knowledge relating to infant feeding.

The following significant statements of the eight Heads of Midwifery (HoMs) and eight Midwives (MWs) participating in this study are highlighted in bold throughout this chapter. Their voices portray interpretations about current IFP (IFP) and reveal unique perspectives of this policy, and the maternity services, located within the National Health Service (NHS) in England over the period November 2011-June 2012.

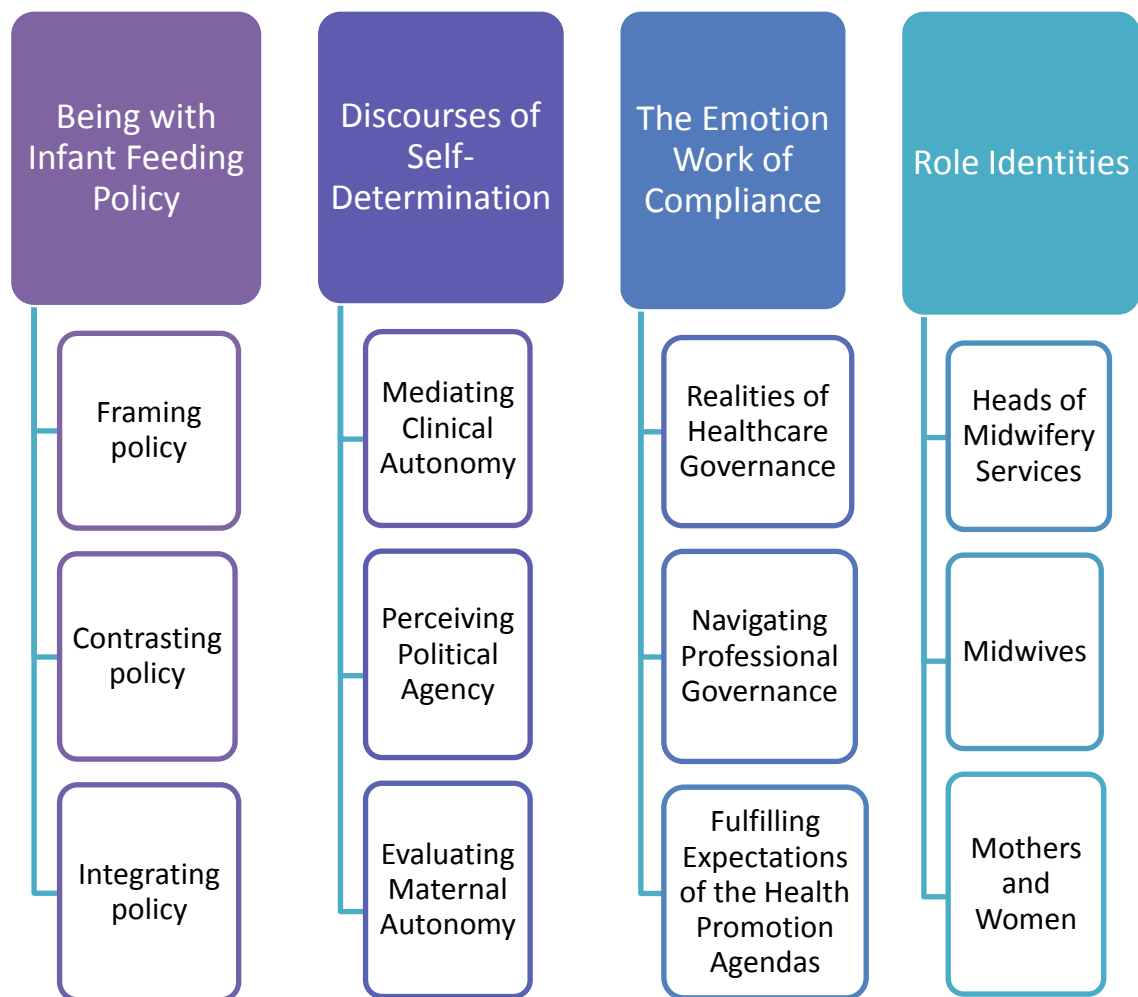
This chapter begins by listing the labels for the overarching Themes, and Subthemes assigned to the clusters of formulated meanings derived during the inductive process of data analysis (see Table 1). An

expansion of the concepts behind the labels these clusters represent precedes each section of the following subtheme analysis. The interview data relating to each subtheme is expressed in a manner based upon the formulated meanings ascribed to the data during the process of analysis. Significant statements, which are verbatim extracts from the interviews with the HoMs and MWs, are written in bold to illustrate the interpretive formulated meanings. Examples of analysed transcripts containing formulated meanings and significant statements are tabulated at the end of this chapter (see Table 2). A certain amount of interpretive analysis is conducted throughout and a comprehensive summary of the data is located at the end of the chapter. Overarching discussion of the significance of how these voices inform and reveal the dominant discourses of infant feeding may be found in chapters six and seven.

4.2 Themes and Subthemes

Four themes emerged from the formulated meanings identified in the data (see Table 1) and were subsequently labelled: *Being with Infant Feeding Policy*, *Discourses of Self-Determination*, *The Emotion Work of Compliance and Role Identities*. Each theme revealed three subthemes which are respectively: Framing Policy/Contrasting Policy/Integrating Policy, Mediating Clinical Autonomy/Perceiving Political Agency/Evaluating Maternal Autonomy, Realities of Healthcare Governance/Navigating Professional Governance/Fulfilling Expectations of the Health Promotion Agendas and Heads of Midwifery/Midwives/Mothers & Women.

Table 1: Themes and Subthemes



4.3 Data Analysis

4.3.1 Being with Infant Feeding Policy

The theme termed *Being with Infant Feeding Policy* was prominent within the significant statements and formulated meanings ascribed to the data. It emerged from statements that portrayed a process of integrating policy by evaluation, or framing policy through description, or contrasting the experience of IFP by means of comparative reflection

by participants about previous approaches to IFP in maternity services.

These three clusters of formulated meanings were termed: *Framing Policy*, *Contrasting Policy* and *Integrating Policy* subthemes. *Framing Policy* was assigned to the cluster that literally described implementing and integrating policy into maternity services. *Contrasting Policy* data was sub categorised because it appeared to set the experience of implementing IFP within the frame of personal reflections by participants contrasting how such policy used to be experienced. *Integrating Policy* data was much more multifaceted comprising of the cluster of formulated meanings that revealed attempts by interviewees to gauge the consequences and effectiveness of current IFP for society, women, midwives and the maternity services.

4.3.1.1 Subtheme: Framing Policy

A diversity of views' expressed by the participants were allocated to the *Framing Policy* subtheme. These interpretations consist of a range of descriptions from contextualising the implementation of IFP, through to depictions about the actuality of implementing policy within maternity services. *Framing Policy* data also included detail relating to the basis and the incorporation of the minutiae of policy, most of which related specifically to the UNICEF BFI (Baby Friendly Initiative) and the promotion of breastfeeding.

I think the current IFP is being driven largely at the moment, in my personal opinion, by the baby friendly initiative to increase breastfeeding rates [HoM 5: 5.2].

Prior to the BFI, midwives were deemed responsible for breastfeeding promotion **“I think before that it was just the midwife’s job and we just did it”** [HoM 4: 4.53]. Policy was acknowledged as promoting breastfeeding **“but not at all costs”** [HoM 3: 3.2] and was nominated

as being duty-bound to **“really be meaningful in supporting informed choice”** [HoM 8: 8.2] by one of the participants.

The foundation for policy was highlighted as individually focussed upon women yet orientated towards holistic health goals **“...it's around bonding and wellbeing and mental health really as well...”** [HoM 2: 2.3]. In this sense, policy was described as a mechanism to address wider areas of infant care and to optimise the maternal infant dyad.

I suppose in the large I think the policies, certainly that we have in the Trust now, are based on UNICEF and they appear to be very sort of individually focused and very geared towards bonding and breastfeeding and nurturing [HoM 2: 2.6].

With regard to contextualising IFP there was a robust sense conveyed from the data that policy was endorsed by the Department of Health (DH), the midwifery profession and the Royal College of Midwives⁴⁷ **“I think it's got strong Department of Health recommendation”** [HoM 1: 1.4]. Policy was described as evidenced based and strategically built upon government health policy and the World Health Organisation (WHO) enterprise via UNICEF, namely the BFI.

Basically our current IFP is evidence based and the evidence and the strategy that it's based upon is the WHO initiative, so we very much adhere to their code of practice [HoM 8: 8.1].

IFP was described as merging with public health initiatives with affiliated health care professionals acknowledged as collaboratively promoting policy in healthcare services as the following illustrates.

We've got a really strong team of people there within our infant feeding, who have informed our policies and I know that they are based in the latest research. So I think if they're right, if you are

⁴⁷ The professional body associated with the midwifery profession.

sure that they are based on the most relevant research, then they are hugely valuable. [HoM 7: 7.14].

There was consensus expressed amongst participants that the BFI had particularly directed current IFP with the expression of a range of detail relating to the BFI. Bureaucracy associated with aspects of the BFI was articulated with frustration by one HoM.

The other thing is that now, we've got these breast instant feed booklets, and every-bloody-feed is documented and the time. I thought we'd moved away from that? [HoM 6: 6.19].

There was a 'sense of gathering' generated within the maternity services, within the description of the cohesion experienced when implementing the BFI over the past few years as the following HoM illustrates.

I had a keen interest in it and did external study, so then was bringing... drip feeding these bits of information back. [HoM 3: 3.6].

She went on to describe how a specific Infant Feeding Co-ordinator (IFC) was then appointed. The IFC had BFI training and the 'ten steps'⁴⁸ appeared in the unit: **"Initially they were just bits of paper on the wall"** [HoM 3: 3.7] creating a sense of momentum throughout the unit whilst preparing for BFI accreditation. The BFI training associated with the accreditation process generated interest in policy especially with Maternity Assistants (MAs) as it extended their role.

The MAs became interested, because they were engaging in something that they felt made their job a little bit better. They weren't just doing the routine cleaning up and...they contributed to women's care. [HoM 3: 3.8].

The above contrasted with the experiences of another HoM who described a more mixed attitude towards the BFI in her maternity

⁴⁸ See appendix 19.

services.

I think it (IFP) creates an awful lot of debate and discussion, I think that when we went for BFI accreditation this time, I (*pause*) was wondering whether we should. But I really did see something I didn't expect. The whole unit came together and really drove forward to achieve this. It was quite unifying! [HoM 6: 6.33].

The IFCs were consistently described by participants as key figures implementing IFP agendas being universally held in high regard and typically referred to as very dedicated and professional. IFCs were viewed as experts on policy.

I guess I'm not an expert on the policy... you know, what underpins the policy. I expect my infant feeding coordinator to advise me on what is best practice and to really analyse and synthesise the evidence. So based on that premise I believe our local policy to be optimal and to do what it says on the tin really. [HoM 8: 8.9].

Policy was described as balanced under the stewardship of IFCs with one HoM citing the IFC in her maternity unit as having prepared a DVD to educate women who wanted to bottle feed their babies.

I know (the IFC) has put together a really good DVD for formula feeding mums, so that they can watch this before they hospital. So it shows them how to safely make up a bottle'. [HoM 3: 3.17].

All HoM participants when describing their maternity units portrayed themselves as dedicated to IFP, committed to raising breastfeeding rates and thereby improving the health of women and infants.

We have got a definite commitment. We're working very hard to promote infant feeding, in particular breastfeeding of course. We

are, like many other Trusts, trying very hard to improve our breastfeeding rates because of course we appreciate how important that is, both in the short-term and the long-term for the health of the population. [HoM 7: 7.2].

The IFCs were described as instrumental in this process of dedication to policy. In one unit, the IFC was credited with having had a significant effect upon the historically existing low inner city breastfeeding rates.

I do know that the infant feeding coordinator here has put a tremendous amount of work in, trying to... because 10 years ago I think our infant feeding rate was 40%... infant feeding, breastfeeding rate, was 40%. It was almost... because you're in an inner city, it was a normal level, nothing could be done about it. [HoM 3: 3.3].

This contrasted with the description by another HoM in a unit where the IFC was also portrayed as inventive at promoting policy. Unfortunately, all effort was evaluated as ineffectual in achieving the goal of promoting breastfeeding.

But I have an absolutely fantastically innovative infant feeding advisor who, you know, makes milk up at her training sessions, has brought everybody a squirty lemon. You know, who's done all sorts of things to get it out there, but that is never going to be acknowledged, even in my own organisation, because the figures are just rubbish. [HoM 4: 4.39].

Reasons descriptively expressed by the interviewees as potential barriers to increasing breastfeeding rates were varied. The professional culture of Midwifery and temporal pressures working within the NHS were amongst participant's views.

...and professional culture is a big thing, and routine is a big part of

that. Not wilfully obstructing. [HoM 1: 1.59].

Obesity was portrayed as another barrier affecting women breastfeeding in a corporeal way. Large breasts were described as physically difficult to handle, especially in public.

So if you think I've got a high obese population, who've already got body image, they're hardly going to swipe their breasts out in a shopping centre. As well, it's physically more clumsy isn't it? When you're a big girl, with big arms, to get a baby on a breast, especially for that first stage. [HoM 4: 4.26].

There was a suggestion by participants that it was more convenient not to breastfeed these days as ready-made formula milk is easily available to purchase.

I think it's convenient not to (breastfeed) isn't it? ...you just go to a supermarket and you pour it in, and it's almost become too convenient. That's where I think the formula companies have got very clever. [HoM 4: 4.6].

Sub-cultural social contexts were also considered by one HoM, in relation to how breastfeeding policy facilitates women in employment wanting to breastfeed.

If I just talk about our midwives coming back...we will provide them with opportunities to express their milk, breastfeeding fridges, the lot and the policy is, that all workplaces should do that. Just imagine you're a young dynamic lawyer or you are working in Costa. I'm just going off for a break to express my breast milk and put it in the fridge. The two are really tricky. [HoM 5: 5.46].

Aspects of the BFI were described by participants as rigid and with BFI assessors setting specific conditions for achieving accreditation status. The effect of these conditions was contradictory. On the one hand, BFI policy was labelled as somewhat prescriptive however there was ambiguity in other perceptions.

I don't have any issues with them (BFI). I think they tend to describe rather than...prescribe although I can imagine that they could feel quite prescriptive maybe to people, but certainly from my perspective it's around describing how best to help support etc. with the problems [HoM 2: 2.7].....like how you manage a baby with... or how you manage a particular problem. [HoM 2: 2.8].

There were several descriptions relating solely to the impact of IFP upon women.

Well I think you know, certainly with the UNICEF about giving the advice by 34 weeks. At 34 weeks they've started drumming up for labour and preparation for labour. [HoM 4: 4.46].

Equally, in the first half of pregnancy, women were described as:

Up to the 20 week agenda they just want the scan photo don't they? [HoM 4: 4.47].

This above significant statement highlighting competing priorities for pregnant women may be viewed as an attempt to rationalise the lack of efficacy of IFP during the antenatal period.

There was suggestion however that self-informed women were thought to be more aware of policy, as were women enrolled in health support services for their children.

I think the informed woman does know, and the informed woman that's been on the websites, that uses mumsnet.com, that goes to the maternity services liaison committee, that uses any of the social networking about breastfeeding, I think she would know a little about some of the directions and policies....I think if she's got a young child moving through health visiting and even into school nursing services, I think that she will have been made aware, along that journey, for her, about the policies and their requirements.

[HoM 1: 1.47a].

Finally, in the maternity services, information about IFP was depicted as a component of standard information.

Our ladies get a copy of the IFP as part of the routine information.

[HoM 1: 1.47b].

4.3.1.2 Subtheme: Contrasting Policy

Most participants in the study underwent some sort of reflection during their interviews where they contrasted policy. These formed a cluster of data representing their thinking about infant feeding issues across their professional experience as midwives and sometimes strayed into territory relating to other aspects of infant care.

One participant viewed promotion of breastfeeding as an enduring aspect of midwifery.

But it's (promoting breastfeeding) not anything in my fundamental daily midwifery practice that has changed in views for me. So the

average midwife, what I did in '88 and '90 in promoting breastfeeding, I'm still doing the same today. And that's why I can say breast is best, which came back from that, I think it was way back. [HoM 1: 1.52].

Another HoM thought breastfeeding promotion had always been an important component of the role of the midwife, yet nowadays was more structured and prescriptive.

I was a student midwife in '92 and I would say I was aware of the importance of breastfeeding promotion then, perhaps not as structured, not as prescriptive, but yes certainly breastfeeding promotion has always been at the forefront...[HoM 8: 8.23].

The above attitudes contrast with other opinions from interviewees who held the opposite view.

I don't think we do hugely to be honest, no (have been promoting breastfeeding for a long time as a profession). **Again, it doesn't feel hugely high on the agenda.** [HoM 2: 2.42].

No, not really (aware of BF promotion in past 30 years.). [HoM 4: 4.51].

Another HoM reflected on the historical culture of breastfeeding promotion expressing frustration due to lack of government funding for its promotion and the historical acceptance of infant formula representatives accessing maternity services with promotional materials. Past culture was thought to have now changed significantly as the following dialogue vividly portrays.

Well I think it always got a bit lost (the culture of breastfeeding promotion, prior to current IFP). **I can remember back to the days when I was... when I used to take a lead in breastfeeding, and the**

frustrations that we had then, and this is you know, 18, 20 years ago, and the frustration that we had, we never had any funds to be able to promote breastfeeding in our organisation. Those were the days when the formula milk reps used to be in the hospitals all the time, giving out their free pens and diaries, giving their lovely lunches etc. Culturally of course, that's exactly the way it was outside of our little midwifery world. On the television there was always wonderful glossy adverts... advertisements for bottle feeding. You pick up a magazine, a mother and baby magazine, they'd be full of bottle feeding, SMA, Aptamil, whatever, whatever and so little about breastfeeding. So I think there has been a bit of a cultural shift in that we do recognise that now at least and we do try very hard to... everybody tries very hard, in fact even the artificial milk manufacturers try very hard to say breastfeeding is the best way. [HoM 7: 7.39].

One interviewee reflected upon the focus and evidence base of breastfeeding promotion historically, and contrasted this with the current state of affairs. She raised the condition of hyponatraemia that has recently gained prominence in the discourses surrounding IFP.

When we started looking at evidence for supporting breastfeeding twenty years ago, when I became a midwife: the evidence in practice, RCM Guide etc. What we wanted to do was baby-led feeding, babies will feed on demand. Well what have we got so wrong that now we have Mothers going home with babies being re-admitted with serious neonatal-hyponatraemia. What the hell are we doing wrong? [HoM 6: 6.17].

However, the HoM was not advocating the past as utopic concerning IFP. Indeed she reflected the women were historically undermined by midwives supplementing infant feeding with formula top ups.

Every time though (years ago), **a member of staff would undermine a woman's ability to breastfeed. I've always been an absolute supporter of women's right to breastfeed their baby. And at that time it was a fight to help them and support them because everyone was to give the baby bottles and supplements. All that time of supplementing babies was undermining breast-feeding.** [HoM 6: 6.8].

The previous culture of nocturnal supplementation, and how current IFP helped to end that phenomenon, was also reflected on by other participants.

But I think with the sort of education, education of the midwife especially, the midwifery assistants... because when I first came, quite often we were still in the arena of taking babies away from mums at night, so they didn't disturb, so give them a bottle to keep... you know, so mum can get a good night's sleep. [HoM 3: 3.4].

Quite a few years ago...on the post natal ward they did bottle rounds last thing at night...at 10 o'clock they got the bottles of formula and they went round even the breastfeeding mums....they offered them all a bottle....So it was overturning that sort of mass approach that I saw the whole baby friendly initiative was a good thing. [MW 4: 4.7].

However, changes in practice of routine supplementation were also associated with temporal pressures and maternity service reorganisation as opposed to being directly attributed to IFP.

I think it (cessation of nocturnal supplementation) **was because... I think it basically came about because you just didn't have the time anymore, because you used to be on the night shift with quite a few members of staff. So you'd bring all the babies out.** [HoM 3: 3.5].

Historical, routine supplementation was also reflected upon by another HoM.

I think it's (BF promotion) different and I think I've changed over time as well. I can remember a long time ago...a decade at least...I was one of the people that initially wanted to bring in the forms for women to sign about, have they received all the information about formula feeding, because there was a real culture of giving babies in the middle of the night. I grew up in the time of student midwife... I'd have 14 babies to look after in the nursery and I was just one... it was just unbelievable. I was really upset that midwives would give formula very freely and without consent of the women. I'm not sure we were promoting breastfeeding at all. [HoM 5: 5.60].

The following participant reflected upon her historical practice of consensual supplementation of infants with formula, to address breastfeeding problems. Such practice is contrary to current BFI policy but she questioned this aspect of current policy in terms of efficacy.

The amount of readmissions we're getting for babies not feeding. Now as a community midwife, a long time ago, 20 years ago, if I had a baby that didn't look like it was feeding or wasn't having enough wet nappies, or the stools weren't changing, I would, at home, implement a degree of formula feeding...if I couldn't get the breastfeeding right...visit two or three times a day...I would intervene at home. [HoM 5: 5.37].

Cultural midwifery practices were revisited by one study participant that are in stark contrast to current IFP.

Oh I'd say phenomenally (how BF promotion has changed over 30 years in maternity services). Yeah, you know we definitely... because we used to give Dextrose drinks. Like until the colostrum came in.

We'd give top ups, we had bottle feeding top ups, even cooked feeding. So you know, like I say we used to take all of those out of the nursery. We used to tube feed babies if they hadn't fed very well, you know, and you just think about the stuff you used to do, criminal. [HoM 3: 3.49].

When you think back to the sort of stuff you did so you'd have a baby, it's not fed for three or four hours. You'd do a heel prick and then you'd stick an NG tube down its throat. [HoM 3: 3.50].

The HoM reflected upon the historical prevailing midwifery culture, as opposed to any particular policy, concerning infant care.

I think it was probably custom and practice wasn't it? I think it was quite a regimented midwifery regime. [HoM 3: 3.52].

They used to bind your breasts as well, that's the other thing we used to do. Yeah, so if people were engorged. We used to...Yeah. We used to... you know draw sheets? I can't remember how... we used to have a funny way of tying the draw sheets so that the breasts were completely swaddled. [HoM 3: 3.53].

They used to give the tablets to dry the milk up. Do a bottle feeding. It's lovely now. [HoM 3: 35.4].

Finally, one HoM saw parallels between the contemporary practice of Frenotomy with her own historical beliefs about anatomy and infant feeding practice.

I grew up in the era of; there were beads around the areolas. I thought I could feel beads, I was convinced by that. It's only when you have the scanning information now...[HoM 5: 5.29].

On midwife reflected on her experience twenty five years previously in a trust where IFP was very proactive towards breastfeeding.

I trained in 1978 in ***, which was far, far ahead of its time and the policy was, if a woman is breastfeeding she may not have formula for the baby unless it's prescribed by a paediatric registrar. It was that prescriptive. But then I went out on community and found out what was really happening. They would... while they were in hospital they'd breast feed because it pleased the midwives. As soon as they went home the baby went on the bottle because that was what they'd intended all along. That was very counterproductive because I found babies had gone straight on to... follow on milk. Because it was cheaper....We didn't half find some constipated babies on community....They were not well. [MW 5: 5.15].**

She went on to reflect that her experience of dogmatic support for breastfeeding alienated Midwives' relationships with women.

So we were failing them (women) because we were pushing the breastfeeding so hard that we weren't listening to the women that said, but I'm going to bottlefeed and some of them just got to the stage where they didn't dare say it. [MW 5: 5.16].

Another midwife reflected upon the use of the evidence base in midwifery, considering the transient nature inherent in knowledge.

It goes in cycles doesn't it (evidence base)...I mean, actually saying that, if you go back years ago and it was three minutes on one side, then five and build up, we haven't gone back to that. [MW 2: 2.11].

One midwife pondered the somewhat contradictory aspect of UK culture surrounding infant feeding and the sexualisation of women's breasts. She contrasted her perception that society had changed in approach to breastfeeding yet sexualised attitudes towards breasts appeared

unchanged.

I thought...it was a generation thing and that in the 1960s and 1970s, you had The Sun newspaper, the page three, boobs were for men, their territory, women saw them as sexual objects rather than feeding their baby and that's socio divide of the classes. But I did think that if children, and in schools, were introduced more to breastfeeding and actually it's a natural thing and that breasts are there to produce milk to feed the baby, not for the man and page three, that society's attitude towards it would change... because you still get the page three in The Sun, you still get the men who go, oh look at the boobs on her... I suppose you've still got grandmas, well I bottlefed you and you're alright. Yeah. You know. But they also stuck us in the garden wrapped up in a million blankets in the middle of winter. [MW 2: 2.26].

4.3.1.3 Subtheme: Integrating Policy

By far the largest cluster of data within the analysis was attributable to the *Integrating Policy* subtheme. To some extent, this subtheme cross-references with various other subthemes presented in this chapter. However, the label Integrating Policy was ascribed to the interviewees' statements below that were deemed to contain an element of 'weighing up' or evaluation of the issue under their consideration. Assessments ranged from positive perspectives to more critical viewpoints of current IFP. Overall, most HoMs and MWs expressed both ends of this continuum, or shades of ambivalence, as the following illustrates.

The participants overviewed current IFP by reference to policy aspiration and actuality. In terms of aspiration, IFP was articulated by one HoM as **“a good lever of change and actually it's very**

influential” [HoM 1: 1.1], flowing into multiple health aspiration pathways.

I still think the policy is just that, that it’s got many triggers, many drivers for change, many initiatives across it and I’m still not sure that we’ve got it right, if I’m being honest. The theory to the practice is what I’m talking about. ...through the Department of Health national documents, down to how we make it happen at bedside and at a woman’s home side, every single day. That’s the gap that I’m talking about. [HoM 1: 1.10].

Current policy was seen as supportive **“I think it targets and focuses attention, which is really helpful”** [HoM 1: 1.30] and applicable to a range of healthcare practitioners.

I actually think it's a positive... it is positive, that you have something to follow, because I think before that there was far too much individual... I welcome the standardisation and I actually think that having something to follow as far as giving information about breastfeeding as well as bottle feeding, there's a bit more propaganda for breastfeeding. [MW 4: 4.2].

I think it is very supportive towards breastfeeding and for mums who want to breastfeed and I think quite rightly, promotes breastfeeding as the best option, if possible, for a mum and baby, outlining the health benefits for mum and baby. [MW 2: 2.2].

The aspiration of policy articulated by participants above, contrasts with the assessment that knowledge about current IFP by professionals was not synonymous with women’s awareness of policy **“I’m not sure that any woman would know anything about it”** [HoM 1: 1.31] and **“To be probably, brutally frank, I bet they don’t know a right lot about it”** [HoM 3: 3.44]. Awareness of IFP by women accessing

maternity services was further qualified by the following typology of mothers.

There's the women that want to know, will know, and the women that need to know, and they find out by accident (about IFP). It's the usual isn't it, you get the committed ones, sort of go to all the classes, listen to everything, but it's the youngsters and it's getting them on board. [HoM 3: 3.45].

In this assessment, promotion of breastfeeding was interpreted as women not necessarily associating it with government policy *per se*.

I don't know if it's so much they would equate government policy to the fact that they're going to breast feed when their baby's born or whether it's the fact that the local breastfeeding promotion campaign we did last year when they got young girls, pictures of them breastfeeding and families with mums and grandmas. [HoM 3: 3.46].

One HoM voiced support for the implementation process of current policy yet contrasted effective IFP promotion with formula milk companies' marketing strategies.

I support the direction of travel (for current policy), although I don't think it's backed up through national campaigns. I think the milk marketing manufacturers spend far much more money and time on the awareness of their products than we do for the breastfeeding products. [HoM 1: 1.12]. Media campaigns (to promote BF), just high profile campaigns, national breastfeeding awareness week, that sort of thing, it all talks about great, but actually the drive and the investment in them is actually quite poor from a national perspective. [HoM 1: 1.13].

Her view was echoed by others who thought promotion of breastfeeding

was still undermined by formula companies promoting their products.

I do think it's been a good message (promoting breastfeeding), but I do think...some of the formula feeding companies, have got very clever haven't they?...very subtle at their advertising. [HoM 4: 4.59].

It's a huge influence. However much we stop them promoting bottle feeding, the message is still getting out. Okay, they say breastfeeding is best but they don't really mean it, they mean buy ** and they put their adverts on telly. We're never going to compete with that because they've got so much money behind them.** [MW 5: 5.23].

The priority of IFP was explored by participants personally and in relation to other government priorities.

I don't think it (IFP) is because I think if the government was prioritising it, at the here and now, I think my Trust would know about that and certainly my region would know about it. It would be driving through to the PCT and the Trust. I think it's not a hot topic on their agenda. [HoM 1: 1.44].

It is important (IFP). It's a fundamental part of what we do. I wouldn't have a full-time midwife working on it in the way that she's doing, we're just about to set dates for assessments for March, April time next year. [HoM 1: 1.44].

One HoM assessed the status of IFP in relation to other policy, viewing infant feeding as a significant part of the experience of childbirth.

Well it's as important as any other policy in my service, you know. It's a very significant part of the childbirth process. I kind of consider it to be the fourth stage of labour really. [HoM 8: 8.16-17].

Participant's discourses were heavily couched in contemporary policy syntax. 'Commissioning for Quality and Innovation' (CQUIN) targets attached to the policy were evaluated as was the concept of 'future cost savings and health outcomes' in the population. The notion of 'quality of care' was also explored and expressed.

When it's got a CQUIN target with it, then definitely it influences (breastfeeding rates). That by delivering breastfeeding you save money to the organisation, you enhance quality of care first off, everything should be a quality enhancement but you always, indirectly it will give better health outcomes, but you will save money. [HoM 1: 1.33].

Yeah. So you do it (promote BF) for health benefits, but you also do it for organisational benefits as well. [HoM 1: 1.34].

'Tick box' aspects of IFP were not particularly popular for a variety of reasons but the following midwife also found them useful, in a self-acknowledged contradiction.

So the infant feeding, I actually think it's probably a good thing and they go home with a post-natal tick chart and I actually phoned up our infant feeding and said this is great, it's really, really good, it's a guideline for the women and it's a guideline for the midwives. I thought it was... you know, for all the paperwork I've seen, I actually thought it was really helpful and we could do with more stuff like that. Which contradicts my idea about all the spawning paperwork. It is a complicated subject! [MW 4: 4.29].

Maternity services were considered key to IFP and this was assessed in relation to other groups in healthcare.

Obviously we are the drivers of infant feeding agenda, but nobody else, later on in the chain, signs up to that do they? So we won't

get the diabetic team supporting us in any way, which could save them some diabetes in later life....It (the service) is far too fragmented. [HoM 4: 4.43-4.44].

Similarly, the impact of promoting breastfeeding in the maternity services was evaluated as short term owing to the limits of the maternity care pathway.

It is very short-term and I think you know, because of how health's working at the minute, and because of certainly acute services and community services, we work in silos don't we. So you know we ditch them at the end of the maternity pathway. [HoM 4: 4.65].

Several interviewees evaluated IFP as somewhat stymied both by the midwifery profession due to task orientated care practices and temporal issues affecting resources and attitudes.

I think they do it... my opinion is, is that it's more of a tick box exercise (talking about infant feeding with women). I think a lot of things in midwifery have become that way, which is very much a shame. [MW 7: 7.22].

The other factor is the midwifery profession....actually, leaving a baby with her mum, it doesn't need weighing, dressing, feeding, sorting within one hour of birth and then out of the delivery suite. [HoM 1: 1.57].

The impact of the sense that IFP gets lost in competing priorities, and that it is entwined with postnatal services, was explored by the following HoM and MW.

We see that time and time again through patient feedback, whether that's a survey, whether that's an informal complaint, whether that's a formal complaint, speaking to women who are in maternity

consultation at the moment. Interestingly, one of the biggest things to come out of the consultation, although it's been around the place of birth and choice of place of birth, we've had loads and loads of feedback about post-natal care, a lot of which has not been very positive. A lot of that is because post-natal care has become our Cinderella service. Of course unfortunately, infant feeding is entrenched in that. [HoM 7: 7.18].

I go round doing the post-natal checks and again and again they're saying they were really nice on *** but they didn't have time for us. Some of them are a lot harsher than that and say, I was ringing the bell, no-one would hand me my baby and my legs still couldn't move after the Caesar. They are definitely and chronically understaffed on *****.** [MW 5: 5.13]. *(Interviewer: So there's a tension between implementing the policy effectively and resources?)* **Yes.** *(Interviewer: Is that what you're saying?)* **Absolutely.** [MW 5: 5.14].

The BFI was consistently evaluated by participants as an expensive, status conferring monopoly by UNICEF in policy terms. One HoM questioned the necessity for current IFP to be dominated by BFI, given the status of UK academia and professional bodies.

Locally, I like to see baby friendly initiatives. As a head of service I am completely frustrated by the fact that that seems to be monopolised by UNICEF, and we do not have a number of national bodies that are driving that in a proactive way and therefore for me to achieve the policy status and the profile of that policy, I've got to pay a hefty amount of money to one organisation. [HoM 1: 1.14].

I think it's a heck of a lot of money (BFI). Hard to say we're baby friendly you know, I mean we should be anyway. I don't... I think it's good in the fact that it's made us address the care assistants and the midwives that aren't perhaps up to scratch, so it's forced

us.....But I'm not sure having the BFI is particularly... is that going to improve our breastfeeding statistics, I don't know, let's see. [MW 6: 6.4].

Moreover, the following HoM evaluated that costing mechanisms for the BFI confer uncertainty about future charges and the acquisition of funding for BFI was evaluated.

I'm not supported through Department of Health initiatives; I'm supported through private finance almost. Because the private finance is they (UNICEF) can quote what they would like to charge for their assessors, for their initiatives. If they put the price up I've no argument on that. [HoM 1: 1.18].

To get finance (for BFI) I have to put business cases for it, I have to get commissioners sign off, sometimes I use charity funds. That again, you know, is enhancing quality, but it should be mainstreamed and as a director of services that frustrates me. [HoM 1: 1.19].

The above HoM's sense of frustration was offset to some extent by the following assessment of the BFI as effective in supplying best practice initiatives.

...and frustration (at BFI) and whilst we support that as well, it supplies us with best practice and which I completely approve of, but I also get frustrated by it and the monopolising attached. [HoM 1: 1.17].

The significant, on-going financial cost associated with the BFI was a recurrent theme in the discourses that lead some HoMs to evaluate the merits of current policy.

We've asked... well the question was asked last time, because of the

cost of the stage two (BFI) what would be the impact if we didn't do it? Obviously the impact is more around the, how we're viewed by other organisations and the fact if your... you know, what your commitment is to breastfeeding, is levelled against the fact that you've actually forked out. [HoM 3: 3.31].

The efficacy of BFI with the paradoxical diminished state of postnatal services was evaluated in relation to effectively supporting breastfeeding.

Exceptionally costly (BFI). I think the fact that we're being driven down... certainly with maternity matters, the reduction in post-natal care; however they expect us to maintain breastfeeding rates when we're not doing the post-natal visiting...[HoM 4: 4.33].

The policy is all out there in name, but there is no time or very little time now, to give to the mums to help them achieve successful breastfeeding... because the post natal visits have been severely reduced to maybe two visits. [MW 3: 3.14].

The issue of Maternity Support Workers (MSWs/MAs), and their use to fill the void in postnatal care by midwives, was raised by several interviewees.

In terms of breastfeeding support and post-natal care, I actually think it's (MSWs) a positive impact. In that women get more support. Because without that, I don't think that hurried visits where your bum barely hits the woman's couch, because you've got so many visits to do that day, is of any benefit to that woman. It's certainly no benefit to that baby. [MW 8: 8.9].

I'm absolutely fine with the MAs going in and helping with the breastfeeding because they have more time....If more MCAs are employed because they are cheaper and it helps mums and gives

mums the time, then actually I'm not against that. But I would miss that role. [MW 3: 3.36].

I think in the next 10 years my job is going to change radically and I'd be very surprised if I'm still providing the same clinical care in 10 years, that I'm providing today. Around infant feeding, I just hope that I am going to have the ability to pass on my skills and knowledge base to those that are going to be doing it in my place. [MW 8: 8.70].

Thoughts about MSWs lead to consideration of the impact of the current state of both hospital and community postnatal services upon the efficacy of IFP and care of women.

I think it's a travesty for women (cutting postnatal services) Because what we don't... what we have in the UK is a bigger gulf between poverty and health inequality than they do in a lot of other European countries. So it's not just about the physical aspects of post-natal care, it's also looking at women's mental health issues. [MW 8: 8.13].

Yeah, it's not a target. It's not a priority (postnatal care). It has a massive impact on women's lives, but it's hard to quantify, so therefore it's not a government priority. But so many things to do with women's health aren't a government priority, apart from breast cancer because that's easy to quantify. [MW 8: 8.16].

I feel sometimes that perception is coming through now (from midwives) that, oh thank god it's going to bottle feed because I've got time to go and do something else now, than support this one, because of time constraints. [MW 3: 3.52].

I mean there's so much within the midwife's role now, the training that we've all undergone in the last couple of years regarding safeguarding, domestic violence, you know, female genital

mutilation, all these areas that we have to know so much more about and then often when the midwife is there, because of a cut in services, a lot of midwives retiring, you come to the poor community midwife who's faced with a breastfeeding mother that needs support... and her diary is full for the day. You know it's a real strain on the maternity services. [MW 7: 7.17].

Peer support workers in relation to supporting breastfeeding were considered by the following interviewee.

To get women to understand that is really hard and I think probably women, as opposed to midwives, possibly women are... breastfeeding support women, like peer supports, I love peer supporters. I think they're probably....better. Because they are so experienced. They don't have an axe to grind, they don't have policies to follow, you know they... just their personal experience and...I think they're wonderful, absolutely wonderful. [MW 6: 6.23].

Prescriptive elements of the BFI drew analysis by participants and were viewed somewhat as a double edged sword with debatable impact upon the efficacy of policy.

I would say the more junior midwives would need that kind of structure in order to help them help women....But a very prescriptive formula is no good for a woman that might not be seen for three days in the community. So who's there to ensure that regime is being kept to? Nobody. [MW 8: 8.19].

Is it effective? (IFP) No, I don't think it is. I think it's too prescriptive. It's too... some of the parts of it are really well thought out and are really good, like rooming in. So you don't... you know, when I was first qualified as a midwife and certainly when I was a student midwife and I was on nights, there'd be a

roomful of babies, either the office or the nursery and you'd spend your whole night...shoving teats full of cotton wool into babies mouths to keep them quiet, so their mothers could sleep. So rooming in is good, not taking babies away from their mothers is good. [MW 8: 8.29].

Similarly, prescriptive policy was welcomed as breastfeeding advice was still perceived as conflicting. Rationales were offered to explain this phenomenon.

But coming back to infant feeding, what you find is, that people don't get the support, and when they do get the support, very often the information is conflicting. Which is a disaster for a mother particularly if she's trying to initiate breastfeeding. (Interviewer: Why do you think it remains conflicting?) I think because we've got... personally, this is my personal opinion...and from my experience over my years in midwifery, is that we all, all of us, bring our personal own experiences and because midwifery is predominantly a service for women run by women, they bring their own personal experiences. [HoM 7: 7.22-23].

Not all interviewees related the prescriptive nature of the BFI as translating into consistent breastfeeding information for women.

Mothers are... I mean I don't work on the post natal ward; I'm only going from what mothers tell me, that they do get a lot of conflicting advice from people. So even though training and things is good...there's a lot of ambiguity.

The above analysis contrasts with an appraisal of the rigid application of the BFI by the following participant.

I think sometimes, I don't know if we do it here, but I think sometimes it (IFP) can be a little bit dogmatic. [HoM 3: 3.9].

Prescriptive evaluations were assessed in relation to consequences for women. For example, another HoM felt current policy lacked a holistic approach viewing it as **“Very prescriptive, rather than looking about an enabling social model of breastfeeding really”** [HoM 4: 4.10].

Similarly, **I would like it (IFP) to be less standardised. And more, as I said before, looking at the whole....Looking at the woman and the baby and the whole...the whole mother.** [MW 6: 6.31].

Prescriptive aspects of BFI were also evaluated by midwives specifically in the context of their care of women.

I just feel that sometimes mums who have gone through a long labour are tired, sometimes emotionally quite upset, to then have the sole responsibility of a baby on a post natal ward, wanting desperately to sleep, and just not being able to do so because of having to look after their baby. [MW 3: 3.18].

In contrast to the above, another HoM evaluated the interpretation of BFI/IFP in her maternity services as rounded **“I think that we are quite balanced here”** [HoM 3: 3.19]. This diverges with other views of policy as **“coercive”** [HoM 4: 4.45] for both women and midwives and perhaps contributing to an idealised, unrealistic portrayal of breastfeeding in promotional materials.

I think I would have probably... in the past, I was the midwife people were pushing to go for the breastfeeding job, ...and I was very supportive of baby friendly and I very am now. However, I do think it is very strict, I really do believe that and I think it can restrict choice, which is what midwives are often trying to give. [MW 7: 7.8].

I think that if your mum's kept the birth to pregnancy books, or they get any leaflets on breastfeeding, which is part of the policy...they're aware of positioning and attachment and you know, they're given the breastfeeding DVD or they're signposted to how they can access it. So all those things only ever really show this perfect scenario of established breastfeeding. [MW 2: 2.4].

But I have seen women that end up hating their babies. I think it's a temporary thing, but you know I've...Why? Because every time they put the baby on the breast, it's agony. You know, she's got shredded nipples but the NCT have told her she's got to keep going on it. She feels she ought to do it and it's best for the baby, but she ends up... hating is probably too strong a word actually, but resenting. [MW 5: 5.27].

The tension in the delicate balance, of facilitating women's choice vs. coercion, was related to the existence of breastfeeding measurement tools within the healthcare system and IFP that creates additional temporal pressure on midwives.

I guess that whilst I say that the policy really... the philosophy is to really offer women informed choice, I do feel that perhaps because of local and national trajectories and KPIs, that there is quite an emphasis on achievement of the trajectory, despite women's choice really. [HoM 8: 8.3].

Then I think that puts pressure on the mums because they feel breastfeeding is what they have to do, rather than what they want to do. From a midwife point of view, the breastfeeding policy, we're told, every single ante-natal appointment you should be drip, drip, drip, information about breastfeeding. But you've also got a million and one other things that you've got to talk to them about, whether it be screening, the routine ante-natal check and how they're feeling with their mental health. So it's very difficult to fit it all in, yeah. [MW 2: 2.5].

This tension was also evaluated in relation to the social context within which IFP exists and the unintended consequences of well-meaning policy.

Often I feel... you know I hear comments about women feeling pressurised into making a decision to breastfeed and I think you know policy is all very well and good but without social and cultural change it's not going to get very far. (Interviewer: No? okay. What, it kind of exists maybe in a vacuum almost?) Exactly. It should be a holistic movement, rather than just an issue or a provider problem. [HoM 8: 8.7-8.8].

I do think some people feel they've got to do it while the midwife's around. Because it's all we harp on about isn't it? Breastfeeding, breastfeeding, breastfeeding. [MW 6: 6.11].

Women's sense of the pressure to comply with IFP was evaluated in a number of ways by midwives. Tokenism was inherent in some of their appraisals as illustrated by the following significant statements.

Pseudo compliance...because she didn't really want to breast feed at all ...and she seemed to be saying to me that yes, I know it's better for the baby, but I find it too depleting. I haven't got much energy; therefore I'm going to carry on bottle feeding. That's my excuse that I'm going to give to you. [MW 4: 4.15]. **So she was doing it for us, not for herself or for the baby....I don't think she is an isolated example.** [MW 4: 4.16].

Some of them (women) I think do just play the game (pretending to breastfeed). Well because we've got it wrong in the first place. [MW 6: 6.34].

They don't know how it's going to work out, and I think quite a few of them do it out of guilt because they probably do believe what

we're saying, that it is the best thing for their baby, so they're... we push them into it and make them feel guilty. I still think we should. Sorry. [MW 6: 6.55].

A sense of embarrassment and desire to rationalise their actions were expressed as occurring in some mothers who were not breastfeeding.

And I've seen women who felt... like feel embarrassed about admitting that they're now bottle feeding, when they weren't... when they wanted to try breastfeeding and they feel like they've got to make excuses of one kind or another. When they needn't. [MW 4: 4.22].

Yeah, there's a lot of... well I'm not going to breastfeed because, and they'll give you a whole long list of reasons why they're not going to breastfeed, because they feel they need to justify their choice to me in order to keep me on their side, if you like. Whereas I'm going to be on their side regardless. You know, as long as they're giving their baby formula milk... I don't mind. Because obviously you know, I've been in houses where the babies are being given chocolate milkshake and tea at six days old. So as long as it's a registered formula milk I'm fine with that these days. Preferably in a sterilised container. [MW 8: 8.43].

Other appraisals suggest more negative impacts of policy on women include oppressive behaviour towards them by healthcare professionals. Practical issues such as lack of information for hygienic preparation⁴⁹ of formula feeds and assumptions based upon women's gravid status were also raised.

I think it's giving them... it's subversive (the way midwives speak to

⁴⁹ See also public health

women about infant feeding). **It's a form of institutional bullying. If you don't do this your baby could end up on a drip on a paediatric unit and you won't like that one little bit. We don't say to them... You know, we don't say to them, if you breastfeed... your baby could still end up on a paediatric unit on a drip, because your baby might be severely dehydrated and ketotic on day four, with an 18% weight loss. We don't say that do we?** [MW 8: 8.51].

Women seem to feel a lot of pressure to breastfeed....I think it's very beneficial on the post-natal ward, to do one to ones about sterilisation of equipment and feeding, but in regards to education, if you have a woman who is making it very clear... I think sometimes ante-natally, it could be perceived on a bullying side, the way sometimes that we are asked to... the pressure of going on and on. [MW 7: 7.2].

The inability or unwillingness of some women to be honest about their feeding activity was evaluated as a direct consequence of current IFP.

I'm seeing far more denial that they are mixed feeding. Yet there is obvious evidence that somebody is having some bottle feeds somewhere along the line or when you go into the kitchen to wash your hands, there's a Tommy Tippee steriliser full of bottles in the corner. [MW 8: 8.21]. *(Interviewer: What percentage do you think of women who are discharged as breastfeedingand you see because you've gone to wash your hands and you've seen the bottles in the kitchen, and you've seen evidence...)* **40 to 50%.And bearing in mind I work in a very affluent area... Well educated.** *(Interviewer: How many post-natal women do you tend to see a week in your work?)* **Well it varies. I would say between 10 and 20.** [MW 8: 8.21].

If a woman's making it very clear from the outset and of course I think education is important along the way, I generally do, but if you have a woman who's very clear that this is her method of feeding, one of the things I know the girls are finding, anecdotally,

is that never, ever with a multigravida presume that she knows what she's doing with bottle feeding. [MW 7: 7.3].

One midwife made the connection between 'coercive' breastfeeding promotion and subsequent postnatal depression in women through her clinical experience. This issue is increasingly highlighted in research publications (see chapters six and seven).

Yeah, well we're getting letters now, because of the perinatal mental health team, we're getting letters of women who've been diagnosed with post-natal depression and then gone on to develop depression and then got pregnant again, X amount of years down the line, and one of the issues in all that, is their inability to be able to breast feed their baby, because they felt the pressure was on them, that they had to do it and it had to be this perfect mum and baby. [MW 2: 2.19].

The subject of evidence generally and the link with IFP was also evaluated. The notion of 'quality' was assessed by the following participant.

Well yes obviously you know, the whole quality agenda is that you strive to do the best that you possibly can for the people who are within your care and that includes babies. So yes, I think we base them on what we feel is the evidence at the time. That evidence tends to change as time goes on I have to say. [HoM 2: 2.11]
(Interviewer: Evidence changes because?) **Our view of the world as human beings changes doesn't it? [HoM 2: 2.12].**

The perception was expressed that the evidence base for IFP can be manipulated in the same manner as statistics.

I think to some extent evidence can be a bit like statistics, that you can make it say what you want to. [HoM 2: 2.13].

Or that the existence of an evidence base may not be persuasive to women.

Yes I think the evidence is there and it will be quite strong evidence to back it up (IFP), but even with evidence women still will decide it's not for me. [MW 2: 2.13].

Opinion about evidence and changes in healthcare advice was also linked to the efficacy of IFP.

You know, one minute it's okay to give your baby cow's milk at six months or something and then the next moment it isn't, so that's not helpful I don't think. It would be hard to argue where the evidence is for a quick change like that. [HoM 2: 2.15].

In contrast, one HoM evaluated the evidence base from policy as not being direct enough about the negative consequences of choosing not to breastfeed, in a manner that diminishes women's autonomy.

Also I think we do... we're a bit paternalistic, we do protect women from the evidence around bottle feeding because everyone's entitled to make a choice etc but actually, we do sugar coat the facts sometimes I think. [HoM 2: 2.16].

When assessing how current infant policy might impact upon breastfeeding rates, views were mixed. Rates were acknowledged in theory as supposed to increase due to IFP [HoM 2: 2.20] and initiation rates were evaluated as having done so by most participants in accordance with expectations relating to implementing the BFI. However, the veracity of breastfeeding statistics was also explored by most interviewees.

I think initially there was a small rise in initiation rates. How much of it is real and how much of it is, you know, what does initiation... does a sniff and a lick count as initiation? [HoM 2: 2.21].

I've picked up with the NHS statistics. Often when I want to compare something nationally, I will go on their database, for example with haemorrhage, so I rang them and I said, What's your definition? How do you know that... I might be reporting 1,000 plus to you, but how do you know the next local hospital's....They said, we don't, and that's one of the problems. So I think there's a massive national problem with maternity statistics. [MW 7: 7.21].

But I'd much rather say I only have 30% breastfeeding rates but that...Is a true reflection. Than be beaten up because I'm not, which makes me fudge my figures [HoM 4: 4.23].

What we do is record who gives the first feed as a breast feeder and that's counted as an initiation. It doesn't look at what the second feed is. [MW 3: 3.49].

There was a perception conveyed that current policy would increase breastfeeding rates especially when policy was linked to targets or Key Performance Indicators (KPIs).

Indirectly yes I do (think IFP will have an effect on BF rates). Because of the focus of attention that it's given. I certainly know that if I've got breastfeeding as a key performance indicator on my dashboard that I have to report to my Trust, if I have to account for why I'm at 68% and not 75%, and there's a policy that supports me in that, then it does affect, yes. [HoM 1: 1.32].

However, another participant suggested officials who generated breastfeeding targets did not understand what breastfeeding means

“and truly don’t know the population we’re delivering healthcare to” [HoM 4: 4.24]. She viewed policy as an ideological aspiration laden with overtones of hypocrisy.

Yeah I think it is ideological. It really worries me that I’m alright to quote that I’ve got a high smoking population, I’ve got an obese population, I’ve got a high teenage pregnancy population, but then I’m not allowed to say, but I haven’t got a population who breast feeds. If you’re going to use my demographics in one way, let me use them back. [HoM 4: 4.25].

Yet the above evaluation contrasts with the views of another HoM facing a similar demographic in her maternity services.

We have low demographics...So we have... if you compare us nationally, quite a low breastfeeding initiation uptake you know. But, if you compare us to other market towns we're quite good. We're doing well. So I guess our policy must be effective in relation to our demographics. [HoM 8: 8.15].

Ethically and practically dubious suggestions⁵⁰ to improve breastfeeding rates by senior management were revealed by one interviewee.

Now the caesarean section rate was not acceptable, I definitely agree, but breastfeeding is very, very difficult.... The guy from finance...he turned round and he said, he'd worked out that if we gave every woman who walked in the door a £10 Marks & Spencer's voucher, just to put the baby on the breast, that we would save money....And this was at quite a senior meeting. [MW 7: 7.31].

When considering reasons for static breastfeeding rates there were

⁵⁰ Now been implemented in Yorkshire

differing views expressed by the HoMs including uncertainty.

So I don't know is the answer (to static BF rates) **and I don't know that anyone really knows what the... you know, we don't know that it (IFP) has a big impact, but I still think it's something we should aspire to.** [HoM 2: 2.23].

If it hasn't changed (the breastfeeding rate), **then women are sending us a very strong message, whether we like it or not, aren't they? Women are making that decision for themselves, with or without all this coercion.** [MW 8: 8.48].

The sociological context of breastfeeding was evaluated as equally as important as IFP by some participants if raising breastfeeding rates was likely to happen in the UK. **“I think bottle feeding is very publicised and media-sised very well”** [MW 7: 7.4].

There is still a society thing isn't there. That it's not cool to breastfeed in public...I think it's getting better. But there's a long way to go before it's a sort of publicly accepted thing that a woman has a right to get her breast out and put a baby on it. [MW 5: 5.49].

We have a large black, African population at ***what is absolutely fascinating is the support from the female family side in regards to, you know, the mother moves in with them, looks after her while she just focuses on feeding the baby.** [MW 7: 7.19].

So we're actually looking at... and I think for me, it's become very much that you know, this is what we expect of you as a mum, rather than thinking, this is what society should be doing to look after breastfeeding generally. So I think we've gone very much woman focused and target driven. [HoM 4: 4.9].

Conversely, one HoM evaluated current UK society as **“much more**

positive towards breastfeeding” [HoM 7: 7.41]. She viewed the process of implementing current IFP in maternity services as an instrumental part of that positive cycle [HoM 7: 7.44].

Media breastfeeding related issues were evaluated as tending historically towards negative depictions which did not assist current IFP [HoM 4: 4.52].

I think that there's a lot of pressure on women to breastfeed, but then a lot of what you see about breastfeeding in the media is negative, especially in the popular press, the Daily Mail etc etc. They tend to go on about extremes of breastfeeding, either babies that have lost a lot of weight and been admitted to hospital because of breastfeeding policy or women that are breastfeeding children who are three years plus and how terrible that is. Who is it terrible for? I'm not sure, obviously the Daily Mail. [MW 8: 8.54].

When evaluating the impact of IFP on a woman's decision to breastfeed various assessments were offered. Some interviewees thought women anticipated that breastfeeding would be difficult and this is evident in the language women use **“...if you ask a woman how she's going to feed and they never say, oh I'll try bottle feeding”** [HoM 3.57].

Similarly,

Women's perceptions of difficulty and behaviours were thought as perhaps arising due to unrealistic expectations about breastfeeding, 'perfect' motherhood and 'good' babies. These notions were raised by several interviewees in their evaluations of the efficacy of IFP.

I think a lot of it comes down to women's expectations, that a lot of people maybe feel breastfeeding is going to be easy. They're not realistic in the time that breastfeeding takes; especially in that sort of first couple of weeks, that breast fed babies do feed more

often. [MW 3: 3.30].

Yeah...and if you're a good mother, your baby will settle and sleep. [MW 8: 8.26]... **I think a lot of it is this... is still this ingrained feeling that the baby should be separate to them. They don't see the baby, once it's born, as part of them. So there's need to separate the baby and get it into a routine a la Gina Ford, -I'd like to shoot that woman, so that they... so that the baby is its own person, it's not an extension of them.** [MW 8: 8.27].

Yes, and that again, in a mum who's vulnerable and who's experiencing maybe feelings of failure because her baby's not the content one that we see on the telly, and that just denigrates her further. (*Interviewer: Not being a perfect parent?*) **Yeah, who is?** [MW 3: 3.33].

I think there's a lack of familial information about what babies do and the normal physiology of infant feeding. So they want a baby that's going to sleep and settle between feeds for three to four hours, and not very many breastfed babies, in the first two weeks, are going to do that. [MW 8: 8.23]. **If they've got an hour between feeds, they're doing well. But there is this perception of feeding and settling and if they don't get that, especially at night, they're reluctant to give it the time for their feeding to establish.** [MW 8: 8.24].

Other participants evaluated rates as probably static because women are already decided about their infant feeding method before they access maternity services and therefore effectively women were largely beyond the reach of current IFP.

Right, I mean ...you've got three types of women broadly, there's the women that say, I will breast feed and they will. There's the

women that say I won't breast feed and they won't. But there's others that say, well I'll give it ago, they won't, because they're not sufficiently committed. [MW 5: 5.17].

From my experience over the years, women either come saying they want to breast feed or come saying they don't. I can't help but think that it their cultural influences. It's probably subliminal to anything that we can do. [HoM 4: 4.57].

Can't be bothered. Everything's at the touch of a button now isn't it, or poured out of a canister? [MW 6: 6.52]. Well, either they don't like it (midwives advice about BF) or they don't want to do it really....Yeah, they can't be bothered. [MW 6: 6.54].

Similarly, peer pressure was viewed as influencing women's infant feeding decisions especially when problems arise.

You know, you've done your best, it's really painful, you're up in the middle of the night, you're upset, it shouldn't be like this, you should be enjoying your baby, give it a bottle. Sadly. [HoM 7: 7.47].

I think their family. Their own personal views. Their partner's views. Whether it's their first baby or whether it's their fifth. Their extended family, especially grandparents. [MW 2: 2.44].

I think their partners have a big influence on them. Some men can be evangelical, that they want their partners to breast feed. Some don't want their partners to breast feed. The breasts are their thing. [MW 3: 3.77].

Some midwives evaluated the corporeal impact breastfeeding can have upon breasts as perhaps impacting upon women's infant feeding decisions.

Teenagers see it as their breasts won't go saggy...I say yeah, but

it'll get your figure back. You'll get thin and then they'll say yeah but I'll get saggy breasts. I say, well that can happen anyway. So I'm always curious to find out. I'm not... and hopefully I'm not doing it in a punitive way. [MW 4: 4.17].

Other participants suggested that breastfeeding is probably not sustaining despite current IFP because breastfeeding can be challenging: **“I think by several days after birth they've either cracked it or given up”** [MW 5: 5.50] **“I also think women are quite lazy. It's too hard.”** [MW 6: 6.22].

I don't think the women realise how committed you need to be for breastfeeding. [MW 2: 2.21].

What else have I heard people say when I've asked them? Pain probably. Painful, bleeding nipples....I would say very, very, very few women have a pain free experience. It is not lack of... I've seen babies go on perfectly, you know, they're seen to be positioned perfectly, seem to be absolutely fine, and yet even those women will experience some transitory pain as well. Yeah, and they've done everything correctly. And yet its not supposed to happen....And it happened with me....Oh, if you position your baby properly, then it shouldn't be painful. That's what it (BFI IFP/research) says. [MW 4: 4.49].

The potential discord highlighted in the above significant statement, between the 'ten steps' BFI research base and clinical experience⁵¹ was evaluated by midwives in a variety of ways with the majority highlighting certain dogmatic aspects of policy as being discordant with their anecdotal knowledge.

There is no argument; some babies need a nipple shield....Most of

⁵¹ This is also considered extensively in relation to the subtheme clinical autonomy

us with any experience know that....They are too prescriptive (the ten steps). In the end, every woman and every baby is an individual. If I've got a baby that's happy breastfeeding with a nipple shield, why should I interfere? The baby's still getting the best possible feed. [MW 5.7-8].

I had that (split cracked bleeding nipples). My best friend, who is the infant feeding coordinator, one of them now, she... well, she had the same, but she wasn't the infant feeding coordinator at the time, and I had her round mine, crying her eyes out... you know...[MW 7: 7.28].

....So it's how to not laden people up with guilt. The women, yeah....It's just too rigid....But that's the nature of all these statistical paperwork things. I'm not sure what the alternative can be, because if you go back, the alternative was much too far the other way. [MW 4: 4.51-2].

Other examples of the discordant nature of the BFI research base with clinical experience and other contrary research include.

Well, some things like the use of dummies is contraindicated between... there's two conflicts isn't there, between the cot death information and breastfeeding, which I think puts women in a really difficult position. [MW 6: 6.66]. Yes. Because we're supposed to be telling them not to use dummies, but then if they read... as soon as they've taken... let it have one suck of a dummy, according to the FSID, they should not take the dummy away from it. They should keep doing it, to help prevent cot death. [MW 6: 6.7].

I've also met two people who didn't have enough milk and they did everything right as well. And one particular woman was probably hormonal because she was hirsute. So I thought there's probably

some testosterone or something there. And one particular woman I remember, she everything right, she had a really rapid home birth, she rested, she ate, she did all around and she did skin to skin and she did everything right. She was a little bit older, she was probably...Yeah, elderly prima gravida, yeah. But her mum didn't have enough milk and her grandmother didn't have enough milk and there was a whole family history....She did everything right....Insufficient milk. [MW 4: 4.50].

Despite stagnating statistics however, IFP was still considered valuable.

Even though we're trying to say that you know, the statistics haven't changed. I still think it's necessary to promote breastfeeding and get that information out there...And I do think that's necessary because like I say I'm aware of what happened, like bottle feeding rounds and all the rest of it and how little support we were given. I still hear women saying they're not getting enough support. [MW 4: 4.26].

As a result of the frequent challenges women face, when initiating and establishing breastfeeding, the primacy of exclusive breastfeeding as a goal was challenged by some midwives.

And like I said, without looking at that baby and having that instinct, it doesn't give you the variances and actually, this might happen or that might not happen. At the end of the day, as long as they feed their baby, you know, and their sanity is more important than whether...a baby gets breast milk or formula. [MW 2: 2.23].

The emotive aspects of breastfeeding and associated IFP were also considered by midwives in several ways. Women (including midwives) who did not have perfect breastfeeding experiences were thought to have strong feelings about the subject.

You used to see perhaps midwives who didn't... who weren't successful at breastfeeding, would not want to be quite so pro breastfeeding and give that information. I've seen that with a lot of maternity care assistants as well you know, so it does... yeah it does lead to emotive responses. [MW 4: 4.21].

It's very difficult to get information across to women about the fact that it's... you know there's lots of research that shows it's nothing to do with the quantity of milk, it's to do with the quality of milk. [MW 6: 6.10].

One highly experienced community midwife felt her ability to encourage confidence in women's breastfeeding was insufficient to offset the emotional consequences of not achieving breastfeeding expectations engendered by IFP.

I will say to mums, you've got to trust your body. You know, yes, you don't know how much your baby's having, but you've got to trust your body to do what it's designed to do. So you're promoting all that, but if it doesn't work for whatever reason, these mums who've had it bombarded to them ..they're probably very emotive. [MW 2: 2.32].

As a result, she advocated balanced information about both types of infant feeding as a way forward to enable informed decision making, highlighting a current imbalance in the perspective of healthcare practitioners too.

I think one that actually gives them complete, informed choice, that will say, these are the options, you know, because there are only two options isn't there, to start off with. Breast or formula. These are the options, this is why this one is promoted and you know, why we say this one. But, as an alternative, there is this and...(Interviewer: You feel it's too weighted towards breastfeeding at the moment?) **Yeah, yeah, because I think you still wouldn't... you**

wouldn't lose those mums who really wanted to breast feed....You wouldn't get all these women going, oh I'm going to bottle feed my baby. [MW 2:2.33].

I think people are scared of telling people about formula feeding because they think oh, everybody's going to do it. [MW 2: 2.34].

Policy was evaluated as singularly lacking in the social care model approach by several participants. Emphasis upon rates and exclusivity perpetuate discord between contemporary target driven approaches to IFP and the ethos of putting women first.

It's just there's been these blanket assumptions about what's right and what the... where the triggers are to look for that. So the emphasis on it (IFP) initiation rates, the emphasis on sustaining that to eight weeks, the emphasis on pure breastfeeding for six months. I think we've gone for sort of like more target driven policy rather than sort of like a social care model really. [HoM 4: 4.8].

Breastfeeding statistics were also evaluated as linked to the notion of measuring quality in the NHS and the concomitant use of 'quality metrics' to evidence this concept in care services. Similarly, IFP and the BFI were assessed as positively impacting on maternity services being linked to quality indicators which are measureable indices.

Yes I think it has a positive effect (on maternity services), because it's something that you can use it as a quality indicator. So that you can say, well actually we're up to this level (BFI) and that we've achieved this. So you know, coming to this hospital, you come in assured. [HoM 3: 3.36].

Yet this model was questioned by others, in terms of clarity.

...like, probably because it became high on the agenda, this whole initiation rate, you know, as long as you've stuck the baby within an inch of the breast it's ticked as an initiation. In terms of quality, what does that mean? [HoM 2: 2.32].

It's playing with statistics as well, because you'll mark that woman down now as breastfeeding initially, when actually she never intended to carry on anyway. [MW 4: 4.19].

Another HoM evaluated the lack of qualitative analysis of women's experiences breastfeeding in the statistics **"It's a measure. It doesn't tell me anything"**. [HoM 4: 4.41]. **And for me, the statistical stuff doesn't reflect qualitative stuff. There's the 30% of women have a good breastfeeding experience and feed for a while, is that not better than 60% of women having a poor experience.** [HoM 4: 4.40].

In terms of priorities, evaluations of IFP were mixed and related differently according to positions in the NHS **"Well yes, I mean I think it's important, I think midwives think it's important."** [HoM 2: 2.37].
In the context of maternity services,

I certainly don't have urgent meetings called to discuss our initiation rates and our sudden drop off or whatever and I certainly don't get an accolade from the chief exec if our initiation rates are high. [HoM 2: 2.36].

Midwives held views about the effect of IFP on maternity services that were more directly related to clinical practice issues. To some extent, these resonate with the clusters of formulated meanings allocated to the subtheme *Mediating Clinical Autonomy*.

I can think of the new latest one (effect on maternity services) it is the new excessive weight loss policy. Until a couple of months ago it was said, anything up to a 10% weight loss on day three for a breast fed baby was acceptable levels and then we would re-weigh on day five to day eight when we're doing the heel prick test, now, if they've lost between eight and 10%, we have to re-weigh within 48 hours. Well because they reckon it's all research based and that up to 10% is acceptable, but that eight to 10% is the top end of normality and that they want to check that this baby is gaining weight. It has increased the workload dramatically...with all these extra weigh visits. [MW 2.14].

The question of what alternatives to current policy might feasibly be explored in future drew a certain amount of cautious deliberation from several participants.

Well I don't know that I like it (BFI) as such, I think there's always room for improvement, but maybe, oh at the moment, it's the best of what's around. [MW 3: 3.54].

The problem is, I think if it's... left... and it's very laissez faire, then it (IFP) would slither down and it would you know, you would lose any gains that we might have got. [MW 4: 4.25].

The thing is, the BFI structure is now very well known, so I think to now reintroduce something else would be a colossal and expensive undertaking. [MW 8: 8.59].

However, some midwives were clearer in their views.

I think it (IFP) needs to be a uniform policy that's used by the whole country, which I know is partly why BFI has been so successful, because it has been adopted by many, many maternity units. It provides a standardised format, so in the hopes that it will

cut down on conflicting advice, which is an impossible situation for women. But I think there needs to be perhaps a better base of evidence around it and I also think it needs to be adopted by everyone that comes in contact with breastfeeding women, not just midwives and those attached to us, but the medical profession in particular. [MW 8: 8.58].

Less prescriptive, but to keep the stuff that works really well, like you know, not separating mum and babies...promoting skin to skin contact. [MW 8: 8.60].

One midwife with over twenty years of clinical experience commented that in her opinion IFP had not particularly changed midwifery practice. Midwives enthusiasm for breastfeeding was viewed as individual although it had perhaps improved (temporarily) in junior midwives with the higher profile accorded to breastfeeding in the education system these days.

I don't think the policies have (changed midwifery practice). I think the way that our infant feeding adviser has gone about it with the two day study days which are based on the BFI policy, they are exceptionally good, if you're in that frame of mind. But I think you've got to have the mind-set that you want to support breastfeeding, you've got an interest in breastfeeding, to get stuff out of it and to be interested enough to do the follow on reading. It's like anything, if you've got an interest in it, you'll learn from it. [MW 8: 8.40].

Infant feeding Co-ordinators (IFCs) were more or less consistently evaluated as key agents to optimally implement IFP. One attributed the increase in breastfeeding initiation rates in her NHS Trust directly to

the IFCs and others valued their multidimensional input regarding infant feeding.

I don't know if it's attributable to the policy per se (existing breastfeeding rates rate), but I think it's probably attributable to the fact that the policy's there and you've got some committed individuals that are making it work within the environment. [HoM 3: 3.38]. I think when you've got somebody who's as committed as our IFC is, the feeding coordinator is, you look to when... you know, to almost succession planning, and what's going to happen when they retire. [HoM 3: 3.43].

Any real problems, IFC is brilliant. I've had one that she's been nursing through with a baby with tongue tie and mum with shredded nipples and she's done far more for her than I have. [MW 5: 5.3].

In contrast to the above:

Twins. One baby breastfed a dream, the other needed a nipple shield. There is no argument; some babies need a nipple shield....Most of us with any experience know that. Most babies don't need one, occasionally you come across a baby, so this is the only way this baby is going to breast feed, the option is a bottle. She (the IFC) got in there and by the time she had finished trying to get that baby off the nipple shield and on to the breast, mum said sod the lot of it. I'm putting them both on the bottle. It's a tragedy....She just got a bit too rigid. [MW 5: 5.7].

Finally, the pressure exerted by IFP upon women to breastfeed was contextualised within the wider remit of feminist issues in society by this midwife.

(Interviewer: So do you think it's creating pressure on them to

breastfeed?) **Yes. Yes, but I don't think it's a positive pressure. Because again, it's another stick to beat women with isn't it? Oh well you haven't successfully breastfed, you know, that's another thing that you've failed at. It's that Daily Mail, ideal philosophy...of how women should be. [MW 8.44].**

It's because breasts... Women's breasts are not their own. They might be attached to your body, but your tits are for other people to look at and enjoy, especially men, and men are the power givers in our society, whether we like it or not. You know I think there's this big thing about your breasts don't belong to you, they're a sexual object, they're not there primarily to feed and nurture your children, and men want them back. They don't want a toddler hanging off them. Ann Oakley started talking about that 40 years ago and nothing's changed, so...[MW 8: 8.56]... Yeah, the choices, and the choices are removed from women right at the last minute. The rug is pulled out from under them, so I don't want to hear about women's choices. Because they really don't exist. [MW 8: 8.57].

Women's roles in society are so conflicted at the moment. Because women of our generation, we were sold a bag of shit, because we were told, if we were really clever, ...that we could have it all, weren't we? We went to grammar schools, and we were told we could have this fantastic career and be self-supporting, and that yeah we could have children, all we needed to get was decent childcare and we could still carry on doing the job and doing everything else at the same time, and nobody would suffer. It would all be great; our kids would be fine because they had a fulfilled working mother, and what a load of shit that is, isn't it? Were we not sold a heap of shit? I think their messages (current mothers) are very much that they can still have it all, but at a price, but as well....the pressure that they've got that we didn't have, is the Barbie doll fantasy as well. They've also, preferably, got to look

like Barbie. And I think that they are less inclined to be as open about their academic abilities, because I think for women now, it's not that great to be as... you know, as openly clever if you like, as we were. [MW 8: 8.73].

4.3.2 Theme: Discourses of Self-Determination

The cluster of formulated meanings that were nominated to the theme *Discourses of Self-Determination*, had a clear and frequent presence throughout the data and essentially incorporate expressions relating to the concept of autonomy. Although the notion of autonomy is addressed earlier in chapter two of the thesis, it is revised slightly here in light of the study findings. Autonomy has a broad remit, but may be described as a sense of agency or self-determination (McLean 2010).

Contemporary notions of autonomy are multifarious yet are ultimately derived from the philosophy of Kant who used the term 'moral autonomy' to describe the notion of "having authority for one's own actions" (Dryden 2010: 1). This contrasted with prevailing concepts of people's decisions as being ultimately determined by people occupying influential positions in society such as politicians or pastors. It is this rudimentary concept of 'moral autonomy' that is the basis of the theme *Discourses of Self-Determination* which was used to describe the cluster of formulated meanings derived from the interviews with HoMs and Midwives. In summary, *Discourses of Self-Determination* refers to ideas articulated that appeared to describe a discourse relating to a sense of self-determination or self-governance.

The clustered meanings emergent under this theme were further divisible into three subthemes identifying data describing the notions of: *Perceiving political agency*, *Mediating clinical autonomy* and *Evaluating maternal autonomy*. *Perceiving political agency* related to expressions by

interviewees of themselves as policy influencers and ‘guardians’ of the midwifery profession. *Evaluating maternal autonomy* described their reflections of the impact of current IFP upon the decisional autonomy of women accessing maternity services. *Mediating clinical autonomy* was the subtheme ascribed to thoughts by interviewees of the rights of the Midwifery profession to set its own standards and clinical practice directives. It also aired views that appeared to convey a sense of what I have termed, in the thesis discussion and conclusion, ‘midwifery confined’ by the NHS.

4.3.2.1 Subtheme: Mediating Clinical Autonomy

The cluster of formulated meanings allocated to the subtheme *Mediating clinical autonomy* are varied in character. However, they predominantly reveal sentiments angled towards a sense of frustration and lack of agency regarding IFP.

One HoM participant perceived a deficit in relation to UK midwifery status in promoting breastfeeding, because international ‘evidence authorities’ currently prevail in this domain.

Locally, I like to see baby friendly initiatives. As a Head of Service I am completely frustrated by the fact that that seems to be monopolised by UNICEF, and we do not have a number of national bodies that are driving that in a proactive way and therefore for me to achieve the policy status and the profile of that policy, I’ve got to pay a hefty amount of money to one organisation. [HoM 1: 1.14].

This view is partially supported by another HoM who was sure of her clinical expertise, yet felt somewhat marginalised in the policy process owing to her position.

I think there is... I'm not an academic, I'm exceptionally academically light because of personal circumstances, but equally, I fully understand my practice. (*Interviewer: Are you saying clinicians are experts and they should inform practice?*). **That's right** [HoM 4: 4.81].

On a different issue, another interviewee explored why she experienced midwives sometimes not succeeding in following evidence based guidelines about current policy.

(*Interviewer: Do you mean midwives not following the evidence-based guidelines?*) **Yeah, you know that sort of thing, absolutely and professional culture is a big thing, and routine is a big part of that. Not wilfully obstructing.**

The formulated meanings ascribed to *Mediating clinical autonomy* suggest that the standardisation conferred by current policy is broadly welcomed but does not always prevent 'mixed messages' around breastfeeding advice.

I think however hard we try to standardise information, we still give mixed messages sometimes. I think in particular, certainly from my Trust the link between special care and maternity could be better and we are working on that. [HoM 2: 2.39].

A number of participants expressed a strong desire for Government to cease interfering with healthcare policy, as the following significant statement illustrates.

I wish that they (the Government) **would butt out of healthcare I have to say and allow us to do our best....**[HoM 2: 2.54].

There were formulated meanings in the data that criticised the BFI for compromising clinical autonomy in several ways. One HoM mentioned Midwives were not allowed to accept promotional materials from formula companies. Whilst unequivocally agreeing that advertising formula milk was not acceptable, she felt information about formula milk for women choosing to formula feed was necessary. Formula manufacturing companies had used to provide information for women and midwives prior to the BFI.

I think that we have... I think we're all professionals and I think we... as long as we aren't carrying round diaries that have got Cow & Gate covers on them, we aren't promoting one thing above another, I think we have to give women the appropriate information and knowledge. You know if they're choosing to formula feed, that they've got the right information to be able to do that properly and safely [HoM 3:3.13].

The BFI was described by most participants as prescriptive and strictly based upon the 'Ten Steps'. This aspect of IFP compromises clinical autonomy for practitioners in the maternity services and is also linked with the subtheme *Navigating Professional Governance*. Several HoMs also noted that such rigidity contrasts with the application of other healthcare policy.

But I don't know how relevant it (BFI) is to actual practice, as other guidelines are, you know, that are evidence based, like the normal birth guidelines. NICE guidelines, you can deviate a little bit from the guidelines. You know, if you've got justification [HoM 3: 3.26]. (Interviewer: Are you saying there is no room for deviation from BFI guidelines?) **No, I don't think you can, can you? I think it's so prescriptive and you're monitored through the BFI and they come and assess you. [HoM 3: 3.27]**

The above view contrasts with another HoM less critical of the impact IFP had upon the clinical autonomy of practitioners. She did however make the following statements.

If you've got a good guideline, it will pretty much précis what is out there [HoM 7: 7.15]. Having said that of course, there's always the danger that a guideline can restrict practice, although I'm not so sure that that is the case for breastfeeding or infant feeding. I think that can be more in clinical practice on the labour ward. But there is always that danger that it stops people from thinking outside of the box and doing something else, because they're scared to move outside of the guidelines. [HoM: 7.16].

The prescriptive nature of BFI policy engendered a confidence crisis in relation to clinical practice by one interviewee that was candidly revealed during interview.

And then when I was out there working as a consultant midwife, I actually started to feel intimidated about supporting women with breastfeeding- have I got it right? Am I doing it right? Because it's become so rule-laden, so RULE-LADEN. I thought, **! [HoM 6: 6.13b]. (Interviewer: Prescriptive?) Prescriptive! Yes! And I thought, I'm scared to do what I've been doing for 20 years. [HoM 6: 6.14].**

The sense of unease the above HoM felt related to the fact that attitudes to infant feeding advice have changed hugely and so she felt deterred from utilising what she viewed as effective practice, because it is forbidden by current BFI policy. This suggests the HoM's clinical autonomy appeared compromised by the 'one-size fits all' approach of the BFI.

I suppose one of the most conflicting things for me at the time was, I was used to saying, when women are struggling with that

very first feed. If you say, “Look, would you like me to help you?” (physically) and they say “Oh please do, I just want my baby to feed.” And so you would help them to have an effective first feed so that they knew what it felt like- and you’re not allowed to do that anymore! And you kind of think, you know what, that actually worked; but you’re not allowed to do it. That prescription made me start to back off. It made me personally feel, a wee bit intimidated [HoM 6: 6.14].

The participants appeared to suggest that conflict exists for some HoMs in relation to current BFI policy. This manifests in an inability to exercise clinical autonomy in their care of women. Another HoM mentioned the practice of physically assisting women to breastfeed, which currently contravenes BFI guidelines. She was mindful about the consequences of practicing outside of them.

I think there is conflict sometimes within what we see in our guidelines or our policies and this is a really good example and it’s again, very much a personal thing. Our policy at the moment suggests that we don’t handle the woman’s breast, for example looking at breasts. You allow the baby to find the breast. Now I come at that and I’ve used it, I’ve used that technique and it has worked very well, but sometimes there are some women who are so frustrated and so desperate to get their baby on the breast that sometimes... and this is my experience as a mother, my experience as an older midwife, sometimes I have to say to the woman, do you mind if I handle your breast and I take the breast and I take the baby and I put the two together. That’s in direct conflict with our policy. Now that woman then may say, well the last midwife put my baby on the breast and it worked, why won’t you? [HoM 7: 7.28].

The consequences of restricting clinical autonomy for midwives described by the following interviewee raises two significant issues relating to mixed messages for women and the experience of tension that IFP may generate.

Sometimes we do things outside the policy and then it makes... and then it actually creates problems for the woman, because the next midwife will say that's the policy, stick to the policy. [HoM 7: 7.27].

The frustrations are very high....Desperation, yes. [HoM: 7: 7.28].

(Interviewer: So are you describing a tension sometimes between the prescriptive nature of the policy and clinical practice?) **I think I do agree with that, particularly with that and I think, the way around that is to be very clear with the woman and to articulate, to say to her, look, we have tried everything now, you are desperate, I am now going to do something that I wouldn't normally advocate. It's not in our policy, but let's give it a try. And of course in the busy environment, that doesn't always happen. You know, the buzzer's ringing, somebody else needs help, so the midwife pops the baby on and runs away.** [HoM 7: 7.28].

The above significant statements are echoed by the dialogue of a MW who sometimes advocates the use of pacifiers, in certain clinical circumstances, despite her doing so being contrary to the BFI's 'Ten-Steps'.

No, because they're not... actually are they looking at what the baby does, because the babies do funny things sometimes that... you know, you get babies that bite down with their gums. ...Okay, it's a reflex, and they grow out of it. Sometimes they grow out of it. The first good night's sleep I got was when I used a dummy.

(Interviewer: So are there facets to that policy, that actually are discordant with our clinical experience... aren't there?) **It's true. So I**

actually bend it when I give out information.....and one of the things I'll say is, one of the things I'll say is, this thing about teats and dummies and stuff like that, if you've got a baby that has read the book and feeds beautifully right from the word go, you can give a dummy, you can give a bottle of expressed milk and you'll probably have no problems. But, if you've got problems with latching on and you've got sore nipples and all the rest of it, you can put the whole kibosh on it by giving a bottle because it is such a different technique. But that isn't what it says in the policy. So I am already bending what I say. [MW 4.4.53].

In common with the above, another HoM also described the prescriptive nature of BFI policy conflicting with her clinical experience of effectively promoting breastfeeding. This was highlighted by the complexity inherent in providing effective breastfeeding advice using the 'one size fits all' approach currently located within BFI policy.

I'm not sure that having a written policy that covers the whole maternity hospital and in our case, a big hospital, is evidence based. I don't know at any level that what's written down you can actually get the people to do, because there's a definite difference between compliance and commitment. I think in delivering compliance we have lost some of the commitment, particularly when you're asking people to do things that they're not quite so switched on about. Going back to the nipple confusion, we have the transitional care unit here and that takes care of the babies below 36 weeks and on our transitional care unit they're using nipple shields. When I went to ***, they were using nipple shields with like a feeding tube, so they'd inject the milk through, into the nipple shield and used things that were absolutely frowned upon here, to get babies to breast feed, and they worked. [HoM 5: 5.18].**

Another example of compromised clinical autonomy for participants

relates to the practice of mixed feeding (breast and bottle) of infants and the use of pacifiers (dummies), both practices now forbidden under BFI policy to promote breastfeeding.

Well that's where I think we go horribly wrong you see (facilitating breastfeeding duration), **because I think we have really high expectations of women, completely high and rightly so, because the benefits are so beautiful. I breastfed my babies, so I'm a little bit biased, but then when they find it more difficult...and they are unable to use a pacifier, unable to give any top ups of any sort, and I'm not saying that's right or wrong, I just think it's difficult.** [HoM 5: 5.30]. **Policy (BFI) prohibits it (mixed feeding). So we have no halfway house for them. So it's totally breast fed or you've failed.** [HoM 5: 5.31].

Or you have a Frenotomy and then you might be successful or fail. I don't think that particularly works. I struggle with that because I think then the health professionals become... and bearing in mind, we disempowered the health professionals as well, with dealing with these... the minority that is difficult. I'm not saying we should go back to the days where we give them formula as they leave the hospital, but I think there is cause for dialogue. [HoM 5: 5.32a/5.32b].

Another interviewee related the prescriptive nature of BFI policy, and the subsequent reduction in clinical autonomy for Midwives, directly to consequences for women. This analysis incorporates expressions that could also be related to the subthemes *Evaluating Maternal Autonomy and Integrating Policy*.

I think my opinion is that regardless of... because we follow the BFI initiative, really we're quite scripted and structured in the way we offer choice and I do believe that the choice we offer is

intentionally quite open and informed. However, I think in reality I think staff and women feel pressurised into making a choice of breastfeeding, because of, number one the pressure on the staff from the likes of need, plus the pressure from the women to achieve. (*Interviewer: Sure, you've got to deliver the service?*) **Yes** [HoM 8: 8.5].

One HoM interviewee considered the prescriptive nature of BFI policy, and the subsequent reduction in Clinical Autonomy for Midwives, as directly linked to physical consequences for infants.

I think the other thing that's going on, and this is a personal thing, is that I think we're creating other ways to fix the breastfeeding problems. One of my big things at the moment is tongue tying. Because we have a growing body of people wanting to clip babies tongues. It's unbelievable. Why have we suddenly grown tongue ties to the extent we have, in 20 years. It'll be the biggest piece of evolution I've ever come across. I think we're using a surgical operation to build women's confidence in their ability to breast feed. Because we can't do anything else. We've got a great big number of breastfeeding, lactation consultants, that thinks it's great to run Frenotomy clinics, where they clip baby's tongues. There's a consultant midwife involved in it. I read an article on it and my... I was just so shocked and I think... and then we have breastfeeding peer supporters, brilliant training, but no professional training, and they recommend Frenotomy. [HoM 5: 5.26].

In relation to BFI policy and clinical autonomy a MW participant identified that discussion priorities with women were constrained by current policy.

I think that if we've got a mum who comes in for ante-natal check,

that's really upset or is having some kind of crisis with her mental health, or depressed or partner's left her, that actually, it wouldn't be a priority for me to be saying, okay well that's really sad that your partner's left you and I understand how you feel, now let's just mention breastfeeding. I would judge that as not an appropriate time to be talking about breastfeeding whenshe's got a long way maybe until the baby's born and to worry about feeding. I would focus on what the priority was at that ante-natal check. [MW 2: 2.9].

Midwifery interviewees described several instances where their clinical judgement was forced to yield to IFP related infant weigh policy.

I think it's all part of the baby friendly initiative (the weigh policy) **and...***(Interviewer: Do you feel it strips you of your ability to make a clinical judgement?)* **Absolutely. Yeah, and when it was brought in I did challenge it, because I said, you're saying at the beginning of this policy, up to 10% is acceptable, and then you're saying within eight to 10 to re-weigh, so it's not acceptable.** [MW 2: 2.15].

In contrast to the above, another MW had more confidence in breaching IFP related policy by exercising clinical autonomy in relation to weight loss and neonatal jaundice policy as the following illustrates.

Ours would purely be on something like a baby in the first couple of days, is it particularly jittery? Does it look dry? Clinical signs yeah, wet and dirty nappies, that kind of thing. We physically ask them. That's in our post-natal guidelines. That's come from the NICE guidelines for post-natal care. How many wet nappies are you having in 24 hours? What does your baby's poo look like? How many dirty nappies are you having? That should be recorded at each visit by whomever the visit is, how many there are, so you can look and see, oh god you know, this baby appears to be

clinically dehydrated. Do we need to readmit it? Can we manage it at home in the community? Or weight loss. Weight loss is another big one isn't it, because the hospital policy is 10%, the World Health Organisation is actually 12%. So again, where's 10% come from? Where's this arbitrary 10% come from? [MW 8: 8.34].

Willingness to execute clinical autonomy when considered to be indicated, in contrast to following IFP related policy, was highlighted as probably the result of greater experience in practice.

I will always stand up for what... you know if I don't... if I go outside the policy, I will be able to argue why....I think more junior midwives find it hard and I think they'll find it harder and harder with more and more policy and guidelines. [MW 6: 6.17].

By extension, general policy and guidelines were thought to impact less on the clinical autonomy of more experienced midwives. This was thought to be more concordant with the art of midwifery.

I think they (less experienced midwives) don't have to think so much about things. I think okay, that's the guideline, we will do it. I've got a few in my team who will go... you know, dot, dot, dot, follow it exactly and then you have the discussion in the office, well how was the mum, oh, well the post-natal check was okay. But have they talked about diet, no, because it's not particularly highlighted. You know, had they... is she resting, has she got six other kids, you know.....Because they hadn't thought about the holistic side of the whole thing and the mother and the baby as one unit.....Yeah, by doing it by rote. As opposed to using your brain. It's more; the science of midwifery and the art is...Eroded. [MW 6: 6.18].

As consequence of the above, concern was voiced that if prescriptive

policy overrode clinical judgements this may impact upon the skills of future midwives.

You're going to de-skill aren't you? You're going to... you're not going to pick up signs and you're not going to have that... the experience and the instinct, because it will be prescriptive. This is what a baby should do, this is what a baby should look like, whereas sometimes you can have a situation where you think well yes, everything seems to be okay but I just know something's not quite right, and that instinct kicks in. [MW 2: 2.16]. And it's too blinkered isn't it? I think if you're following a policy, you just follow a policy and it's one after the other. Whereas if you're using your judgement... [MW 2: 2.17].

In contrast to the above, some midwives were conflicted about the extent to which their occupational autonomy was compromised by IFP, but this seemed to depend on the intervention at stake.

No I'm very clear, because I am an autonomous practitioner, policy... yes, policy is there to be followed, and I support the policy because it's... you know, breastfeeding is ideal, but equally, I will listen to the women and.....I will, if they ask me about bottle feeding, then I will give them the information. I will you know, as I said before, I will discuss the advantages and disadvantages of breast and bottle feeding. [MW 2: 2.28-2.29].

In other instances, breaching policy was deemed acceptable with appropriate rationalisation.

But you know, I'm prepared to justify what I've done by... this isn't policy, no, but in this case it was the right thing to do and I'll stick by it. [MW 5: 5.10].

More broadly in relation to policy, diminishing autonomy in the current role of the midwife was considered by the following MW.

So you still have a little bit of autonomy, it doesn't seem so but..*(Interviewer: Why do you think it's removed your autonomy?).* **Why do I think it's removed? Because there's so much more that is prescribed, you know, how many ante-natal visits you do, where you actually do them, the time that you've got to do them in, it's all prescribed. It's, a lot of it seems to be coming from the NICE guidelines and CNST I think.** [MW 4: 4.10].

4.3.2.2 Subtheme: Perceiving Political Agency

The subtheme of *Perceiving Political Agency* that emerged from the clusters of formulated meanings relates to concepts of self as 'political influencers and guardians of the profession' and included what the interviewees thought generally about affairs of government and politics.

The study participants revealed mixed views about their sense of political agency. In terms of perceiving themselves as being able to influence government or political affairs and NHS policy, most HoMs felt they were able to contribute, that their voices were heard **"I would like to think so...probably"** [HoM 5: 5.76] **"Yes I think I do. I hope so."** [HoM 7: 7.58]. Their perceptions in particular related to the formal mechanisms that exist in maternity service provision such as (then) Strategic Health Authorities (SHAs) and Local Supervising Authorities (LSAs).

Yes (influence health policy). **By being vocal. Being involved with PCT colleagues, the commissioners, peers, The LSA, professionally wherever you can go really.** [HoM 4: 4.70].

Absolutely (influence health policy). **I think I'm very lucky in that I have a joint role as a professional lead and a business lead or whatever...It gives me the ability to identify professionally what my service needs and negotiate that with commissioners.** [HoM 8.8.37].

One HoM study participant viewed the extent of her political agency in a more diplomatic fashion, perceiving her autonomy as directly connected to her relationship with peers and colleagues in the managerial sphere of maternity services.

I do find... I think a lot about... as well, about... to be fair, I think you have to take your time (to influence policy). **To be in a position like this, you have to gain respect and that takes time and once... and I'm not saying that I've got everybody on side, of course I haven't.... You know that you are making a difference when you hear people say, no we must ask HoM about that.... So I think yes, we are in a position ...but what I would say is, that there's so many other things that are happening at the same time, you know, things... our cost improvement programmes, our efficiency targets, any target, whatever that may be, our quality targets, actually then have... there's a conflict of interest, always.** [HoM 7: 7.61-63].

In contrast to the above, some HoM participants felt their political influence was waning.

I have to say recently it doesn't feel like we... (influence policy) I mean certainly the changes in the NHS were a surprise to everyone and nobody...Nobody expected them or has been consulted probably, although we like to think so, the answer is no. [HoM 2: 2.53].

Another HoM participant viewed her perceived lack of political agency as related to her role and the status of the midwifery profession in England.

I speak up all the time, but where I feel rather hamstrung really in my role, and it comes back to business, in the NHS, you know when the NHS gobbles you up, I would love to write more, I would love to write articles and I would love to voice some of the opinion I have. I have represented midwifery at the house of commons select committee and been invited there on a few occasions so my voice has been hear there, but not as much as I would like to, no. Not as much as I would like to influence policy. [HoM 6: 6.55].

The following significant statement reveals a midwife describing her challenging recent IFP related infant weight loss policy yet concluding the views of 'coal face practitioners' are neither valued nor sought in maternity services.

(Interviewer: Able to influence policy?) **No, because I get told I'm too challenging. Well I don't get told I'm challenging, I just get... like I challenged that new excessive weight loss one and I said, it's going to increase the workload, oh no, no, no it won't, yes it will and I just... I think if they want to do something they're going to do it....Yeah, and unfortunately, it's been proved time and time again hasn't it, people who are not in that top management structure, who've got lots of experience, will say, if you do that, this is what's going to happen because we're working it and we can see it. A bit like the government you know, not living in the real world. They say, oh no, it's going to be absolutely fine and then X amount of time down the line, it's shown that what you said in the beginning is actually right, but at the beginning, the problem is, I don't think we can influence it enough. [MW 2: 2.38].**

Another MW did not view herself as politically dynamic due to a lack of motivation to engage obviously in policy processes but nevertheless felt

aware of the issues important to the profession.

(Interviewer: What about... you just used a phrase I was quite interested in, 'I'm a lowly midwife'. Do you feel able to influence health or maternity services or midwifery policy in any way?) **No.** *(Interviewer: Why not?)*

Not in a... maybe because I'm just too tired to do it. I'm not a huge political activist, but tend to get on in my own quiet corner, rather than getting out there and waving banners, which is probably my fault, but with all my bits as you know, that I do, I get in there.

[MW 3: 3.62].

This perception that political matters were important to midwives was redirected towards the purpose of the Royal College of Midwives by some participants.

They are (important). I don't feel that the RCM do a huge amount for us and if I'm honest, I'm only subscribing to them for the insurance indemnity. [MW 3: 3.63].

With this in mind, the issue of political activism in the RCM was raised.

I read their (RCM) magazine. I just don't hear them out there shouting for us I suppose. Now, maybe quietly they are and it's not reported on the news because we're a small body compared to the Royal College of Nursing. [MW 3: 3.63].

The RCM is really just a bunch of old birds in cardigans isn't it? It's a bit toothless. Because they have never managed to effect any change at all. Certainly there are things happening to their members at the moment that they are very... they're very...Yeah, they're quite happy to accept. You know, the constant downgrading of senior midwives. [MW 8: 8.66].

Similarly, another MW participant articulated a personal sense of lack

of agency with regards to policy, perhaps because midwives lack professional cohesion. Also, they are predominantly female and as such their status in society is weak due to gender inequalities.

No, I feel less so (able to influence policy) the older I get and the closer to retirement I get. I just feel that midwives sit and mutter and mumble and complain but don't actually unite and do anything about it. I'm not really sure if I've got the energy anymore, there's lots of things I can do outside that... and that feels like a failing in me as well. I also think it's a female problem. I think it's to do with us being women and our position in society as women, we are powerless. [MW 4: 4.36].

In a similar vein, another MW participant voiced a lack of political agency in midwives and related this phenomenon to the concept that the profession is marginalised in relation to other health professionals, especially medics.

(Influence) **Policy? No. I don't think they listen to us.** [MW 5: 5.36].... **I must admit I simply don't have time to be active in the RCM, I would like to be. Not half as effective as I'd like. Because when you compare with the doctors' organisations, no-one listens to the midwives do they? We're not big enough and we're certainly not politically powerful....We're women. If that's not a stereotypical thing, but I think there is still a lot of misogyny around**[MW 5: 5.37-8].

However, in contrast to the above, one participant was less condemning about the current status of the midwifery profession in the UK political arena.

(Interviewer: Do Politics matter to midwives?) **Only in so far as they depress us. The politicians still don't have... give us enough weight to our opinions. It's actually... the latest round of government's initiatives has been very interesting because the newsreaders are**

now saying that the doctors and the midwives and nurses are all saying. They've actually paid notice that it's the midwives and nurses saying....it as well. [MW 5: 5.41].

One MW participant with a sense of being able to influence policy notably felt that way in the context of her role as supervisor of midwives and clinical governance supervisor.

Well if you came to our supervisors and midwives meeting, yes I do (feel able to influence policy). I'm very vocal. You can ask....people listen to us there as well. I also sit on a clinical governance group because... as a supervisor, the labour ward one, so yeah I do think... I think I can influence some things and you know, policy writing... what happens if I don't like them, I know we've got to have them...I read... you know we get all policies, midwifery ones come through. [MW 6: 6.39].

Similarly, a research midwife revealed a strong sense of agency, commenting upon her work influencing policy as **“It's probably the best job satisfaction I get”**. [MW 7: 7.37]. Another midwife with considerable clinical experience, and a self-identified personality that facilitates challenging policy, made the following significant statement.

Yes. (Feel able to challenge policy). Because I'm quite bolshie by nature and because if I'm in the right frame of mind I like to challenge a paediatrician or a colleague, that I feel is doing something to the detriment of a mother and baby.... to involve yourself in structuring guidelines and policy. It's certainly up to you, you know, your own reading and your own career development is down to you at the end of the day. [MW 8: 8.67].

Perceptions about the importance of government or political affairs were

prevalent in both participant groups. Some interviewees were unequivocally certain about the importance of government/political affairs **“yes, definitely”** [HoM 3: 3.84] and **“Yeah I follow them closely”** [HoM 5: 5.86] especially if politicians were currently involved in the subject of maternity services provision.

Critical (government/political affairs). **They make or break my day to day job. But that’s because again, in the position that I am, that might not be for every midwife, but for me absolutely. If you get a politician that’s pregnant or his wife is pregnant, it affects the direction of travel, everything. You know, from the day job right up to the top job.** [HoM 1: 1.65-66].

Yes (important). **I think... yeah I think the more senior you become in an organisation, you look at things very differently and you see something on the television that comes out and you immediately think ah, that’s going to have a direct impact on this, this and this.** [HoM 7: 7.66].

The following HoM articulated broader views about the importance of the political affairs of government:

Absolutely (important). **I would just say it as a citizen first of all. I mean I live in the UK, so government policy affects me and mine you know, it affects my family, it affects everything.** [HoM 8: 8.40].

That's a difficult one actually. I think they're (political affairs) **important... it's important to keep abreast of what's happening so that you're aware of some changes that might be coming your way.... They have to be, whether we like it or not.** [MW 8: 8.68].

However, others were less convinced, for a variety of reasons ranging from a lack of a sense of political agency to the discernment that gender inequality dominates the current government/political landscape in England.

Yeah totally disillusioned with it really, with any Government. I suppose that's because I'm older now, I don't know....I don't think whichever flipping Government's in, really has much of a difference. I mean it does worry me from time to time...[MW 6: 6.41].

No (not important). Because I don't think there's enough women in it. Both sexist as well as pragmatic. I think it's a male agenda and I think it's... I think the bureaucracy attached to it almost makes it meaningless. Why do I use the word meaningless? Because it's meaningless to me. [HoM 4: 4.73-74].

The jaded view reflecting a lack of political agency revealed above was allied to that participant's insights about meritocracy and her perceptions relating to regional differences in the credibility and profile of other HoMs.

But equally, I can speak as, I have as much value to add to that, and sometimes I...look at and the nepotism involved in it and you know, even regionally, the LSA forums are guilty of it; they pick the same head of midwifery from the biggest Trust, with the most reputation. Well actually...have I got more experience in that area than they have?You know, you go to some of these things and it's the London HOMs that are involved and then they start the sentence by, well I was doing a water birth last night. Well I don't need to do a water birth to be a good head of midwifery, thank you.....I think you've just got to be in the in crowd, and I'm not sure the in crowd are always the ones that are seeing it broadly you know? [HoM 4: 4.83-84].

The participant equated regional differences between HoMs as impacting upon perspicacity about a region's population demographic.

Well I think the trouble with the in crowd and that perception of them is they're in a different demographic as well. You know,

totally alien to yours in a way. They just reflect the diversity in services don't they?....Well I went to a national heads of midwifery in December and I suddenly thought, I think I'm in a parallel universe. I sometimes feel that when you see people that have informed policy, well which universe are they living in? [HoM 4: 4.85-86].

There was a perception articulated that government affairs had radically changed the NHS and maternity services landscape.

Well because they're (political/government affairs) just shaping everything you do at the minute aren't they? Everything, our organisation has changed, the management structure has changed. Yeah, the pace has changed; the pace at the minute is overwhelming. [HoM 3: 3.85].

Another study participant voiced opposition to certain aspects of contemporary political agendas, again allied to gender inequality.

They've (current government) been disadvantaging women...the big cuts have hit the women and children, and the poorest women and children. So they have gone about alienating society from single mothers, as if they're some...demon of society. So their benefits are reduced, they can't stay off work, their tax credits are reduced, so if they're in low pay they have to go to work, and then their childcare is almost unaffordable. So increasingly, they just have less and less money....At the same time, (the government's been) - rewarding marriage, and traditional families, but they're already better off, because there's already two of them. [HoM 5: 5.87-88].

The sense of political agency was eroded in the following HoM participant by the perception that current and previous political

rhetoric about maternity services paid lip service to midwives. Gender discrimination was also identified as a reason for lack of germane policy in NHS and maternity services.

And previous governments, I think and this government will do the same as well I'm sure, and I've seen it politically, year on year... election in, election out now, they make all these promises about maternity services, because they're the cornerstone of public health, they're the cornerstone of our society. (Interviewer: Lip services to the midwives?) **It is lip service, totally. My feeling is, that it's because maternity services are used by women and our government is male dominated.** [HoM 5: 5.91-93].

In relation to professional bodies and the subject of political agency in the midwifery profession, the following analysis was offered.

I think our professional bodies are almost fighting with one hand tied behind their back because they're a trade union and a professional body. They're not separate. [HoM 5: 5.94].

...as midwives, we're not paid as much as doctors, we don't have the huge private practice, we don't have... we haven't grown up in that big professional lobbying body. We haven't got the same political clout. So we're not going to score the big wins at the GMC, and are the midwives going to be able to afford to pay into a professional body that doesn't give them the trade union arm? Most of the midwives who are in our professional body are in it for the trade union arm. So then you look at two things. So do you invest in the political lobbying for the greater good, or is it the trade union, we need more money, better pay conditions and I think that they get caught between the two and consequently fall down. [HoM 5: 5.95].

Finally, academia was also viewed as a potential, yet currently lacking collaborator in the realm of political agency for the midwifery profession.

So I do get frustrated with academia and I did big time a few years ago. We have all these professors of midwifery and yet the BFI are in NICE. We have all these professors of midwifery and yet elective caesarean section is now in the NICE guideline. I'm frustrated with academia. I think they've got big teeth and they act like they're little gummy bears. [HoM 5: 5.99].

4.3.2.3 Subtheme: Evaluating Maternal Autonomy

Reflections of the impact of current policy upon the decisional autonomy of women were evident in a cluster of formulated meanings that expressed conflicting views of policy on the one hand constraining women and on the other, having no impact at all. Significant statements relating to the perception that policy probably had no impact include the following.

I think her view on the take is what her personal choices and her opinions are, which informs her decision making, rather than a policy. [HoM 1: 1.49].

Well I don't really, (think IFP has an effect on women) other than I think sometimes we... I would like to think that we don't coerce or persuade, but I guess the reality is at times perhaps there is pressure to do so. [HoM 8: 8.22].

This concept described above, of IFP exerting pressure on women to breastfeed, was perceived as influential upon women undecided about infant feeding method.

I think it (IFP) can influence women, but it will influence the

ambiguous women, not the ones that have made up their minds...For the black and whites, the yes's and the no's, will know where they are and no amount of policy will change that. [HoM 1: 1.50].

The static rates for breastfeeding duration were explained by one participant in relation to women exercising their autonomy **“The primary factor is the woman’s choice”** [HoM 1: 1.53]. Accordingly, mother’s opinions were viewed as creating a weight that impacted upon their infant feeding decisions. In this sense, mother’s opinions, and their sense of agency, was identified by several study participants as connected to personal backgrounds and existing peer group relationships.

Women’s choice will often will be... they will have a strong opinion before they’re even pregnant, about what they feel, and this goes back to schooling, it goes back to education, it goes back to pre-conceptual care, it goes to...(Interviewer: Social culture as factors?) Social... yeah absolutely, right across the board. It goes to their peer groups, it goes to family influences, their partner influences and there is a mass. [HoM 1: 1.54].

So even before we get that pregnant woman into our care and services, she’s got a strong opinion. I think that is the driving force. [HoM 1: 1.55].

The decisional autonomy of mother’s who had decided not to breastfeed prior to accessing maternity services was viewed as compromised to some extent by current IFP.

I think that we do have the occasional woman using services who wants to bottle feed and for whatever reason then feels she's

forced... or not forced, she doesn't want to hear about breastfeeding and therefore....Midwives feel it's their job to tell people about breastfeeding, as it is, and sometimes that can cause a clash I think. [HoM 2: 2.40-41].

Well it (IFP) can have a huge effect on women can't it? Because you know, for example, next week we're not going to be offering formula milk to women who come into hospital. That's going to have a huge effect on our population. Our policy is dictating that we will no longer offer free milk to babies. [HoM 7: 7.37].

Similarly, the following participant suggests IFP leading to increased initiation rates may have compromised women's sense of volition in relation to their decision making.

Yes, yes, we have seen a rise (as a result of current IFP). Some of our feedback from Mothers is, 'Well, I've got to, haven't I?' but not all, I mean I don't get a flood of complaints, I wouldn't say that, but there are definitely times when you do hear from Mothers and think, ooh, you know, they're probably initiating breastfeeding because they feel that they've got to but don't really want to. [HoM 6: 6.32].

Some participants viewed IFP as overtly effecting mother's autonomy **"There's no room for freedom of you know, supporting women"** [HoM 3: 3.25]. Similarly, in the vein of policy failing to address mother's infant feeding autonomy:

I think that puts pressure on the mums because they feel breastfeeding is what they have to do, rather than what they want to do. From a midwife point of view, the breastfeeding policy, we're told, every single ante-natal appointment you should be drip, drip, drip, information about breastfeeding. [MW 2: 2.5].

A lot of women perceive that we are going to push breastfeeding on to them. Maybe some women feel that they have to say they're going to breast feed, to please the midwife. [MW 3: 3.38].

The following judgement was made about the efficacy of coercive feeding policy.

Are we forcing people to breastfeed who don't really want to? What is it? There's something there that we're not doing right. I've always and still think, if you tell me you want to breastfeed, I'll give you my 100% support, but I'm not going to make you do it, because actually making somebody do it is never going to work. [HoM 6: 6.18].

A balanced appraisal of policy that suggests how to address maternal decisional autonomy was offered by this MW.

I think it probably is evidence based (IFP) and the evidence is out there, which is why, as a midwife, promoting breastfeeding I think is important, but I think it's getting that balance with saying to a mum, this is what we promote, because of X, Y and Z, however when you've been given the information and you've made that informed choice, not to feel guilty if you decide that breastfeeding isn't for you. I think that's where it slips up. [MW 2: 2.12].

She had particularly identified that current IFP interpretation meant information was not offered to women in the same manner as other information presented to women accessing maternity services.

Well I think like any information that we're giving them, we should give them the informed choice, so we tell them about screening, we tell them why we want them to have the blood tests and why we say about having the screening test for Downs Syndrome. But we also... there's that option of, actually you might decide you don't want to do it. Apparently now, we're not allowed to talk about

bottle feeding and parent craft and I think breastfeeding and bottle feeding have both got their advantages and their disadvantages. I feel the women should be given the information about the advantages and disadvantages of both, so that they can make the right decision for them and their family....[MW 2: 2.18]

Some midwives were more confident about how in practice they promoted maternal autonomy with regards to IFP.

I think postnatally you can see sometimes mums just don't want to breast feed, they don't want to carry on breastfeeding, it's not for them, and that's their choice. But they sometimes maybe feel that the midwife's going to come in and bully them into breastfeeding, which I will tell all mums, if they've made a choice as to what they're going to do with their baby, it is their choice and I will support them in their choice. [MW 3: 3.39].

There was inconsistency regarding some midwives' conceptual understanding of maternal autonomy in that breastfeeding promotion was considered paramount, despite women's decisions to the contrary. Implicit acceptance of the supremacy of IFP was not viewed as incongruous with the notion of promoting autonomy in women in some midwives.

I think midwives, some midwives are quite... almost frightened because they have to go by policy you know and there's big words like CNST and the BFI. I suppose they think they have to do what they've... what they think they... they haven't read it properly, probably or they haven't understood it. [MW 6: 6.27].

I just feel that people make a choice over their child issues, as to how they're going to bring up their baby. If they want to bottle-feed, I'm certainly not going to dissuade them from doing that, but I will point out the benefits to their baby and actually, that there could be benefits to them of nursing their baby. [MW 3: 3.40].

So I think they're getting the message that midwives want them to breast feed, there's a pro sort of...breastfeeding thing, to the point where they have to make excuses. Yeah, and they're still going to do what they're going to do. [MW 4: 4.18].

Well it's just the way of talking down to women, which some midwives do. I've heard them do it. I have heard them do it. I think you just have to get in your head, it is their choice, it's completely up to them....But I feel my job is to try and let them know what is ultimately the best thing for their baby. [MW 6: 6.28].

Yet other midwives appeared to explicitly support the compromise of maternal autonomy in the interest of promoting breastfeeding.

I think it needs to be made less easy to give the baby a bottle (What women need from IFP). [MW 5: 5.47].

I do have an opinion that I still, even after everything I say, I still believe women should breastfeed their babies. Like I believe women shouldn't smoke. [MW 6: 6.35].

In complete contrast to the above, the following midwife thought women needed midwives to respond to their decisions and unequivocally support them in their individual decision making processes about feeding or other issues.

(Interviewer: So are you saying you think we shouldn't be telling women how to feed, that it's their decision?) **Yeah. I think the only time we should ask a woman how she wants to feed her baby is when she's in labour, so we know... what to get ready. That's all. Because all babies should have skin to skin contact, regardless...of how they're going to feed their baby. [MW 8: 8.45].**

I think they need support, however they decide to feed their babies, and they need non-judgemental support...for the situation that they're in now. It can be either answering questions ante-

natally, it can be as a formal discussion in an ante-natal group, it could be helping a woman with positioning and attachment, 10 minutes after she's birthed her baby. It could be supporting her through a big weight loss post-natally. It could be anything...throughout their period of exposure to us. [MW 8: 8.71].

What the above statements illustrate is the conflict between the role of the midwife and adherence to IFP or other policy in maternity services. This is exemplified by the following midwife's analysis.

Because things are very strict...The one that comes to mind is when you walk in and you find the woman who's breastfeeding, giving a teat and of course you're absolutely going to have that education and support, but you go back in again later and again the teat is there. It gets to a point of, you've given her the information, and she is making that decision herself. We can't make her do anything. But sometimes because midwives are so drummed into, these are the guidelines or the policy....The need to be compliant. But I told you, you couldn't do that and there seems to be...[MW 7: 7.23] I mean I had a midwife come to me a couple of weeks ago who said, I had a woman who declined anti-D this morning what do I do? You document it in the notes, you've counselled her, she has declined it. [MW 7: 7.24].

Finally, and in contrast to the above IFP specific commentary, one participant voiced her own interest in the concept of promoting autonomy in women **"I've always had an interest in promoting women's autonomy actually"** [HoM 6: 6.2].

4.3.3 Theme: The Emotion Work of Compliance

The theme entitled *The Emotion Work of Compliance* was derived from the data in response to identifying the formulated meanings from the significant statements of the HoMs that reflected collective decision making processes where multiple actors or organisations exist. It related principally to issues of governance but also included data associated with fulfilling health promotion and public health agendas. Governance is a notoriously difficult concept to define due to the 'slippery' nature and cross-disciplinary aspect of the phenomenon as previously discussed in chapters one and two. In the past twenty years however, it has ascended conceptually largely due to changes in society and researchers' responses to attempt to understand the phenomena they are observing. Existing literature and methods were thought to be not adequately capturing the evolving concept of governance (Chhotray and Stoker 2009).

With the above in mind, three subthemes emerged from the data allocated to the theme *The Emotion Work of Compliance*. *Navigating Professional Governance* was the subtheme used to ascribe the formulated meanings from narratives that related to the impact of what I have labelled the 'Evidence Authorities' upon clinical practice. Such authorities encompass NICE, WHO, the Royal Colleges and literature from academic institutions or sources. The subtheme *Fulfilling Expectations of the Health Promotion Agendas* was used to identify the formulated meanings directly relating to the rhetoric and policy of this aspect of Public Health. This seemed to occupy a distinct entity within the data, potentially because as a concept Public Health exists in national (and international) discourses in a range of intentional guises collectively aimed at directing the approach towards a population's health. The final subtheme was termed *Realities of Healthcare Governance*. This referred to the clusters of formulated meanings referring to the state provision of healthcare services, predominantly the NHS. It includes references to policy and interpretations about

controlling and monitoring the operation of the NHS, as a healthcare system. These interpretations by the participants contribute to the political science analysis in chapter one.

4.3.3.1 Subtheme: Realities of Healthcare Governance

In relation to the state provision of healthcare services, IFP was described by this participant as being the vanguard of ‘investment for change’ by government and thereby directing maternity and healthcare services.

It’s at the forefront really of investment for change you know. Certainly an infant feeding midwife is very prevalent, it’s a key performance indicator, which means it’s high on everybody’s agenda, commissioners as well as providers. The policy that goes through that directs the day to day job I think, of a midwife. I think education for midwifery is high on it; the profile in it for parent education systems, maternity services, liaison committees is very, very high and very well known. [HoM 1: 1.9].

Accordingly, IFP was accepted as having primacy and longevity in healthcare service provision.

I think we’ve all signed up to the theory, and the policy is really non-negotiable, it’s been going through for such a long time. [HoM 1: 1.11].

On the other hand, frustration was also expressed that the BFI was a monopoly and comparisons were drawn with The Clinical Negligence Scheme for Trusts (CNST) and targets in the NHS.

That frustrates me immensely, that it’s actually a monopoly from

Unicef, and there's no other governing body that can... it's almost like CNST you know, it's the same monopoly... [HoM 1: 11.16].

It's targets and it's... you know, we need to do this... Yeah, it's ticking boxes, it's like CNST, it's baby friendly, just tick the box. [MW 2: 2.40].

To some extent, some comments about IFP appeared to bridge the two clusters of *Realities of Healthcare Governance* and *Mediating Clinical Autonomy*. CNST a compulsory mechanism for management of the NHS healthcare system was identified, sometimes negatively, as directing clinical practice. CNST dominates contemporary maternity service provision yet some recommendations were regarded as opinion, as opposed to evidence based.

CNST now, is completely directing the way...maternity services are going. It's really... for me, some of the things that have been implemented as a result of what CNST want, and we have to demonstrate, they're not even evidence based yet. They're ideas they're bringing in to say, you know, we think this is quite a good idea. They've used it in other settings, give it a go basically. It all comes down to... people's opinions of what they think is best practice and last year for example, with the obesity, one of the recommendations was, all women with a BMI over 30, need to see a consultant obstetrician. That was a massive order on maternity services and not achievable and a lot of us said, do you know what we're going to locally do it at 35 and a community midwife will do the 30 to 34.9. [MW 7: 7.11].

In contrast, CNST has a key contemporary role in standardising training and delivering it to the multidisciplinary team. This attracted the following assessment by a participant about the efficacy of this approach.

In the last 18 months our mandatory training has gone multi-

disciplinary as requested by CNST. It has been a real battle with some of their views in the meetings. I don't know if it's because they don't like being trained by a midwife, doing it....Yeah, and the midwives even offer to step aside for some of the sessions and the consultant can do it. But one time we did and it was horrendous ...And it wasn't evidence based at all. [MW 7: 7.38].

Public health alliance with IFP was thought to have recently changed the profile **“It feels to me that it’s stepped up a notch”** [HoM 1: 1.51] as policy was now interpreted as being part of the government’s wider public health agenda.

There's all sorts of estimates around the huge impact (of BF) on obesity rates and cardiac illness etc. isn't there? The long term stuff that then has an impact on healthcare. [HoM 2: 2.26].

The issue of NHS targets, and how they are used by government to direct healthcare services, was considered by all study participants. One HoM expressed uncertainty about their origin **“I don’t know where they come from”** [HoM 1: 1.35] but nevertheless welcomed their existence.

I think they are used as a measure and a driver of change. So in that way they are good. They do focus attention where they need to be, so I think that’s good as well. They are good for benchmarking purposes. So I do like the targets. [HoM 1: 1.35].

Similarly,

It's very much a target culture I think in some ways they are (a good idea), if it gets people seen more quickly, if it gets them in... you know, generally within the NHS, if they have to have been seen by a certain time, I think a target is a good idea. [MW 3: 3.55].

Despite the approval expressed above, there was uncertainty voiced about the veracity and efficacy of targets and of how they inform policy.

How they go back to inform national policy, is a challenge for me, because I... whilst I know that there is work that goes back, and I do know the data is collected nationally, how that influences future policy directly, I don't feel it... I haven't seen any major policy change from breastfeeding, for a little while, because the things have been on things like intra-partum care or caesarean sections and things like that. [HoM 1.1.38].

I think people can quite often get moved from one waiting list to another and then it's a way of making their eventual treatment longer, but they've been seen within the target. [MW 3: 3.58].

IFP related targets were viewed as comparatively less important than other targets.

It's a target (IFP). But I'm not beaten by a stick with it. On a monthly basis. That's the bit that measures how important it is. That sounds horrible, beaten by a stick but held to account for the rates that are happening, is what I mean. [HoM 1: 1.40-41].

Positive accounts of targets include the perception that they raise the profile of initiatives and are not overly onerous on maternity healthcare systems.

I think government targets, to some extent are good because they raise the profile and that there's not a huge amount around maternity and the importance of them comes and goes, like booking by 12 weeks. [HoM 2: 2.28].

I think sometimes they can raise standards and make you try and improve your services. For example, you know the 12 week and six

days bookings, has made us implement our direct access and now we've got over 90% of women that are accessing maternity services. [HoM 3: 3.76].

Other views about targets were more balanced with a call for practicality in the target content.

I think they're good, provided they have a degree of realism. I think they are set and delivered to organisations by people that can't truly inform how deliverable they are, so some of them (target) you are set up to fail through no fault of your own. [HoM 4.4.66].

Targets can be very useful but what comes with that is a lot of frustration for us as heads of service I think. You know we are so target driven and we get beaten with targets sometimes. [HoM 7: 7.30].

The majority of things, I think it's been quite handy to benchmark against. I do like having the maternity dashboard as a report for all specialists when we're at our local governance meetings, to look at, this is what should be happening nationally and this is what we're doing. [MW 7: 7.32]. (Interviewer: It's a stimulus then for better practice?) It can be, yes.....When financial targets are put on it, that can make it... how can you say, very focus driven by some of the management team. [MW 7: 7.33].

In contrast to the above, there were more cynical and less complimentary views of targets.

Yeah, but I'm not convinced about government targets, certainly in other areas all do is cause knee jerk responses that usually have a detrimental effect elsewhere in the system, in order to pump, prime or juggle the figures or whatever. [HoM 2: 2.31].

Temperature, pulse rates, you know the obs charts (critical standards of care targets) **sometimes they're not... if you don't achieve 100% it's not because the observations aren't done, it may be because you've not put the ward area on the chart. I think that gives... it doesn't give a true reflection.** [HoM 3: 3.79].

I'm a bit sceptical about government targets (intake of breath) **I suppose to an infant feeding extent it drives you forward if you've got to.** [HoM 6: 6.38].

The 'tick box task orientated' aspect of targets was assessed as being detrimental to the care of women by more than one interviewee.

It's when targets in the ticking boxes type situation becomes a problem that the patient then doesn't get the appropriate treatment and care that they should have, because they're too busy seeing the next person. [MW 3: 3.56].

I think there's far too many of them. It takes away... yeah, just because there are. It takes away your time, your ability to actually practise...Yeah, loads of tick boxes. There's too much. [MW 6: 6.36].

Breastfeeding targets were viewed with hostility by one midwife who deemed them as removing the holistic approach to healthcare services.

I think whoever devised them (targets) **should be shot. Because they are used as a stick I think, to beat women with. Women know full well that there is a big government drive towards the promotion of breastfeeding and that they are really just part of this, that them, their babies and their individual needs aren't coming into consideration, it's all about the target. But that's the same with**

any target led service. The actual consumer of the service ceases to become important. [MW 8: 8.27].

Although she did acknowledge targets constituted an attempt by government to control the efficiency of healthcare services.

I think what they were trying to do (with targets) was increase efficiency and that's not a bad thing. An increase in efficiency is not a bad thing. But the thing is with the NHS, is that it is such a large, unwieldy organisation and money in the NHS is like pouring water into a bucket with no bottom. There will never be enough. [MW 8: 6.63].

Targets were viewed as being fundamentally out of touch with the reality of people's lives by this midwife:

I think any government targets are totally in cloud cuckoo land. I just think they haven't got a clue, that the government sit there, they think oh let's create utopia, we're going to have this breastfeeding population and they're all going to have their 2.2 children, they're all going to have a house to live in and a job to go to, and then employment's going to be this, and breastfeeding ratesand they don't live in the real world. [MW 2: 2.35]. *(Interviewer: You just think they're unrealistic?)* **Absolutely, Absolutely. But it's like our latest isn't it, a matron or a nurse will do an hourly ward round. She has 22 patients on that ward, and she gives them two minutes each, only two minutes. By the end of the hour she's starting again, so she can't do anything else but just be on a wheel.** [MW 2: 2.36].

Correspondingly, targets were viewed as futile by the following midwife because they failed to educate the population and address the socio cultural issues underlying health related behaviours in people.

Well I think it's a bunch of crap really (government targets). It's a bunch of crap. Because...I don't know how... it's important to get the information out there, because I do believe that drip feeding... it's a bit like home birth you know, which culturally, women in this country still believe you've got to have pain relief and you've got to be in hospital to have your baby because it's safer, especially with the first one. You can see all these things coming out and their families say that and they hear all of that and it's the same with feeding. You see in Holland, you know they believe they can get...through the birth without pain relief and they believe that the... you know, in Scandinavia, why, why...are the breastfeeding rates so brilliant up there, when they're not down here? I mean are they all middle class? Yeah, they've got more money, exactly. I don't think you can just decide that there's a target, without looking at all of those aspects and poverty and... [MW 4: 4.33].

The onerous bureaucracy associated with targets and the associated inadequate funding for the intended health outcomes they were supposed to address, was voiced by this midwife:

My experience is, that when the governments produce a target, they say that there's some money coming with it. The money is spent on an administrator to check that the targets are being met. It never actually results in half a dozen breastfeeding assistants on the wards. [MW 5: 5.28].

Stretched targets as a means of healthcare governance were deemed as imbalanced by this participant.

I think the thought of having stretched targets is ambitious if there's a problem, but shouldn't be universal because, if I give you a for instance, my caesarean sections run at about 16% and they tried to impose a stretch target on me last year, of year on year a

1% reduction. Well when you look at national statistics you know...I'm already way below that. [HoM 4: 4.67].

Government driven IFP targets were perceived by the following participant as raising the profile of breastfeeding but caution was expressed about their impact upon women.

I guess it's a double edged sword isn't it? Yes if it makes high profile that's good. I'm not sure that women appreciate... you know I think you do get a bit of a backlash from women feeling they haven't been given a choice. If the government are pushing it (BF) at them as well. [HoM 2: 2.33].

The impact of targets upon the promotion of breastfeeding was compared with potential cultural influences upon this mode of infant feeding.

Certainly thinks like... I think things like having it (BF) on EastEnders and things like... has helped perhaps more than government targets or whatever. [HoM 2: 2.34].

There was a perception that targets and policy were reactive political tools and an expression by participants of 'change fatigue' associated with them.

You know, we do a lot of knee jerk changes and target changes, related to the ... that actually aren't helpful I think. It would be nice if all the political parties could sign up to leaving the NHS alone. It's very, very hard. [HoM 2: 2.55].

I don't... not that keen on the government, any government...policies. Well because I don't think any of them believe... well they do believe in what they're doing, what I'm going to say is. They're all very much the same really. Nothing ever

happens differently in this country, much. You know whatever Government's in. I personally believe in...They've got too many agendas. [MW 6: 6.37].

Finally, some participants expressed the sense of targets being somewhat of a blunt tool in terms of measurement of service.

It doesn't tell you about the quality of the care (performance indicators), **but it's all the...Those are the things that the Trust would look and say, I'm not interested in the narrative underneath it, all we see is the figures. So yes, the stuff like the cancer targets, ... absolutely no problem with, but you know, direct access, fantastic breastfeeding figures, it informs, we don't have a problem with. But there are some targets that I think yeah. They don't actually relate to quality** [HoM 3: 3.81].

The issue of re organisation of maternity healthcare services in the NHS was commented upon by midwives (and by HoMs in the *Role Identity* subtheme). Views were mixed about government imposed changes in maternity service provision, notably in relation to the relatively recent extended role of MCAs and MSWs. Negative comments related to the notion of the midwifery profession becoming marginalised in comparison with the nursing profession, due to midwifery changing and becoming more orientated towards extended roles of maternity assistants, thereby diminishing the traditional role of the midwife.

It does worry me about the professionalism of midwifery, but that's worried me right from the... about the time I first qualified....Well, losing it really, and getting engulfed in being a nurse, you know, a nurse midwife or whatever...The maternity support worker. I don't like having them. We haven't got any maternity support workers here; we've got maternity care assistants. I personally don't like the idea of having a maternity support worker because it means

there's going to be less midwives. That's the only way I can see it really. It probably reduces our numbers, possibly... I personally think it will probably make us more into high tech, canulating, Ventouse practitioners. Which isn't a bad thing. I mean that's... some of that's good. But I think that's sort of... specialist midwife, yeah. Whereas I mean I personally class myself, although I do coordinate the labour ward as well, as, a specialist midwife for normality, which is what midwives are really. [MW 6: 6.42].

It's de-professionalising us. They are now saying that we don't need two midwives at a home birth and the MSW can be the second midwife. We are fighting this furiously. If you were at a home birth and mum haemorrhaged and the baby was flat, which one are you going to deal with? The MSW sure as hell can't deal with the other one. [MW 5: 5.32].

4.3.3.2 Subtheme: Navigating Professional Governance

The clusters of formulated meanings revealed expressions from most participants that were classified under the subtheme *navigating professional governance*. These dialogues contained reference to maternity healthcare related evidence and the state provision of healthcare services, predominantly the NHS. It includes interpretations about controlling and monitoring the operation of the NHS as a healthcare system, as well as discourse relating to comment and analysis about the 'Evidence Authorities' and the impact these institutions have had upon the operation and policy foundations of current maternity services.

In general, evidence based healthcare was welcomed but anecdotal experience was also valued.

I support evidence based practice because that's how we learn and move forward and go. I'm still a little bit old fashioned in sometimes that things just work because we know that they work, but there's no evidence out there to promote that and to say well actually, yes this does work. [MW 3: 3.34].

In regards to looking at... from NICE to RCOG, to what you stipulated with WHO, no we don't differentiate between them. [MW 7: 7.34].

One participant felt overwhelmed by the amount of policy and increasingly less confident to comment upon the accuracy of their evidence base.

I get inundated with all these sort of policies and who's making what and things, but I am getting more sceptical and more sort of, what's the agenda that comes out of it. So something from a WHO or a medical type of research, I'm perhaps more inclined to subscribe to. Whereas I think government types of things which you know, they're in an awful place, they're trying to balance books and they're trying to do whatever, but I do feel that government stuff, sometimes I am a bit more sceptical as to what is the agenda here. [MW 3: 3.59].

The National Institute for Health and Care Excellence (NICE), as a prominent 'evidence authority', featured widely in the views of all interviewees with one HoM desirous for NICE to be more explicitly involved in breastfeeding guidance and policy.

I'd like a NICE guidance on breastfeeding, if I'm being truthful I think. Getting some systematic reviews from good evidence based work and getting it into NICE documents. We have... it's bolted on to several other sources; it's certainly with post-natal guidance.

But I'd like a freestanding NICE guidance. [HoM 1: 1.22].

I'm wary of stuff (evidence based documents) that comes from the government. Because it's usually got an agenda....NICE, even though it's a government organisation, I'd say...it's better. I think the NICE guidelines for post-natal care are actually very sound.
[MW 8: 8.65].

UNICEF's BFI was specifically appraised by several participants in the study with the equilibrium of evidence it presented being questioned **"I don't know how balanced it is?"** [HoM 3: 3.26]. Additionally,

In many ways I'm disappointed with NICE, that it wholeheartedly adopted the BFI, when they have not critiqued the evidence based under...No critique whatsoever and so they didn't give... you know, we had this hierarchy of evidence, that drives me crackers and qualitative stuff doesn't normally rate particularly highly, and yet, they just said the BFI has come in, and they did an economic evaluation of it, based on what it cost to implement the BFI, because they had all these advisers... and not on, what could we do to implement the support for breastfeeding. [HoM 5: 5.49].

In the absence of support from an 'evidence authority' or the Professional Midwifery College, this participant felt unable to criticise the BFI owing to the taboo aspects of dissenting about IFP.

In terms of myself personally, I haven't tried to influence it (IFP) on feeding, because actually I see it as too much of a political hot potato, because there's a huge backlash whenever you... it's almost like our Holy Grail. You can't...To criticise the BFI, with me as a whole, would be a politically dangerous thing for me to do. So it's not something...Whereas through our professional organisations I have certainly had these conversations at the highest level I could have and at one point we were considering...So those conversations have been had. But I wonder whether even the Royal College of

Midwives are nervous of taking on an industry such as the BFI.

[HoM 5: 5.79-80].

In view of certain misgivings about IFP, the HoM sought a comprehensive and impartial review of the evidence relating to BFI.

I would like to see the evidence base for infant feeding actually explored and acknowledged and acknowledged where we haven't got good evidence...the pacifiers links with cot death and preventing it. Also, Suzanne Colson and her biological nurturing...I don't care where the evidence comes from, but I'd like to see us use it and I don't think we do. You know, they say... I think is it, 15 years for research to come in some ridiculous time, I think it's beyond 15 years for maternal feeding and maternal infant feeding.

[HoM 5: 104-106].

In contrast, NICE guidance was highly valued and accepted by several participants, being perceived as possessing integrity and high status.

I think it's recognised (NICE guidance) and I think it's standardised and it carries a credibility with it that's tried and tested and that's why I like it in all sorts of fields. It's used widely across all disciplines and agencies and that's why it's useful. I do think that it gives it a visibility and a credibility that local, other initiatives, don't. [HoM 1: 1.23].

Well I think I have to say that guidelines can be really very useful in informing people. If you're confident that you've got the right people writing the guidelines, that they've been reviewed by the right healthcare professionals. [HoM 7: 7.12].

The main general criticisms of NICE were levelled against the quality of

evidence it utilises and the way it applies the 'tier category' system to different types of evidence.

I think some of the bits that NICE have put out are, as usual with NICE, a bit flaky on their evidence base. [HoM 4: 4.14].

I think sometimes they (NICE) sneak in quite a profound statement, that when you read down to the minutiae and forgive me, I'm out of date with what levels they use now. But say it's their third category of evidence, they can sometimes almost be anecdotal or one off evidence. I think they've got very clever at sneaking something in without the background to it, but making it quite profound. [HoM 4: 4.14].

Another study participant disclosed her awareness of a midwife becoming part of a NICE expert panel, in a manner lacking in meritocracy.

Yeah, and certainly you know, obviously as you rise through the ranks you hear different things don't you, but for instance there's a colleague from ***that was allegedly an expert on the ***** NICE guidance, and was part of this *****debate. Her Head of Midwifery said to her, how did you get on the group as an expert? She just expressed (her) interest. The Head of Midwifery said (to the midwife) "nobody's asked me whether you're an expert or not, and I wouldn't have said you were". [HoM 4: 4.77].**

As a result of the above, misgiving was expressed by the HoM for the reliability of NICE findings.

So the credentials of the people that inform the panel, and for me, there still seems something of an old boys network along with that. (Interviewee: Nepotism?) Yeah There's nepotism....When you look at these sort of like policy documents, it's always the same ones that are pulled out. [HoM 4: 4.79-80]

Two relatively recent NICE guidelines on Caesarian Section⁵² and Neonatal Jaundice⁵³ generated ambivalence and exasperation in several study participants. The relationship between NICE and the media was also questioned in relation to CG132 being equitably interpreted by the press.

With NICE, for example the latest caesarean section, how it was taken out of context and suddenly every woman who's having a first baby is entitled to a caesarean section, when actually it didn't say that. It's (NICE CG 132) the women who have you know, issues or stillbirth or whatever. But there are other routes available for them. For example, peri-natal mental health, that might influence their decision making as to c-section, but you know the Daily stupid Telegraph and papers, they just highlight the one. [HoM 3: 3.90].

I think sometimes, a good example of that in a flip way is that you can look at some NICE guidance, for example the recent guidance with the caesarean sections. I'm sure that was said with the best intent possible, but the impact on us...In retrospect that could have been sold in a much better way. [HoM 7: 7.67-68].

In relation to Clinical Guideline 98 concerning Neonatal Jaundice:

The one that probably bugs me the most and it isn't directly about infant feeding, but it's about jaundice. Bilirubinometers, you know they've snuck that in, the degree of evidence is minimal and yet the cost to services is phenomenal and actually, with very little benefit, from assessing jaundice with the naked eye. (Interviewer: It stops midwives making a clinical judgement?) Exactly... and we've got

⁵² guidance.nice.org.uk/cg132

⁵³ <http://publications.nice.org.uk/neonatal-jaundice-cg98/guidance>

to look at that (jaundice) in the context of hypernatraemia, weight loss, certain behaviours, wet and dry nappies. You know we've suddenly, out of nowhere, stuck Bilurubinometers in, and ...You know, let's measure something. Well actually, let's look at the signs, the baby as a whole baby really....But it confers a certainty that people... that practitioners latch on to, as well as women...What we say is, they lull practitioners and consultants giving us a false sense of security. The reason we're midwives, with legislation, is that we do make judgements. It's horrid. (Interviewer: *The midwifery profession is being deskilled?*) Oh absolutely. [HoM 4: 4.16-4.20].

In contrast to the above, the following participant appears to have a more balanced view the evidence base directing clinical practice, recognising that 'good evidence' may be garnered in favour of supporting clinical judgement.

I think some of it is quite arbitrary, especially around blood sugar monitoring and the lack of recognition for things like normal physiological jaundice with the newborn, also in terms of policies for IUGR babies and things like that. The non-recognition of the fact that they have fewer brown fat stores to burn and that kind of thing. I have a few issues there with those policies. But generally the policies are well thought out and they do give us some ammunition to fire back at the paediatricians, who pluck arbitrary figures out of the air and say, oh I think we'll use this as a marker, with no evidence behind it. Then that does give us, the more bolshie of us, the ability to say to them, well where did you get that figure from because...what's your justification for that? Because you know, if we've got to stab this baby every hour, pre and post feed, I'd kind of like to be able to have some evidence...to present to these parents to say what we're doing has some

evidence behind it. [MW 8: 8.33].

But what the evidence does, is it gives us more of a tool to use, so when you have to phone the paediatric registrar, which is what we do as community midwives if we've got more than a 10% weight loss on day five, we can argue the fact against readmission by saying, six wet and dirty nappies in 24 hours, the baby not clinically dehydrated, etc etc. Remind them of the World Health Organisation guidelines, remind them of other pieces of evidence that you might have, they won't have a clue what you're talking about. But you can blind them a bit with science and say, we'll go in and re-weigh the baby tomorrow, are you happy with that? Ninety-nine out of 100 of them will say yes. *ibid* [MW 8: 8.35].

Evidence Authorities in general were respected with no particular distinction made between their reliability as sources of information although academic journals were thought to have risen in status with regards to their evidence content [HoM 3: 3.93]. The quality of the evidence was deemed the most important aspect by the majority of study participants.

As long as it's good, thorough research, with a good sample size and a good you know, mode of research, qualitative, quantitative, whatever, as long as it's done properly and it's enough of the population...to provide a true picture, I don't mind the source. Because if they've done it right, it will be unbiased. [MW 2: 2.37].

I've seen good research, I've seen poor research, I've seen absolutely crap research and if you want an example of absolutely crap research, have you looked at the term breech trial? You could drive a coach and horses through that methodology. And the

doctors swallowed it hook, line and stinker. And now we're not allowed to do vaginal breech deliveries. [MW 5: 5.34].

A lot of people always go straight for a discussion and conclusion page, but I learnt a long time ago, you should go straight for your methodology....Because that's where you'll find...[MW 7: 7.35].

One HoM voiced that the content of many midwifery journals was probably beyond the scope of interest for the majority of midwives. As a result, much research was not communicated to midwives unless published in *Midirs* or the RCM journal *Midwives* [HoM 5: 5.109-111].

I think regarding infant feeding I tend to be guided by the WHO because I think the DH is guided by the WHO. However, what's important for me is not where the guidance comes from; it's the actual validity of the guidance. (Interviewer: Right, so it's the integrity of the research itself?) The integrity of the research, the methodology, all analysis of....as somebody who worked in education for eight years, as a midwifery lecturer, so I guess I can never just skim a piece of research, I tend to critique. [HoM 8: 8.42-44].

This was echoed by the views of several midwives one of whom expressed particular frustration at the dominance of medical model orientated research in the maternity services arena.

I love Midirs because it makes it easy for me. But I just think they follow the trend really....for NICE guidelines and their medical models to be paramount. [MW 4: 4.35].

If it comes out of the RCM I'd respect it. If it comes out of the BMJ I'm very much less likely to.... Because I'm frankly fed up with doctors' opinions on what we ought to think. Because they don't understand our job anyway. [MW 5: 5.33].

I'm very, very keen on the Royal College of Midwives because obviously the Royal College of Midwives is very much into midwifery as a profession and what's right for women. [MW 6: 6.38].

The evidence presented by NICE was questioned by some participants in relation to NICE policy and NHS functioning.

I'm a bit sceptical. I think NICE, I have to pay particular attention to because we, as an organisation have to...implement NICE guidelines. So that's the NHS policy. The WHO policy, I don't see influencing practice greatly here, sadly, because I think some of the WHO policies are very good. [HoM 5: 5.109].

I wouldn't necessarily trust the government (policy/evidence), because they do have an agenda. Which means they would select very carefully, so I don't trust them. And I see NICE now, as part of them. (Interviewer: But NICE has a remit of being at 'arms-length' from the government?) I'm afraid that that is not the case anymore. [HoM 6: 6.67-68].

NICE as an 'evidence authority' was also declining in another participant's estimation concerning costing agendas [HoM 6: 6.66] and the caesarean section policy referred to above.

I think it (ranking of the evidence authorities) matters hugely. I'm beginning to lose faith in NICE. I used to think, Oh great, get rid of the postcodes lottery, everything all draws together, published through NICE. But then some things have happened that have made me question that. Principally, the most recent example is this massive publication of women's right to choose a caesarean-section as the safe option... Where have they got that from?! [HoM 6: 6.64].

Midwifery led care is the safest option for well, low-risk women...I just don't get it, I don't get it. [HoM 6: 6.65].

There was a sense of convenience and confidence conveyed by the existence of 'evidence authority' documents.

I would pull them off ('evidence authority' documents) **they are... the standards are set, to be honest I trust the standards that they produce, I don't check the evidence or if they have evidence behind it, because I assume that once it's got WHO and UNICEF, it's credible as well. I think it gives me a quick fix as a service leader that allows me to implement policy.... I haven't time to do the academics. I trust what the governing bodies produce.** [HoM 1: 1.25]

However, one participant with experience of academia did not unequivocally accept 'evidence authority' findings.

Well I think for me, I would look at the study and look at the methodology and all the rest of it and where it had come from really. But certainly we tend to trust evidence that's come from professional bodies, over and above other things, I would think. [HoM 2: 2.57].

Moreover, another participant was uncomfortable relying solely upon one source of evidence **"You can't just take it from one authority can you?"** [HoM 3: 3.86] and she guarded against perceiving one particular 'evidence authority' as superior to another **"I think I'd view them all with caution.** [HoM 3: 3.87].

The relationship between evidence and the generation of authoritative policy by Government was also contemplated.

Or sometimes you still don't get a choice. And the government will still jump on the bandwagon and regardless of how robust the evidence base is, we still have to go along with that because it gets written in policy, yeah. [HoM 2: 2.58].

There was esteem for the WHO and concern about the decline in CMACE expressed by another HoM.

But I kind of think, you know, they're World Health Organisation, we're looking at trying to reduce overall maternal mortality rates- wherever that is. I would listen to that; I do listen to CMACE when that existed, 'Why Mothers Die'. CMACE is gone and at the National Homs the other day we said, what are we going to have in its place? We're not clear as to what we're going to do. [HoM 6: 6.70].

4.3.3.3 Subtheme: Fulfilling Expectations of the Health Promotion Agendas

Discourses relating to *Fulfilling Expectations of the Health Promotion Agendas*, as a subtheme of the theme *The Emotion Work of Compliance*, were prevalent throughout the HoM's interviews. This aspect of the public health agenda has ascended politically in terms of overall health policy in recent years creating temporal pressures in maternity services as the following illustrates.

I spend half of my specialist midwifery time, on providing support to key public health agendas, and the midwife is central to it all. [HoM 1: 1.63].

It's the screening now, it's the going through the screening leaflets, it's the forms that are so repetitive. You know you'll do a first contact and even the couple will sit there and say, you've written that once already and now you're writing it for the fifth time you know. You've got your scan form, you're got your family origin questionnaire form. You've got your stork form and you've got their notes. Then you've got your perinatal and mental health referral, which nine out of 10 need, your smoking cessation

referral, which nine out of 10 need your inter-agency communication form because they're under 19 or they're vulnerable in some way because of they don't speak English or they're not from England and it's the paperwork. And so you find that now you're doing more and more paperwork, rather than spending time with the woman. [MW 2: 2.43].

Improving breastfeeding uptake and duration was seen as an important public health initiative, but the participants revealed other concerns too.

Key public health? Oh God I could go on... mental health, domestic violence, social isolation, teenage pregnancy, substance misuse, I've put breastfeeding in there as well. [HoM 1: 1.61].

Obesity, smoking, domestic violence, cot death, because they're statistics that haven't changed for decades, apart from obesity, which is rising. [MW 8: 8.69].

Well, breastfeeding obviously is one of them. Smoking. Mental health, a huge mental health thing at the moment.... I think we're identifying them (mental health issues) better than we did do. It's difficult to say, because I think in the long term we'll be able to see whether it's like a static level, because we've only really been identifying them, probably for the last three years in proper questions and...substance misuse, safeguarding, domestic violence. Again, that's always been around...Alcohol. [MW 6: 6.43-6.44].

The connection between social circumstances and public health was strongly endorsed by this participant.

Yes, in social... in areas of social vulnerability it's socially

acceptable for a young girl to have a baby at whatever, and then have another and another baby and then in 16, 17 years time, that baby is doing exactly the same thing. Because it's so quick. We don't... and who are we to go in and preach to people and say, that's not the right way to do it. [HoM 7: 7.55].

How do you break that mould? How do you move on from that? Even with all of the research that we have at our fingertips these days, that suggest that people who live in that way have far less prospects in life, both financially, certainly in terms of health. (Interviewer: Much poorer health outcomes?) Yes. [HoM 7: 7.57].

The formulated meanings also establish that obesity, smoking, vaccination and poverty as well as domestic violence are viewed as key public health issues facing women today, as the following significant statements illustrate.

I think domestic violence and things like that is quite a public health issue that's coming up with not only just domestic violence but things like alcoholism and depression. [MW 3: 3.74]. Mental, yeah. Mental health issues.... Very important. They seem to be, over the last five years I would say, have...Yeah, really escalated. [MW 3: 3.75].

What worries me? I think... the obesity I think, is one, and I think the government...and the smoking...what I want to say is, you know, you've got a baby in there, you shouldn't be smoking. With my mums when I see them what I... when we talk about smoking I say to them, just imagine that baby smoking that cigarette with you and even if it stops you from having one less a day, it's a step in the right direction. [MW 2: 2.41].

British society is sort of very... we're still very ignorant about

healthy eating even and you know, that's why the obesity rates are going up and we're starting following American trends. There's a huge cultural issue. Towards feeding and feeding your child. [MW 4: 4.31].

Breastfeeding was thought not to be construed as public health related because it lacks a high profile.

I think if you... in terms of importance, I think if you asked... because it's not in your face, people would say it's not huge (BF as a public health issue). But actually you know, if you... it would go a long way to...Yes. I think it is huge but it's not perceived as huge. [HoM 2: 2.50].

Other important health issues highlighted by participants included: **“For me I think it’s still sudden infant death. I think it’s co-sleeping”.** [HoM 4: 4.61]. Parenting style was also linked to public health by some midwives.

I think the whole sort of mother nurturing role as well, is being demised really in that again, it comes down to economics. Mums are having to go out to work more and more. [MW 3: 3.71].

One HoM viewed the ascendance of breastfeeding policy as distorting priorities in public health.

I do feel that all the prominence of breastfeeding at times... and other issues like smoking cessation, is kind of neglected, like Cinderella and potentially has more of an impact on peri-natal mortality. [HoM 8: 8.26].

In a similar vein a MW cautioned that breastfeeding does not confer certainty for health.

And it doesn't mean to say if you're breast fed it's not going to get diabetes, it's not going to get asthma, it's not going to get eczema, it means the risk is reduced. Well my breastfed one gets hayfever, my bottlefed one gets nothing! [MW 2: 2.26].

Smoking was particularly cited as a public health issue by participants managing maternity services dealing with a local population that had higher than average smoking levels. Sometimes these levels were linked sub-cultural population demographics.

The other thing is...we're an ex-mining community....they've still got the mining traditions. Certainly you know, with the smoking agenda, you can smoke and bottle feed, you can't smoke and breast feed. You need two hands. They (attitudes) are entrenched you know. [HoM 4: 4.28].

Well we've got really high referral rates for smoking cessation through our quit programmes, but the take up rates are abysmal. You know, because they're in the culture and they don't go. [HoM 4: 4.29].

The participant above highlighted the inequity between a standardised national breastfeeding target rate and the lack of weighting given to the target for socio demographic factors.

I think a blanket figure (as a target breastfeeding rate) is just wrong. I would like to see... what would I like to see? I would like to see some public health analysis of a realistic level, for your demographics. [HoM 4: 4.36].

One HoM acknowledged the ostensible public health benefits of increasing breastfeeding rates but viewed improvements as

immeasurable by the maternity services.

I think if we wanted to be sort of in that utopia, it (IFP) is very important isn't it, because we've got to look at the longer term public health of our population. So certainly with the gastroenteritis, the diabetes, the obesity agenda, it's got to be in there doesn't it. The allergies. But there's no way of measuring the effectiveness of that long-term, from a maternity service. [HoM 4: 4.42].

She subscribed to the policy of promoting breastfeeding to promote public health but questioned the delivery of that policy being weighted upon maternity services despite the benefits of policy being across people's whole lifetimes.

I think it's quite integral (promoting breastfeeding as a public health issue). I think it's really quite central and pivotal but I don't think anybody... because of where the other services that that could impact on, are with... managing their services, they're not going to spend time supporting me to invest in that, with a longer gain. Also, you know, I'll lose them at six weeks, so actually how much investment should I put in, for that long term gain really. [HoM 4: 4.64].

Her stance is also linked to another participants view that the latest evidence suggests that breastfeeding could have a substantial positive financial effect upon the NHS 'under quality'.

Yeah, and it's... if you look at the recent findings and financially how much it could save the NHS under quality, the impact of breastfeeding, then... Just from a quality perspective, the impact it can have on a child's health and women's health, then you know I guess if you were to rank policies in order of importance it would certainly be in the top five. You know, both from a financial and a quality point of view. [HoM 8: 8.18/8.19].

Several participants viewed women as particularly receptive to messages about public health whilst pregnant and this was contemplated in various ways.

We don't tend to see them between 20 and 28 weeks anymore you know, so we need to engage with them in a better way, and that's where I think there should be something more public health focused and out of maternity services, because we tend to be very... now ante-natal care is very intervention focused isn't it?
[HoM 4: 4.48].

Another interviewee acknowledged the opportunity to promote health when women are pregnant and integrated this with initiation of breastfeeding.

I think initiation is high (Interviewer: as a result of the policy?) partly. I think women do always, and I use always deliberately as well, or I should say usually, but my impression is, women want to do their best for their baby, and particularly when they're pregnant. Some of the things women do for their baby when they're pregnant, is huge. I think they do listen. Pregnancy is a window of opportunity for the public health agenda, I've no doubt. So all that input about, this is best for your baby, women do listen. So I think they do do the initiation. So I think that's really good. So I think it does stimulate initiation. [HoM 5: 5.24].

This HoM also thought that the notion of public health in relation to infant feeding should be more prescriptive and extend to psychological health too.

It's interesting. I think we've got hung up on some of the smaller bits of the public health with infant feeding. I think the biggest bit

of infant feeding, and we were talking about it, I think is actually this notion of building confidence in mothering and feeling able and confident in caring for their baby. The psychological health of breastfeeding. [HoM 5: 5.70].

Another participant contemplated women in the maternity care pathway making decisions and the midwife's role in that process.

I think to begin with, you know when you've got somebody, a new, a primip; she's a bit like a blank piece of paper. In that case, scenario, I mean she'll come along with her own personal opinions and what she's seen with her friends and what her mum's told her and Great Auntie Flo etc. etc., but essentially, most women will come to the service, come to us as... what they see as the expert, and we then have a lot of opportunity to do that real nudging and that real, come on, this is what you want to do. But also, particularly as we go through the pathway and certainly towards the end, we are more facilitating. She's made her decision probably and we need to facilitate, particularly those women who have made a choice to breastfeed, facilitate their desire to continue with that. (Interviewer: To sustain that decision?) Yes, yes. [HoM 7: 7.36].

As previously shown, the subject of poverty was raised in relation to *Integrating Policy and Healthcare Governance* subthemed statements. However, discourses about poverty arose also in relation to the *Public Health* subtheme through being acknowledged as having a huge and sometimes lethal impact on maternal and infant health.

"Poverty generally....The poverty issues are acute in some areas" [MW 5: 5.42].

Yes, and actually that's something that I didn't mention actually (the impact of poverty on health). **But yes, we've... yes it is, and you see it with the rare but unfortunate maternal deaths that you get sometimes. When you look into their histories ...and we're a first world country.** [HoM 2: 2.59].

The connection between poverty and public health was explored more deeply by this midwife who considered the concept of relative poverty and the prevalence of materialism in current society.

Poverty, unemployment...The root causes of all those things, yeah..yeah, and yet I can think of several people who have been... and our expectations are much greater now, who've been successfully rehoused, through the housing policy, and they've got lovely flats, they've got more things than I ever could possibly have imagined, so it's almost like, what we think we need isn't necessarily what we do. Our expectations have risen. [MW 4: 4.38].... **It's about new sofas, big TVs, the latest phone, Blackberry and all the rest of it, without thinking about their diet or giving up smoking or any of those things, because they look around and they see people that have....**(Interviewer: Status orientated?) **Very.** [MW 4: 4.39].

(Interviewer: There's almost... there's a materialism. You're identifying...?) **Yes, yes.** *(Interviewer: Materialism, consumerism?)* **Yes.** *(As being dominant interests for the client group?)* **Yes.** *(Interviewer: For the women?)* **Yes.** *(That wasn't the case before and they're not necessarily equated with health?)* **Yes. Yes definitely and it doesn't go along with it (health). Yeah, that is what I'm trying to say.** [MW 4: 4.40].

Public health was linked with the concepts of safety and choice for women too, with midwives viewed as key agents to provide health

related information to women.

I think it's a key important thing (breastfeeding as a public health issue), **but I also think that things like women's safety, the choice agenda, all those other things actually influence as well.** [HoM 1: 1.62].

In the ante-natal sessions, education, and it's back to informed choice. Okay, you're going to bottle feed, do you realise the implications of this. You're going to breast feed, you need to know. Education is... well I think midwives are educators as much as we're anything actually. It's so desperately important. [MW 5: 5.44].

The efficacy of what impact midwives can realistically achieve as key agents 'bombarding' women with the public health agenda was explored by this midwife:

Yeah I think probably quite a lot of them still do feel pressured because we do have a checklist to go through and we've got to tick this, that and they get tons of information from the start. We're supposed to talk about it at every blooming meeting. Every single time we're supposed to mention breastfeeding and smoking and drugs and psychological wellbeing, you know. So what they take on board and what they don't, lord alone knows now, really. [MW 6: 6.34].

Well, and I mean there's definitely... I suppose there always has been, a divide between professional people and non-professional people and some people will take advice, some people won't take advice. It's like everything. I mean I don't take advice quite often, if I don't like it. [MW 6: 6.53].

Finally, the clusters of formulated meanings identified that obesity was predominantly viewed as a key public health issue today, especially in maternity units with a high number of clinically obese women in the local population. Obesity was linked to future health problems in subsequent pregnancies and the impact of obesity on the children of such women was also explored.

Because looking here, at the women that are coming through, the number of obese women, about a quarter of our women have got BMIs over 30 now. It's just rising... so they start off their pregnancy with a BMI over 30 and then when they come back for the second pregnancy and it's over 35, it's the relationship that women have with food or health I think. [HoM 3: 3.63].

Obesity. Because over half the women that died in the last CMACEs report were obese. Because of all the hype... well, as well, they're expecting by 2050, half the population are going to be obese, this has a massive impact on our group of women coming through our doors, in normality aspects, in regards to... a lot of these women won't be, if you like, in the... we're tagging them as low risk, they won't be. [MW 7: 7.41].

4.3.4 Theme: Role Identities

This theme emerged simply because the data's formulated meanings yielded dialogue from the participants that were self-reflecting upon their personal roles and identities. The subtheme *Heads of Maternity Services* was used to represent HoMs views of themselves' appraising contemporary maternity services and juggling competing priorities to deliver government NHS agendas. *Midwives* related to the subtheme describing the HoMs sense of camaraderie as a cohesive and discrete

healthcare professional group. It also included their interpretation of the tensions inherent within the ideology vs. the actuality of delivering maternity care to women. Similarly, significant statements by MWs were included in this category when they reflected upon their core role. The third subtheme, *Mothers and Women*, included reflections by participants of their experiences in their identity as women and mothers. Perhaps unavoidably, the territory of this research personally impacts upon women engaging in the study and their narratives relating to this subtheme were distinguished as a result.

4.3.4.1 Subtheme: Heads of Maternity Services

The HoM interviewees occasionally contemplated their identities in their role as Heads of Midwifery. For example, one HoM viewed IFP as being specifically related to her role.

I think it's (IFP) relevant to my role. It's something that I don't take for granted and I certainly realise the importance of it, definitely. [HoM 3: 3.42].

Similarly, delivery of services and policy trajectories were expressed as paramount components of the HoM role **“Absolutely. I've got to deliver the service as well as trajectories.”** [HoM 8: 8.6].

On the subject of research, frustration was expressed by one participant who experienced email consultations as difficult to undertake due to temporal pressures.

I think the most frustrating one for me, is the email consultations you get because actually, you never really have time to read it and think about it and then truly consult. It's the wrong medium. [HoM

4: 4.71].

Another interviewee envisioned herself in her HoM role as a facilitator between research findings and midwifery practice. She was motivated to try and implement key aspects of research findings that were external to the 'evidence authorities' and government health care policies.

I was talking to students...I said, look, there's these guys who do the research then there are people like me, who are trying to put all this evidence into practice. And you know, birth-place UK, saying midwifery UK, improved outcomes. Let's run with it. [HoM 6: 6.4].

Several participants evaluated their role in relation to maternity service direction, in the context of their experience head-shipping a maternity service. One HoM reflected on the role of midwives in current maternity services.

I don't think midwives are really being facilitated and supported to midwife. Maybe we need to face the reality, we've talked about skill-mix, we've talked about what do we not need to do so that other people can do it. Well if we're going to give up anything, maybe we should look at what we're doing in the acute service, which is obstetric nursing most of the time, obstetric midwifery. Maybe we can do a bit more skill mixing there and get the midwives to focus on the midwifery stuff, community midwifery. [HoM 6: 6.23].

In relation to assessing maternity service direction, the subject of MSWs was explored by one HoM who considered they occupy an increasingly essential support role in services [HoM 6: 6.24]. As a result, MSWs may inevitably redefine the role of the midwife [HoM 6: 6.25] a direction she

felt was acceptable [HoM 6: 6.26] albeit somewhat controversial.

If I had two routes of midwifery, you'd all come into midwifery from one route, and then if you want to be an obstetric midwife, after gaining experience, then you become an obstetric midwife. That's how I would sort it. Now I know not many people agree with this, they see it as a schism; they see it as splitting midwifery. I don't think it is. Let's be honest about what midwifery is and focus midwifery where it needs to focus. [HoM 6: 6.27].

All that is needed to promote normal birth and promote successful breastfeeding is skills, experience, it's invaluable. It has improved outcomes we've got the research to show that. Why don't we focus our assets on that? [HoM 6: 6.28].

What is essentially being advocated (above) to address the issues that preoccupy other Heads of Midwifery (below) and the **“terrible, really terrible”** [HoM 6: 6.30] state of postnatal services, is in her view a potentially effective and convincing solution to the crisis of resources.

I just think it's really interesting because what HoMs often say is: we're not training midwives for the reality of practice. And I'm saying, well then you ought to train obstetric nurses because that's the reality of our current situation. And they're (HoMs) saying, but you need a midwife to facilitate for that early-infant bonding, you need a midwife for that mother-midwife relationship. Well you do, so let's have obstetric midwifery, so you've got all the skills that you need to be a midwife but you're high-tech and, you know. Yes, the two can interweave and cross over, and I'm not trying to separate midwifery, I'm trying to be more honest about it....So if we had more nurses doing the post-op care, they could look at wounds they could look at urine output. And our midwives could concentrate on the feeding. Then we could release them throughout the community. [HoM 6: 6.29].

One interviewee identified her role as a HoM as conferring a particular perspective from which to assess the Midwifery profession. She viewed a core role of midwifery to be the art of communication and explored this role's compatibility with the current arrangement of maternity services.

If I take the blood pressure of somebody, I'm also talking to her, communicating with her. It's the relationship (with women), and that's harder to capture isn't it? I don't want just somebody just reporting back the blood pressure and temperature to me. So it's the core element of midwifery and if we don't get that right now I think we're in danger of losing it. [HoM 6: 6.58].

Similarly, in relation to her perspective on the concept of skill mixing being high on the current maternity services agenda, she made the following suggestion.

And there's this big thing about skill-mixing let's get other people to do it, let's release midwives so they can just be in charge. [HoM 6: 6.59].

There was an acknowledgement by several participants that general policy changes with each government, but common themes across successive government administrations remained. One HoM identified her role as comprising of an expectation that policy would always be complied with and supported.

When government makes a new policy- you jump; and everybody is hell-bent on implementing that policy, and then you start thinking, Hang on a minute, you know, it's like the Emperor's new clothes, you dress things up, you use different words, change the language. Innovation, productivity ...my standard phrase at the moment; we're going to work leaner, harder, cleaner, smarter, keener, more

for less, more quality all at the same time! [HoM 6: 6.60].

Although this HoM viewed the concept of quality as a huge motivation for improving maternity services and supported policy that addressed this aim, there was an expression of discernment that ‘quality’ cannot be adequately quantified.

It’s extraordinary (the policy rhetoric and change). **Yes, I want to improve quality of care, but quality to me means something very different than something written on a paper.** [HoM 6: 6.62].

Another participant contemplated the frustrating aspects of her role as Head of Midwifery. These tensions arose because despite her commitment to IFP, temporal issues constrained her role imposing the position of ‘juggler’ of competing priorities in maternity services, thereby making implementation of policy especially problematic.

Having said all that (primacy of promoting IFP) **as a Head of Midwifery, my frustrations are that there are so many other priorities too. You know the breastfeeding does get lost in those other priorities. You know when you start thinking about insuring every single midwife and every single commission. I’ve been through their skills drills and you know, you can be confident that every midwife can manage a post-partum haemorrhage, a breech, a shoulder dystocia. When you start looking at how appalling our appraisal rates are, when you start seeing how supervisor midwives are struggling to find the time to do their supervisory reviews, etc. etc. etc., breastfeeding then sort of gets lost.** [HoM 7: 7.10].

As a result, despite her ‘passion’ for breastfeeding, a sense of ennui and tension arises when she tries to perform her role as HoM and successfully implement IFP.

Yeah, and I’m afraid sometimes, can get a bit... even me, as a Head

of Midwifery and who's passionate about midwifery, you're like oh, just can we stop talking about breastfeeding for five minutes, because I've got all this other important stuff to do. [HoM 7: 7.12].

The role of another participant incorporated that of general manager and she viewed her dual role as conferring greater 'top level' support for IFP from the management board down.

Well, I guess, as the professional lead and general manager, because I have a... kind of a unique role in that I've got both, I guess based on that I can ensure that we have appropriate resources (to implement IFP), although that is getting increasingly difficult. To implement the policy and to support the initiation of breastfeeding and also I guess support from the top always helps, no matter what the project is, if you have top level support from the exec board right the way through the management hierarchy it always adds weight to policy you know. [HoM 8: 8.12].

All HoMs throughout the interviews viewed their roles positively and they supported the NHS in the context of overarching government policy.

You know I'm a huge supporter of the NHS, I'm aware of the weaknesses, the gaps and limitations, but I think overall we have one of the best health services in the world. So from a health perspective, absolutely government policy is hugely influential in my life and also it's my bread and butter you know. The changes the government make affect me professionally. And it affects my ability to provide a service. [HoM 8: 8.41].

One HoM, as an ex academic and in common with others portrayed in the *Integrating Policy* section of this chapter, felt frustrated by the lack of integration between academia and maternity services. She viewed her role as necessitating support from academia, an institution she respected, but she felt terribly frustrated at what she essentially viewed as academia's inability to understand the reality of her role.

As an ex-academic, I think from an academic point of view I think universities you know obviously are a huge resource, I often find that the midwifery academics have long lost their finger on the pulse. I'm so glad I did leave. When I look at things now, I get incredibly frustrated with academics now. (*Interviewer: Right, but why, what do you think they're not highlighting that they ought to be doing?*) **I think it's a very idealistic... it's not reality. You know I too quoted that you have to be idealistic because then you'll achieve somewhere in between, but actually I would challenge most academics. I know a lot that are very, very credible. But I would challenge them... most of them to do what I do and manage within the resources I do and provide a good service. Do you know what I mean?** (*Yeah, the disengagement is with the practical application of the service is it?*) **Yeah it is and it's about, you know, how do you bridge that theory to ...bridge this gap?** (*Interviewer: Sure yeah... are you describing like an acute lack of awareness of the actuality of the experience of being a midwife these days, and being a head of midwifery, or anyone in any position in the services?*) **I totally am.** [HoM 8: 8.46-49].

4.3.4.2 Subtheme: Midwives

The analysis suggested many HoMs identified with the role of midwife despite their management position. One interviewee felt midwives help

to influence women and can do so particularly in relation to infant feeding.

We can help to influence that (women's opinions about infant feeding). **We can help to make a difference on that. As midwives we can do all sorts to make a difference.** [HoM 1: 1.56].

The following HoM eloquently exposed the ideology of an egalitarian relationship between midwives and women when she recounted herself in the role of midwife 'with women' when negotiating policy and evidence authorities as influences upon her practice.

I'll take all of those (the sources of health guidance/policy e.g. WHO, DH, NICE), **because I have to in my role. I'd also take the woman's story at the bedside as well, it's important. Because her experience and her... the value of her knowledge and her journey is just as important to me and I'll use it all.** [HoM 1: 1.69].

Another participant reflected upon her experience of education, fifteen years ago in a supervisory capacity, and the pivotal influence this had upon her practice as a midwife.

It's (the Supervisors of Midwives course) **probably had the biggest impact on me as a professional** (*Interviewer: Why?*) **I think because I just think it put patients, the mum or anybody, at the heart of any decision making. At the centre of my thinking. I think it was, that was the most cathartic thing, it sort of made me grasp that really....Those sort of the principles are just embedded in me really.** [HoM 4: 4.2].

At the heart of this principle, centralising women in decision processing, the HoM additionally felt that it was the midwife's role to respect how

families negotiate events in their lives by 'normalising' their experiences.

I'm a great believer in normalising the event, whatever that might be, whether it be an operation, whether it be a birth, whether it be a death even. We've got to normalise that event for that family because there is so many other factors that influence how they feel about that. The variables are just vast aren't they? If the woman or the family feel right with what's happened for them, that's much more important to me. [HoM 4: 4.4-4.5].

Effectively, she viewed the role of a midwife as epitomising the holistic approach to midwifery care. This ensures women and families are respected as having true agency despite the existence of policy that may contradict their decisions, as the following illustrates.

The variables (in experiences) are just vast aren't they? If the woman or the family feel right with what's happened for them, that's much more important to me.....It's (care) about dynamics of the family. You know we all stereotype don't we? And assume that this sort of family will have these sorts of issues and values. I think that's a worrying assumption to make. I think we sort of categorise these women and their families. For me, we get it wrong about... we look at models of care, and we should be looking at philosophies of care. [HoM 4: 4.5-4.6].

I think for me, you know, we are bad at categorising and stereotyping and you know, why is the woman that chooses an alternative that wouldn't be my choice, wrong? [HoM 4: 4.7].

Similarly, the following midwife felt clearly that her core role was to engender self-assurance in women as they journey into motherhood, regardless of their infant feeding choices.

My role is to make that woman as confident as I possibly can in her relationship with that baby and as attached as she possibly can, to

feel like she's the best mum ever and that she can give the best care to that baby, so she's well and truly bonded. I guess that's my role, however she chooses to feed. That's my role, that's the bottom line....However they choose to feed. But I want them to have the information to make sure they've got an informed choice as well. [MW 4: 4.41].

I don't want to be undermining their confidence and their abilities to be a mother, at all. The second route of that, and I want them to have all the information to make sure they've made the informed choice, but I don't want to be... you know, again hopefully it's going to be... and I have had people that have said, I didn't know that...[MW 4: 4.42].

One HoM accepted the financial restraints relating to maternity services in the policy driven NHS, yet the conflict this brought in relation to her view of the role of the midwife as a communicator was also evident. Essentially, the art of communication between women and midwives was viewed as being eroded due to the direction of current policy impacting upon midwifery services.

Rather than... and because it's become that... we make it quite prescriptive what we expect of the midwives. We've fought hard to try and keep the birth plan visit where we do try and go in the home and have a cup of tea, but even that has been eked out and it's also... when midwives get challenged with doing social coffee morning and chat visits, actually that's where you'd make the most impact isn't it? [HoM 4: 4.49]

But we would be highly criticised if we just put another visit in and went and had a chat for an hour [HoM 4: 4.50].

Breastfeeding promotion was viewed as an intrinsic component of the midwife's role. This was considered by one participant, in relation to current policy.

I don't think we did (historically) promote it (breastfeeding), but I think we thought... we just knew that that's what midwives did. Like midwives put hands on tummies and felt contractions. [HoM 4: 4.54].

Yet sensitivity was conveyed in relation to such breastfeeding promotion by the following midwife:

I think it's... there's a whole load of defensiveness against the women that aren't... that don't want to breast feed and there's a lot of guilt that you sometimes have to deal with, because I know I should and I know it's best for the baby, but. I think you know, sometimes it's my job to sort of bring them down from that guilt thing. [MW 5: 5.26].

In the post-natal period, it's listening to them and supporting them. If they want help getting the baby on the breast I will help them get the baby on the breast. If they need suggestions as to how to do it better, how to look after their breasts, anything like that, I'm ready to help them. If they want to bottle feed then I see it as my job to make sure they're doing it properly and they're happy with their choice. [MW 5: 5.46].

The public health element of bottle feeding “properly” was expanded by this midwife:

Are you ever going to improve that (hospital admission rates of bottle fed babies for GI) if you don't discuss safe sterilisation and preparation of feeds there? [MW 8: 8.50].

Several interviewees voiced a particular passion for breastfeeding:

In my early career, but when I was prior to becoming a ward sister, I led on infant feeding with another colleague and we set up some workshops for midwives (around breastfeeding). [HoM 7: 7.9].

I just think it's so important for babies and women. I mean it's...I am passionate about it, yes. [MW 6: 6.45].... My role is to empower women who... to breast feed. [MW 6: 6.46].

Other midwives shared their enthusiasm for their practice supporting women and IFP.

In parent craft I say that this is how we do it, bring your teddy along to the next class and we'll talk about positioning and what's good. I'll show them the video of how it's done and of course it looks dead easy then. But I'll say okay, it doesn't start this easy, this is when someone's... it's a learnt skill, don't... the first time you got behind the wheel of the car, you didn't expect to be able to drive down the motorway, because you had to learn it. [MW 5: 5.24].

Finally, one HoM delighted in what she viewed her role to be, namely firstly and foremost a midwife **“I never get bored...being a midwife!”** [HoM 4: 4.87].

4.3.4.3 Subtheme: Mothers and Women

Several participants reflected upon personal experiences as Mothers and Women. Accordingly, these meanings were identified as the *Mothers and Women* subtheme of the overarching theme *Role Identities*. Their reflections were varied in with two HoMs [3, 5] sharing their experiences

of finding breastfeeding easy.

I suppose as well, I have to acknowledge my own biases, so my first baby is now 23, I breast fed, I didn't find breastfeeding particularly hard [HoM 5: 5.33].

This participant viewed her maternity unit's current policy as greatly facilitating any extended duration of breastfeeding that might be personally undertaken by midwives [HoM 5: 5.46b]. In common with her perception, another participant acknowledged that her maternity unit's supportive work environment was a key factor in maintaining her perception of ease relating to her personal breastfeeding experiences.

I was privileged because I had crèches on site that I could put my baby in (and continue to breastfeed when at work). **So I think there is an element of that isn't there? I think initially it's easier because you can lie in bed, rather than having to get out of bed and go down to the fridge** [HoM 2: 2.46].

Some interviewees linked the fact that midwives were women who may have had breastfeeding experiences that would inevitably contribute to the infant feeding debate.

We polarise it (the infant feeding debate) **because it helps us understand it. But it's not helping us and I think midwives themselves are women, who may or may not have had their breastfeeding experiences, and those also play out** [HoM 5: 5.12].

I think women... midwives who have had children and how they fed their children, has a massive impact on how they feel about the whole debate. I see that when I go for my annual update and I'm sitting at the back every year and you always get at least a couple of either midwives or support workers, who are very vocal in... I fed my baby bottle feeding, it had no harm. [MW 7: 7.25].

Another HoM shared her passion and commitment to breastfeeding by drawing on her experiences as a woman and role as a mother.

I've always had a really keen interest in breastfeeding and as a mother of two, was very keen and really enjoyed my own breastfeeding experience. So I think, as a midwife and a mother, I am absolutely passionate about breastfeeding and feel that it's something that... I think it's such a shame, the culture, you don't see it, as the most natural thing to do. Until we do, we won't ever get every single woman breastfeeding, because it's not seen as a natural thing. [H7: 7.9b].

The ardent desire expressed above, for a culture where breastfeeding is normalised, was not shared by another interviewee despite her positive reflection of her experience as a breastfeeding mother. In contrast, this HoM viewed the concept of women's choice as fundamentally important when delivering healthcare services. This position orientates her focus upon the perspective of women primarily and their decisional autonomy.

I mean I have a professional view but I also have a personal view. I breastfed both my children and that is my personal view. But I think what always for me, is pivotal, is women's choice. So I guess with that view, that would be my message to my staff, that yes we've got these trajectories and it is important to promote breastfeeding, however women's choice is fundamental for me. [HoM 8: 8.13].

Difficult personal experience of breastfeeding was candidly acknowledged by this midwife as negatively impacting upon her view of breastfeeding yet she felt this enabled her to empathise with mothers.

As a midwife I had a baby that I couldn't breastfeed because he had a condition, and even as a midwife I felt really guilty and that I'd failed, and that's having the professional experience and information. So then you can understand how these mums feel.

[MW 2: 2.24].

Similarly, this midwife's personal experiences breastfeeding as a mother were contrary to her expectations from BFI policy.

For myself, absolutely hand on heart, it's one of the things I've always been very honest about, is that I did not truly understand it until I'd had a child myself, in the view of, I was always... you know, having the chat, the textbook chat if you like, with women, of, it's... an ooh feeling, it doesn't hurt, and it was the biggest shock of my life with my first child. The second one wasn't a problem, but for me, it was very uncomfortable for a long period.

[MW 7: 7.25]

4.4 Summary of Data

The next section of this chapter summarises the study findings in the subtheme groups.

Being with Infant Feeding Policy; Framing, Contrasting and Integrating

The Framing Policy subtheme revealed a broad range of descriptive labelling of current policy by participants from detail about the minutiae of the BFI to the ideological endorsement of such 'evidence

authority' endorsed policy as 'holistic'. The BFI was also portrayed as bureaucratic and acknowledged as having changed maternity services provision by creating specialist IFC roles and MSW support services. Suggested barriers to policy were stated by participants as related to: social influences particularly in areas where high volumes of local population demographics did not include the middle classes, formula feeding simply being an easier method of feeding and temporal issues in maternity services impacting upon the capacity to deliver IFP.

Reflective comments by participants contrasting policy were a fascinating, if somewhat disconcerting, reminder of past cultural practices surrounding the promotion of breastfeeding by midwives. There were strong affiliations with the present climate in the perennial endorsement of the 'breast is best' culture appearing incongruous alongside the continuous reality of inadequate funding of effective breastfeeding support services. The serious issue of Hypernatraemia and the prevalence it occupies in comparison to the past is thought provoking, -is it connected to current IFP in any way? The historical culture of routine supplementation of babies with formula milk was strongly endorsed as being rightly consigned to history and attributed to the BFI yet there were several expressions that the current policy stance of rejecting mixed feeding techniques was a step too far in the wrong direction.

Evocations of previous clinical practice firmly consigned to history remind us of the 'culture and practice' that perhaps remains perpetually inherent in all aspects of healthcare services, despite contemporary belief to the contrary that 'evidence based policy' bestows certainty in practice by negating the impact of culture and routine. Routine use of: NG tubes, dextrose supplementation, binding breasts, prescribing medication, applying feeding regimes and conceptualising 'beads around areolas' were amongst reflections shared by participants. The recollection by one MW of then 'progressive' policy in the 1970s providing formula milk by prescription only emulates the current

position of IFP. Her reflection upon the consequences of that approach is absorbing. As a community midwife, she regularly encountered babies in the community who were very constipated due to not being formula fed properly, having been discharged from hospital without appropriate infant feeding advice because mothers were untruthful about their preferred feeding method.

The largest body of expressions by HCP participants related to their integrating policy. They were largely evaluative in character, constituting their assessment of the efficacy of current IFP. These comments provide a substantial contribution to the context of current policy in maternity services and reveal a range of perspectives from positive to negative. Most participants endorsed current policy and equated it with drives aimed at improving public health, although when questioned about what public health priorities they thought were important breastfeeding was not usually prioritised. Instead, domestic violence, smoking, substance misuse, obesity, social vulnerability and mental health were cited as key public health issues by participants.

IFP was seen by midwifery participants as pivotal in reversing the negative impact on breastfeeding that formula advertising had upon women, because it had led to a ban on the advertisement of new born infant formula in hospitals and television. This impact was not shared by women interviewees (see chapter 5) although both groups shared a common perception that formula companies remain powerful actors in the arena of infant feeding, influencing women with ‘subliminal imagery’.

Many evaluations were expressed that current IFP is inadequately funded. Optimising the efficacy of current policy was viewed as very difficult in the current climate of the “travesty” of drastic cuts to post natal services. The lack of sufficient investment in policy was viewed as being the principle barrier to the efficacy of promoting breastfeeding. In recent years MSWs and peer support workers have ascended in profile

in maternity services in line with government policy. They have played a key role in improving the efficacy of IFP and were positively welcomed by all participants who rationalised their existence as a very welcome remedy to the issue of diminished postnatal midwifery staffing resources. Frustration was frequently expressed about the cost of implementing the BFI with funding for it not even directly allocated by central government. Most HoM interviewees referred to it as an expensive, status conferring monopoly by UNICEF.

The prescriptive nature of the BFI received mixed reviews from study participants. No one welcomed the increased bureaucracy associated with the policy and the ensuing temporal pressures it generated in maternity services. Many evaluations about BFI were contradictory, prescription elements were valued at providing 'evidenced based certainty' in clinical practice yet 'conflicting advice' about breastfeeding was also evaluated as stubbornly persisting in current maternity services. This phenomenon was rationalised by several participants as being due to what midwives as women, with their own infant feeding experiences, bring to their postnatal care of women. However, the measureable approach to contemporary care services, typified by government health policy, were appraised by one participant as having a profound effect upon the Art of Midwifery.

A perception of significant degrees of pressure being exerted upon women to breastfeed was highlighted by all study participants and directly attributed to current IFP. This was acknowledged as at odds with the concept of promoting choice by some interviewees. The impact of the pressure on women was evaluated in several ways relating to behaviour and emotional consequences for example: 'pseudo-compliance', 'pretence', 'guilt', 'failure', 'resenting baby' and 'perhaps contributing to depression'.

The validity of the evidence base for IFP was not entirely endorsed by

several participants. One viewed it as capable of being manipulated in a similar manner to statistics. Another regarded evidence as ever changing, thereby generating doubt. The salient point was made that evidence is not necessarily persuasive enough to induce health behaviour change. However, one HoM thought the negative health consequences of formula feeding were not highlighted enough.

Breastfeeding statistics drew criticism from most participants concerning definition of breastfeeding initiation, the parameters of the statistics and the veracity of their collection. Targets and statistical collection relating to breastfeeding were viewed as effective at increasing rates to a certain extent. However, IFP was considered ideological with several participants suggesting policy makers lacked comprehension of the population accessing maternity services.

Society featured prominently in the evaluations of the efficacy of current IFP by participants being viewed as equally important as policy to encourage breastfeeding. The sexualisation of breasts in society and problems with acceptance of public breastfeeding were seen as barriers to successful policy implementation. Midwives especially cited the static rates of breastfeeding over the years as probably attributable to both the perception and reality that breastfeeding is difficult to establish.

Bottle feeding was viewed as a tool to settle babies and help them sleep better. The notion that social pressure on women to be perfect mothers created expectations that their lives would be 'back to normal' and 'perfect' was raised as a barrier to the reality of breastfeeding. Some participants suggested policy generates an expectation that women will initiate breastfeeding because they want to be 'seen to be trying' but actually when they arrive in the maternity care services system they have in fact already decided how they want to feed their baby.

Current IFP was viewed as impacting negatively upon women by creating a 'perfect picture' of breastfeeding that belies the reality and this resonated with women's views (see chapter 5). Many participants

cited women experiencing pain when initiating breastfeeding, despite the rhetoric of the BFI, and that this factor principally caused them to stop breastfeeding. Partners, grandmothers and friends were described as readily advocating bottle feeding to women when problems arose. The dissonance between the interpretation of BFI that breastfeeding will be a 'trouble free' decision and the reality of many women's experiences of breastfeeding was pervasive throughout the discourses.

Discourses of Self-Determination: Political agency, Maternal and Clinical Autonomy

Clinical autonomy was a recurrent theme expressed by participants with conflict identified in the mediation of prescriptive aspects of current BFI policy. Frequent expressions of constraint in exercising certain clinical practices relating to infant feeding were present in the data. Although contrary to the BFI, these practices were deemed appropriate in certain situations and included: handling breasts, use of dummies, nipple shields, mixed feeding techniques to deal with painful breastfeeding and prevent infant dehydration. The rise of Frenotomy, in association with IFP, was heavily criticised by one participant who drew attention to the fact that peer support workers -who lack professional training, regularly identify tongue ties in babies and recommend Frenotomy.

The rise of infant weight and jaundice policies in relation to IFP were also viewed as problematic because they inhibited some midwives from exercising clinical autonomy in relation to these conditions. However, willingness to exercise clinical autonomy in contrast to following policy was expressed by some midwives and correlated with their greater experience in clinical practice. By extension, general policy and guidelines were thought to impact less on the clinical autonomy of more

experienced midwives. This stance was thought to be more concordant with the Art of Midwifery. One potentially serious consequence of prescriptive policy overriding clinical judgement was explored in relation to the impact it may have upon the skills of future midwives by many participants.

The study participants revealed mixed views about their sense of political agency. In terms of perceiving themselves as being able to influence government or political affairs and NHS policy, most HoMs felt they were able to contribute, that their voices were heard. Their perceptions in particular related to the formal mechanisms and that exist in maternity service provision such as (then) Strategic Health Authorities (SHAs) and Local Supervising Authorities (LSAs). One HoM viewed the extent of her political agency in a more diplomatic fashion, perceiving her autonomy as directly connected to her relationship with peers and colleagues in the managerial sphere of maternity services.

In contrast to the above, some HoM participants felt their political influence was waning. Other study participants perceived the lack of political agency as related the status of the midwifery profession generally in England offering a variety of reasons for this phenomenon including a lack professional cohesion and gender issues –thus relating midwifery status in society as weak due to gender inequalities. In a similar vein, one participant suggested a lack of political agency in midwives was related to the idea that the profession is marginalised in relation to other health professionals, especially medics.

Perceptions about the importance of government or political affairs were prevalent in both participant groups. Some interviewees were unequivocally certain about the importance of government/political affairs. However, others were less convinced, for a variety of reasons ranging from a lack of a sense of political agency to the somewhat jaded discernment that gender inequality dominates the current government/political landscape in England.

A midwife with a sense of being able to influence policy notably felt that way in the context of her role as supervisor of midwives and clinical governance supervisor. Similarly, a research midwife revealed a strong sense of agency, commenting upon her sense of satisfaction at work when influencing policy.

The perception that political matters were important to midwives lead to reflection about the status of the Royal College of Midwives by some participants. With this in mind, the issue of political activism in the RCM was raised and found to be lacking in all but one interviewee. In relation to professional bodies and the subject of political agency in the midwifery profession, the identification that the RCM was both a union and a professional body was viewed as a barrier to effective political lobbying by the RCM.

There was a perception articulated that government affairs had radically changed the NHS and maternity services landscape with the notion of the pace being 'overwhelming' articulated by several interviewees. Another interviewee voiced opposition to certain aspects of contemporary political agendas, again allied to gender inequality, with the sense of political agency being eroded by the perception that current and previous political rhetoric about maternity services paid lip service to midwives. Gender discrimination was also identified as a reason for lack of germane policy in NHS and maternity services. Finally, academia was also viewed as a potential, yet currently lacking collaborator in the realm of political agency for the midwifery profession.

Reflections upon the impact of current policy upon the decisional autonomy of women were evident in the conflicting views expressed of policy as on the one hand constraining women and on the other, having no impact at all. This concept of IFP exerting pressure on women to breast feed was perceived as influential upon women undecided about infant feeding method –this view was not supported by women in the

study.

The static rates for breastfeeding duration were explained by one participant in relation to women exercising their autonomy.

Accordingly, mother's opinions were viewed as creating a weight that impacted upon their infant feeding decisions. In this sense, mother's opinions, and their sense of agency, were identified by several study participants as connected to their personal backgrounds and existing peer group relationships.

The decisional autonomy of Mother's, who had decided not to breastfeed prior to accessing maternity services, was viewed as compromised to some extent by current IFP. Similarly, IFP was thought to have led to increased initiation rates but in doing so may have negatively impacted upon women's sense of volition in relation to their decision making.

Some participants viewed IFP as overtly effecting mother's autonomy.

The efficacy of coercive feeding policy was questioned with the identification that current BFI interpretation meant information was not offered to women in the same manner as other information presented to women accessing maternity services i.e. interpretation of BFI does not promote the 'choice' health policy agenda.

Some midwives were more confident about how in practice they promoted maternal autonomy with regards to IFP but there was inconsistency regarding some midwives' conceptual understanding of maternal autonomy in that breastfeeding promotion was considered paramount, regardless of women's infant feeding intentions. Implicit acceptance of the supremacy of IFP was not viewed as incongruous with the notion of promoting autonomy in women by some midwives.

Additionally, other midwives appeared to explicitly support the compromise of maternal autonomy and rationalised their stance by their perceived superiority of breastfeeding as an infant feeding method.

In complete contrast to the above, some midwives were clear about their role supporting women in maternity services, believing that they need

midwives to respond to their decisions and unequivocally support them in their individual decision making processes about feeding or other issues. This mirrored a key finding of the interview data from women (see chapter 5) that they were ‘seeking companions’ on their infant feeding journey.

The Emotion Work of Compliance: Healthcare & Professional Governance, Public Health Promotion Agendas

In relation to the state provision of healthcare services, IFP was described by one interviewee as being the vanguard of ‘investment for change’ by government and thereby directing maternity and healthcare services. IFP was accepted as having primacy and longevity in healthcare service provision. On the other hand, frustration was also expressed that the BFI was a monopoly directing services and comparisons were drawn with the Clinical Negligence Scheme for Trusts (CNST) and the target culture in the NHS. Some CNST recommendations were even regarded as opinion, as opposed to evidence based. In contrast, the CNST occupying a key contemporary influence by standardising training in a multidisciplinary team context was welcomed as an efficacious approach to optimising evidenced based care services.

The issue of NHS targets, and how they are used by government to direct healthcare services, was considered by all study participants. Despite some approval expressed, there was uncertainty voiced about the veracity and efficacy of targets and of how they inform policy. Positive accounts of targets include the perception that they raise the profile of initiatives and are not overly onerous on maternity healthcare systems. Other views about targets were more balanced with a call for practicality in the target content.

In contrast to the above, there were more cynical and less complimentary views of targets. The 'tick box task orientated' aspect of targets was assessed as being detrimental to the care of women by more than one interviewee with breastfeeding targets viewed with hostility by one midwife who deemed them as detrimental to the holistic approach to healthcare services. However, she did acknowledge targets constituted an attempt by government to control the efficiency of healthcare services.

Targets were viewed as being fundamentally out of touch with the reality of people's lives by several midwives and viewed as futile by one midwife because they failed to educate the population and address the socio cultural issues underlying health related behaviours in people.

The onerous bureaucracy associated with targets and the associated inadequate funding for the intended health outcomes they were supposed to address, was voiced by several participants and there was a call by one midwife to extend the target culture to reflect other issues of interest to maternity services such as staffing levels. Government driven IFP targets were perceived as raising the profile of breastfeeding but caution was expressed about their impact upon women.

There was a perception expressed by many participants that targets and policy were reactive political tools and that they engendered 'change fatigue' in healthcare professionals. Finally, some participants articulated the sense of targets being a somewhat blunt tool in terms of measurement of service.

The concept of Professional Governance arose in discourses relating to the issue of re organisation of maternity healthcare services in the NHS. Midwives' views were mixed about government imposed changes in maternity service provision, notably in relation to the relatively recent extended role of MCAs and MSWs. Negative comments related to the

notion of the midwifery profession becoming marginalised in comparison with the nursing profession, due to midwifery changing and becoming more orientated towards extended roles of maternity assistants, thereby diminishing the traditional role of the midwife.

In general, evidence based healthcare policy was welcomed but anecdotal experience was also valued. The amount of current policy was viewed as overwhelming at times by more than one interviewee.

Randomised controlled trials, the backbone of empirical medical model research, was commented upon by one midwife as being unable to provide holistic evidence for care. 'Evidence Authorities' in general were respected with no particular distinction made between their reliability as sources of information, although academic journals were thought to have risen in status with regards to their content. The quality of the evidence being presented was deemed the most important aspect by the majority of study participants. One HoM voiced that many midwifery journals were probably beyond the scope of interest for the majority of midwives. As a result, much research was not communicated to midwives unless published in Midirs or the RCM journal Midwives

The National Institute for Health and Care Excellence (NICE), as a prominent 'evidence authority', featured widely in the views of all interviewees with several interviewees desirous for NICE to be more explicitly involved in breastfeeding guidance and policy. UNICEF's BFI was specifically appraised by several participants in the study, with the equilibrium of evidence it presented being questioned.

In the absence of support from an 'Evidence Authority' or the RCM, some interviewees felt unable to criticise the BFI owing to the taboo aspects of dissenting about IFP. In contrast, NICE guidance was highly valued and accepted by several midwives and HoMs, being perceived as possessing integrity and high status. The main general criticisms of NICE were levelled against the quality of evidence it utilises and the way it applies the 'tier category' system to different types of evidence. One

interviewee disclosed her awareness of a midwife becoming part of a NICE expert panel, in a manner lacking in meritocracy. As a result, she expressed misgiving about the reliability of NICE findings.

Two relatively recent NICE guidelines on Caesarean Section and Neonatal Jaundice specifically generated ambivalence and exasperation in several study participants. In relation to Clinical Guideline 98, concerning Neonatal Jaundice, the evidence base was considered insufficient. The evidence presented by NICE was questioned by some participants in relation to both policies. There was a sense of convenience and confidence conveyed by the existence of 'evidence authority' documents. However, one participant with experience of academia did not unequivocally accept 'evidence authority' findings and another was similarly uncomfortable relying solely upon one source of evidence. The relationship between evidence and the generation of authoritative policy by Government was also contemplated. There was esteem for the WHO and concern about the decline in CMACE expressed by another interviewee.

Role Identities

A variety of views relating to the role of HoMs were derived from the interview data. Delivery of services and policy trajectories including IFP were expressed as paramount components of their role. Several participants evaluated their role in relation to maternity service direction and the role of midwives, in the context of their experience head-shipping a maternity service. There was awareness that the role of midwives and postnatal services were particularly under pressure in the contemporary, financially challenged NHS. The core role of midwifery, including the art of communication was viewed as increasingly incompatible by one HoM with the current arrangement of maternity

services.

There was an acknowledgement by several participants that general policy changes with each government administration but that common themes across successive governments remained. One HoM identified her role as comprising of an expectation that policy would always be complied with and supported. Improving 'quality' was expressed as a huge motivation for optimising maternity services and therefore policy was welcome that addressed this aim. However, there was an expression of discernment that 'quality' cannot be adequately quantified and frustration about tensions arising because despite one HoM's commitment to IFP, temporal issues made implementation of policy especially problematic. As a result, despite her 'passion' for breastfeeding, a sense of ennui and tension arises when she tries to successfully implement IFP.

All HoMs throughout the interviews viewed their roles positively and they supported the NHS in the context of overarching government policy. Several HoMs expressed frustration at the lack of integration between academia and maternity services. One HoM especially viewed her role as necessitating support from academia, an institution she respected, but she felt terribly frustrated at what she essentially viewed as academia's inability to understand the reality of her role.

Overall the data suggests participants believe they can influence women's infant feeding decisions but this is incongruous with views about placing women at the centre of care services and the role of a midwife as epitomising the holistic approach to maternity care, ensuring women and families' agency is respected despite the existence of policy that may contradict their decisions. Similarly, some midwives expressed that their core role was to engender self-assurance in women as they journey into motherhood, regardless of their infant feeding choices. Yet polarised views about promoting breastfeeding were evident too with one participant expressing a passion for breastfeeding and of

her desire to change culture and normalise this method of infant feeding. However, creating a culture where breastfeeding is normalised, was not shared by another interviewee, despite her positive reflection of her experience as a breastfeeding mother. In contrast, she viewed the concept of women's choice as fundamentally important when delivering healthcare services. This position orientates her focus upon the perspective of women primarily and their decisional autonomy.

Table 2: HoMS/Significant Statements and Formulated Meanings

Reference	Subtheme	Significant statement	Formulated Meaning
H.6.46	Integrating Policy	It needs a nationwide approach to it (promoting BF). It's not just a health issue, well it is a health issue, but we're almost paying lip-service to it. Here we are saying: your babies will be reduced risk of diabetes and infections, etcetera. And then we're promoting bloody Cow and Gate on the television! Growing-up follow on milk. You know breastfeeding is best for your baby, but when you're ready to move on, let's make it easy for you. It's still there, that advertising.	A nationwide focus promoting breastfeeding needs to occur to maybe shift the culture against breastfeeding including a ban on follow on formula milk advertising.
H.6.47	Integrating Policy	God knows I would kill to support somebody breastfeeding, it's an innate human right to be able to do it. And it's tragic when a woman genuinely doesn't manage to do it, particularly if we've failed her. But I'm not sure we are, in the main, responsible for failing her. I think there's not enough community, social support I think that's why it falls off.	Women might not achieve breastfeeding because of the lack of community support. It is not necessarily a failure in maternity services.
H.6.48	Integrating Policy	And there's not real, despite the so-called feeding areas for mums and babies, what are they- they're in the toilets.	There are very few dedicated spaces for breastfeeding in public.
H.6.49	Fulfilling expectations of the Health Promotion Agendas	I think that women have been de-skilled through schooling and education (key public health issue). And there is this thing that everything's so easy! Meals are ready-made and Mcdonalds and so I think we've got a massive job to do to re-educate mothers.	A key public health issue is the deskilling of women through the ready availability of convenience food and lack of schooling about cooking.

Chapter 5: Analysis of Women

5.1 Introduction

This study was designed with the aim to answer the overarching research question:

What are Mothers' and Healthcare Professionals' experiences of infant feeding within the current policy context and culture of healthcare in England?

One key objective of the study was:

To use qualitative research methods to follow the infant feeding journeys of women and explore how their infant feeding decisions are made and maintained.

An associated objective of the study was:

To ...identify the dominant discourses relating to infant feeding dialogue within the research groups ... To inform maternity service provision through making a contribution to the body of knowledge relating to infant feeding.

The following significant statements of the eight women participating in this study are highlighted in bold throughout this chapter. Their voices portray their infant feeding journeys and experiences of current IFP (IFP) whilst accessing maternity and healthcare services located within the National Health Service (NHS) in England over the period November 2011-June 2012.

This chapter begins by listing the labels for the overarching themes which were assigned to the clusters of formulated meanings derived during the inductive process of data analysis using Colaizzi's method. Explanation of the discourse characteristics that the clusters of themes

and subthemes represent is located below and in Table 3. The interview data relating to each theme is expressed in a manner based upon the formulated meanings ascribed to the data during the process of analysis. Significant statements, which are verbatim extracts from the interviews with women, are written in bold to illustrate the interpretive formulated meanings. Examples of the process of Colaizzi's method are located at the end of this chapter (see Table 4). A certain amount of interpretive analysis is conducted throughout the sections of theme analysis and a comprehensive summary of this data is located in the latter section of the chapter. Overarching discussion of the significance of how these voices inform and reveal the dominant discourses relating to infant feeding and associated policy may be found in chapter six.

5.2 Themes

Women were interviewed three times during the study. Analysis of the interviews with the women participants was conducted in three discrete phases according to when the interviews took place. Whilst there was some commonality between clusters in each phase, in fact they were quite distinct in character so were distinguished separately for the purpose of analysis. The data relating to interview three, at six months' postpartum, was not included in this analysis because it yielded very little information relating to the research question, study aims and objectives. The phases of data collected were labelled as follows.

Interview 1: Planning the Journey.

The First Interview at 8 months pregnant.

Interview 2: Making the Journey.

The Second Interview at approximately one month postpartum.

Interview one (Planning the Journey) generated three themes: *Adopting a Stance*, *Formulating a Vision* and *Processing the Dialogues of Infant Feeding*. The theme *Formulating a Vision* was further differentiated into two subthemes labelled *Forecasting* and *Drawing on Others*. Interview 2 (Making the Journey) similarly developed into three themes subsequently termed: *Being with the Reality of Infant Feeding*, *Regaining Selfhood* and *Seeking Companions*. Interview 3 (Six Months' Later) contained very little data that was related to the research question, aims and objectives and that had not been expressed in Interview 2.

Table 3: Themes and Subthemes.

Interview One: Planning the Journey		
<p>THEME 1 Adopting a Stance.</p> <p><i>Forming opinions about infant feeding</i></p> <p><i>Expressing determination</i></p>	<p>THEME 2 Formulating a Vision.</p> <p>Sub theme: Forecasting <i>Expressing a vision of feeding the baby by considering previous experiences of self and others.</i></p> <p>Sub theme: Drawing on Others <i>Making assumptions about how infant feeding might be experienced from other sources of information (social/peer/family/healthcare professionals).</i></p>	<p>THEME 3 Processing the Dialogues of Infant Feeding.</p> <p><i>Family, peers, society, government, professionals: considering their opinions, views, experience and input.</i></p>

continued

Interview Two: Making the Journey

THEME 4: Being with the reality of Infant Feeding

Infant Feeding Experiences including what was not anticipated and reflections upon expectations.

THEME 5: Regaining Selfhood

Justifying infant feeding decisions

THEME 6: Seeking Companions

Expressions where women sought validation for their decisions

5.3 Data Analysis

5.3.1 Interview 1: Planning the Journey

5.3.1.1 Theme 1: Adopting a Stance

The theme *Adopting a Stance* applied to the cluster of formulated meanings where women expressed their opinions and stated their position on infant feeding. All women in the study expressed a commitment to breastfeeding although the level of commitment and determination was varied between participants. Despite this variation in resolve expressed, all stances appeared to suggest the importance of breastfeeding for women, of not 'failing to achieve' their goal.

But then I agree with breastfeeding. I think I... if I couldn't have done it I'd have felt like I'd have failed. So I think it's almost like your first test isn't it? You know, whether or not you can... and

depending on how much persevering you want to put in.... . I think I would have just felt like I'd... that's almost your first, that's the first thing you can do for your child and if you don't do that, then I think you're not off to a good start. I deem... which is... I would never judge anybody else for doing that, but that's just the way I feel about my children and what I'd like to do. But you know, if one of my friends decided that, I wouldn't think god, you've failed as a mother for not doing that. It's just the way I perceive...[W3 1.40].

One woman appeared surprised by her increasing awareness of her opinions generated during pregnancy, yet felt a sense of ownership about them too.

I have opinions I didn't know I had....I think as soon as you know you're going to have a baby, then you suddenly get these views, and you don't know where they come from....[W1 1.1].

Every opinion I have about my birth and about breastfeeding, I've got no-one to share it with. So I know it's definitely my own. [W1 1.11].

She expressed a high level of resolve to breastfeed, equating accomplishment with a personal sense of achievement.

I had my baby shower the other day and people were saying to me, as a child I had an iron will. I said did I? I don't... but I think I've always been like that. I've been really sort of stubborn and I decide something in my head and I think no, I've got to do that, I've really got to do it and I get an incentive that I need to do it, like with the water birth and with the breastfeeding and everything. I think once I've got an idea, I want to do that and I have to prove to myself that I can do it, even if no-one believes in me. Because I don't really care if I fail to them, it's more a personal achievement. I need to feel like I have accomplished something. [W1 1.4].

Another participant was adamant about her decision to breastfeed.

It was never even a question for me, I always going to breast feed. My mum breast fed, it was important to her. It just seems like the complete natural thing to do. I never considered bottle feeding as an option and always believed that everybody could breast feed if they want to.... there's a few exceptions. [W4 1.2].

Her unyielding commitment endured despite experiencing an enduring medical condition that made feeding her first baby extremely painful for the first four months.

(Interviewer: Okay, so why do you feel determined to overcome that obstacle?...because I mean that's a really big hurdle... So, why do you think you have those thoughts and feelings?) **Well, I don't know. I'm quite a... I don't know. Even as a child I imagined breastfeeding and it felt so sort of natural, that whole kind of bonding with the baby. I can't say I actually experienced that much in reality, but the whole kind of fantasy around breastfeeding; the image... the kind of just... everything about it just seemed to kind work with who I was. I'm quite a kind of motherly type. In some respects I'm quite a motherly type person.** [W4 1.9].

Examples of participants' stances towards breastfeeding that were more balanced include:

I was going to see how it went really. I didn't want to put too much pressure on because we'd had no experience of kind of breastfeeding in my family, I didn't know if I could, I didn't know how or what to do. So really I don't think I put too many expectations on me. [W2 1.7].

The third time round I suppose it doesn't... really I just assume that that's what I'm going to do, and I don't... I assume that it will

be fine and that'll be... breastfeeding. [W3 1.2].

I think that my... everyone has asked me what I might do and I've just been and said exactly the same as I've said to you, that I'm going to give it a try and if it doesn't work out, I'm not going to beat myself up about it. [W5 1.16].

I think I have been thinking about it a little bit. A couple of people have asked and again I just said, well I'm going to try and see what...Try and see what happens. [W6 1.19].

Breastfeeding was frequently characterised as 'natural' by women adopting their stance on infant feeding methods although realism about the solitary aspects of, and commitment required for breastfeeding were also common. Breastfeeding was frequently positioned as superior to bottle feeding **"The breast milk is the best for the baby"** [W1 1.29].

I think naturally it's the best thing to do, but it's not... the best thing isn't always the easiest thing at all. The easiest thing is usually going to the shop and getting a bottle and not having the effort of being tired and having your partner taking over, rather than you being the sole feeder of your baby for a while. [W1 1.22].

One participant in the study particularly related her position towards breastfeeding by comparing her views about formula feeding.

Yeah, I mean I look at my friends babies who were bottle fed, they're perfectly healthy and there's nothing wrong with them. In fact they're... you know, in some ways they sleep a lot better than the breast fed babies and they're more contented babies and having a contented baby means having a contented mother. [W5 1.63].

5.3.1.2 Theme 2: Formulating a Vision

There were a cluster of formulated meanings apparent in the data that appeared to relate to women seeking to justify, or explain their ideas about how they might experience breastfeeding. This was termed the theme *Formulating a Vision*. The cluster was further differentiated into two sections ascribed as subthemes: *Forecasting* and *Drawing on Others*

The subtheme *forecasting* relates to the formulated meanings expressing women's rationalisations for their visions of feeding the baby they were expecting. Sometimes they considered their knowledge of feeding or recounted previous infant feeding experiences of themselves (or others) to explain their opinions. Other ideas were garnered from how they imagined they might feel, or how they had felt previously, in certain circumstances. The subtheme *drawing on others* related to their assumptions about how breastfeeding may possibly be experienced, as opposed to their expectations for themselves. These assumptions were drawn from other influences such as sources of information from, or contributions by: friends, family, peers and healthcare professionals.

5.3.1.2a Forecasting

A sense of apprehension and potential embarrassment was expressed by all women when they considered breastfeeding away from the home.

I did it (breastfeeding in public), **but I can't... yeah I can't say it was... I can't say it was... you know, a pleasant, enjoyable experience.....**[W2 2.10].

Yeah, if I was on my own, I would have felt quite uncomfortable. I used to have to hide myself into a little corner. If I was for example in town, then I know there's like a... one of the coffee shops actually put a poster on their door saying you know, breastfeeding is welcome here. So I felt comfortable enough to go

in there. I still felt uncomfortable though. I still felt kind of like; I wanted to hide myself away. I used to panic a little bit if I was out, like say doing my Tesco's shopping and **would be crying and I'd be thinking, oh my god he needs a feed, what am I going to do, I'm going to have to go.... [W4 1.29].**

However, the only woman in the study expecting her third baby appeared to gain more confidence in public breastfeeding as she gained more experience.

Whereas I think you know, when I had (BOY 1) I used to freak out about going shopping because I was thinking, oh my god where am I going to feed him. So I just used to take a bottle, so that if I was out, I could just give him that and he... and both of them, I've always... they've never cared, as long as they were getting fed, where it was coming from. [W3 1.11] With the second time, I mean you know, just in front of friends or... the first time round I used to... we used to go somewhere and then I used to feed him in the car before we'd go and I was always very... whereas the second time round, obviously you're probably much better at it anyway and much better at being discreet and you just think, I can't make my other child sit in the car while I do... or I can't make him come over in the park while I... so...You just get on with it...and then I think you start to care less about what....[W3 1.12].

This sense of discomfort about not feeding in private also extended for the following participant to situations where she considered herself feeding with her family present. She rationalised her feelings by reference to her embarrassment engendered by the over familiar behaviour of other family members.

I mean my mum supported you but she didn't really like it. My dad goes all silly....He thinks his daughter's got her boobs so he can't look, so he wouldn't be in the room. You know it felt fine for me. Whereas I found (Husband's) mum possibly a bit over-familiar so

like would come up right close while I was feeding and I felt it was...I felt it private. So I didn't really want people coming too near me when I'm doing it, like right up to say hello and kissing when I've got (First Child) feeding there. [W2 2.13].

References to the sexualisation of breasts in society were made by some interviewees, which lead to their explanation of anticipated breastfeeding behaviours.

Well I think I'll definitely probably go into a corner and I'll try and keep some dignity. I think I'll probably have a shawl or something. But I was also saying to my boyfriend and I know this is a really strange way of thinking about it, but you see more people's breasts when they're drunk and they're taking their tops off, than you do when they're feeding their children. I think that just shows what our society is like now. It's more acceptable to get drunk and take your top off than it is to be sitting in a restaurant feeding your baby. [W1 1.10].

Expectations about how breastfeeding might establish were varied. Some women were relatively cautious about how easy they imagined breastfeeding might be for them. The concept of potential complexity was drawn from knowledge acquired by the following participant who rationalised the lack of general discourse about this issue as being related to women's fear about their lack of expertise at breastfeeding.

Yeah, you can't just expect it just to happen. I think people have the idea in their head that the baby comes out, you can put it on and it will drink and it will be fine and that's it. But there's a lot more learning and bonding and other things that people don't really discuss. Like even about how to latch on properly. [W1 1.10].

Some women had a clear expectation that they might encounter difficulty with breastfeeding.

It was too hard (with last baby). **I know that's kind of... you kind of look at it and it's not... you kind of think, oh it's not that hard really, but...your own sanity and things like that, but then once we did finally go to bottles, we just hated doing sterilising, absolutely... we were just like, oh it's so easy.** [W2 1.27].

I don't know. I think it's going to be...(feeding this baby) really hard....I think it will be very hard, yeah. Definitely....Until it sleeps through. Because of the tiredness and then having to...[W2 1.30].

Yet the following participant saw difficulties as being able to be overcome, given sufficient persistence.

12 weeks (last baby), **I wanted to stop, I was knackered, so you're three months in of not a lot of sleep....Yeah, teething might have started, they start waking up again, they might be having a growth spurt and you think it's because your breastfeeding's not enough....You question yourself a lot and it's those types of times and then yeah, I mean luckily I continued and was happy for that and after a week it settled down again and she went back through.** [W2 1.26].

The idea that breastfeeding infants could be directed was expressed by a few participants. For example the introduction of bottles, containing expressed milk or formula, was raised and sometimes rationalised by reference to inclusion of partners, or management of lifestyles. Mixed feeding was also an issue appraised in relation to the exclusive breastfeeding element of current policy.

You know, people go back... some people go back to work after six weeks. So you know, how do you breast feed then? I can't work

from home, I can't come home every five minutes to feed my baby, so I have to find a way of feeding that child. [W5 1.58].

About two months, I'm going to try and do that (introduce expressed breast milk in a bottle) and then I think six months I'm going to slow it down, well every two months I'm going to slow it down and bring in another bottle. So around four months then it will probably be maybe almost half and half. Six months it will be half and half. By eight months she'll be more bottlefed than breastfed. [W1 1.27]

I suppose the only thing I think... like think a little bit is, if I'm kind of solely breastfeeding, that like (Husband) misses out a bit on kind of a bit of... that kind of thing. That's the thing that kind of has crossed my mind a little bit. [W6 1.15].

The following participant felt justified with her previous mixed feeding decisions although she appeared to experience a sense of conflict about her stance.

I think I want to give this baby the same you know, experience, well not the same experiences, but kind of like the same opportunities if you like, as I did with Boy 1. Actually I did used to... from quite an early age I did start giving ** one bottle at bedtime, because I just used to get to a point in the evening where I just couldn't cope anymore and I kind of felt okay about that. So I kind of forgave myself that one. I didn't feel entirely comfortable with it but I'll probably do the same...(Boy 1) was less than six weeks because I know six weeks is a sort of typical age when they say the nipple confusion thing kind of subsides, but it was less than that. So he might have been between four and six weeks. Yeah. But you know, he used to kind of feed so continuously, from about six, seven o'clock till about 10, that I just used to go, I can't cope anymore and go to bed. I suppose... I'm open to the idea of**

giving her (the expected baby) a bottle in the evening but I will start off with a view of not necessarily doing...[W4 1.14].

Rationalising the introduction of bottles by some interviewees was also viewed as important to help exhausted women needing a break from having the sole responsibility for the feeding of infants. This was articulated by women who already had experienced breastfeeding as well as women expecting their first child.

I think you feel...a little bit, you have to maybe kind of justify... you feel like you have to justify introducing a bottle and you worry that it's going to lead to problems I suppose. I was just tired and it was easy and it meant my husband could... because he was giving the expressed breast milk but it meant it wasn't as much on to me ...[W2 2.8].

One interviewee articulated the expectation that breastfeeding would be a good way to calm their baby by reference to their previous experience. However, in common with the above, this conferred the position as comforter of the infant exclusively on the mother.

It was such a good tool for when she was upset or it would just always calm her down and would just put her on, but I think it did exclude quite a few people in certain ways as well, grandparents.....Because they couldn't feed her. They couldn't calm her down, because a lot of the time when they're that young it is just the milk.... [W2 2.12].

The concept of support was part of the views women held about their likely success at breastfeeding. **"I just think it's probably lack of**

support” (Why women stop BF) [W3 1.16].

One woman expressed confidence in her ability to breastfeed her third baby because she viewed her previous success at breastfeeding as being attributable to the support experienced from family and staff at the special care unit where her first baby spent some time.

I just really wanted to do it and my husband was very good with... because there's lots of... obviously he was older when his little sisters were... so he was very good. I mean I hadn't even changed a nappy, so I was a bit like... so it did me a huge favour staying in to be honest, because otherwise I think I'd have... (Interviewer: let you get some confidence, is that what you're saying?) Yeah, yeah. Absolutely. The downside with special care is of course, they get obsessed with blood sugar levels and... They were pricking his foot every three hours. [W3 1.5].

The extent to which infant feeding information from internet sources is nowadays available to rationalise views of breastfeeding was discussed by this participant.

I don't really interact with things like online forums or anything. I have signed up for a couple of newsletters from places like Bounty, Mothercare and places like that, which send you bits and bobs. Mostly just advertising for their products and again, I would say that they are more pro breastfeeding than bottle feeding, but they are more balanced, whereas our ante-natal classes have only focused on breastfeeding....And generally the... if you talk, asked about bottle feeding, you kind of were told like you're poisoning your child by giving them the evil formula milk. [W5 1.31].

5.3.1.2b Drawing on Others

The subtheme *drawing on others* related to women's assumptions about how breastfeeding may possibly be experienced, as opposed to their personal expectations of how they might experience feeding, as described in the forecasting subtheme above. Their assumptions derived from other influences such as sources of information from, or experiences shared by: friends, family, peers and healthcare professionals. In essence this category of meanings revealed a context of infant feeding dialogues derived from significant people in their lives.

Some participants identified potential difficulties breastfeeding by rationalising prolonged, exclusive breastfeeding as inflexible and thereby problematic because it considerably altered mother's lifestyles.

I know my friend, she's breast fed her daughter the whole time and now she's finding it really difficult, she doesn't know what to do, because the baby doesn't know anything else and the baby's a year and a half and she wants to give it a cup and the baby looks at her, like no, I'm not having that. ...She's made it a lot harder for herself, because she hasn't given herself that option. [W1 1.26].

I think it's probably... well, I'd say more bottle. But that could just be...kind of a more convenience thing for people I suppose....I could be kind of having this opinion of the past that isn't actually very realistic because it wasn't something that people have spoken about...You know, everyone didn't go back to work; they just spent their days sitting at home breastfeeding. [W6 1.34].

Exclusive breastfeeding promotion was assumed to be problematic by the following interviewee because it prevented women from feeling able to mix their feeding techniques.

Yeah because I do know of people that have given up after three

weeks, because you know, their health visitor or someone has said, no (mixed feeding)... you don't you know, and they just give up completely and then just go straight to bottles. [W3 1.15].

This participant assumed that exclusive breastfeeding caused problems for a friend because the baby was unsettled and not gaining weight under that method of infant feeding.

Well, I think it's not that they wanted, it's that it's just... they're not, their babies weren't getting enough nutrients from it and they were starting to lose weight, so clearly there's something not quite right there, and not all babies will breast feed very well and some babies are happier having the bottle. Both of them have... now they've went on to formula feeding, have got a much more contented baby, that is sleeping properly and feeding well and everybody in the whole situation is a lot happier. [W5 1.8].

Another interviewee foresaw 'lack of support' for breastfeeding as happening to women and this was a principle reason women experienced difficulties with feeding.

But really they (women) need to be supported more in... I think breastfeeding, because I think then they've got a lot of guilt about stopping the breastfeeding, whereas actually, if they were just given a little bit of more support and guidance and about what is fact and what is fiction, then you know, maybe just persist a little bit, one more week and then... so, I don't know. I think yeah, there's times when support is needed. I think that happens at around about six weeks. [W2 1.25].

The notion of supporting decision making around stopping breastfeeding was explored by this participant and her assumption was that midwives tend to promote breastfeeding.

Their (woman's friends) general consensus is that their midwife hasn't been very supportive when they've wanted to give up breastfeedingBecause they said that you know, they're pushing them to continue with it, when it's not really working for either of them. [W5 1.7]. So I kind of just think well, I haven't got the same midwives as them, I've... I'm a different person, and I have a different baby, so we'll just wait and see how it goes really. [W5 1.9].

There was a certain amount of difficulty associated with breastfeeding that was assumed by participants from their rationalising the experiences of their friends or peers.

I think, as time's gone on more recently, like I'd say kind of... before I was pregnant, it was like the last year and a half, when I've had friends that have... quite close friends that have fallen pregnant and been chatting with them, I think I've got a better understanding from perhaps them, and speaking to them, than I have from any... That it's perhaps made out to be quite easy, and actually it's not. [W6 1.5].

The following interviewee assumed that the establishment of breastfeeding as particularly difficult and that this was the biggest hurdle to overcome to successfully breastfeed.

I'm the only one in the class (antenatal) that's got (children)... they're all first time mums. I was saying to them, if you get through the first week (breastfeeding), you've made... like you're halfway there. If you get through the first month then you've cracked it. So many people don't. (Interviewer: Why?) I don't know. [W3 1.17].

5.3.1.3 Theme 3: Processing the Dialogues of Infant feeding

This cluster of formulated meanings, where women recounted dialogues of infant feeding, was prominent throughout the data. They are distinguishable from the *Formulating a Vision* theme because they tend towards a more descriptive meaning, and are not constructed in a self-rationalising manner. In essence, they related to a participant's recounting of the views of society, family, peers, government and healthcare professionals as part of the infant feeding landscape.

Some of the dialogues related by women described difficult breastfeeding experiences of family and friends.

I was breast fed but I'm not sure how long for. I don't think I was breast fed for long because I think my mum said that she struggled and she never felt like she had enough. [W1 1.6].

One participant recounted dishonest behaviour in relation to pressure to maintain a façade of successful breastfeeding, felt by an Aunt who was a breastfeeding advisor.

Some of them did (talk about infant feeding) **and my auntie... I remember specifically saying to me, because my cousin's had a baby with his girlfriend and I think her mum... she has something to do with breastfeeding, she either helps women to breast feed or she does lectures about it or something, so she really believes in it, so she felt a lot of pressure I think and she actually... my auntie told me that she'd been lying to people and saying that she'd been breastfeeding when she hadn't, because she struggled. My auntie was saying, in secret, that she thinks she didn't try for long enough. But I think she had so much pressure that...Well I think she must have had so much pressure, so she just expected to be able to do it within hours or days, really easily....**[W1 1.16].

Dialogues about family and peer opinions of infant feeding were varied.

One participant's family wanted her to express so that they could assist her with feeding.

But yeah his mum was very supportive and stuff with the feeding, but then also wanted me to express so that they could give a bottle and things like that...W are very, very lucky, both our families are very family orientated and we've not really got selfish parents at all, it's all about...I know from some of my friends how their parents don't... I just can't understand it because we've always been such a close family and it's all about the children and children are lovely. [W2 1.14].

Some women described their family background as not being particularly pro-breastfeeding.

Yeah, no no-one in my family... we're quite... there's a lot of females, my mum's one of three sisters, no-one breast fed. We were all bottle fed. ...Yeah, very close. But none of them... I think they didn't like the idea. My mum still doesn't really like the idea. I think boobies are sexualised in our family, so it was more embarrassing, so to speak...Yeah, which is a real shame...But I think my job (diet related healthcare professional) obviously changed my ideas around that. [W2 1.2]. **Yeah, yeah it (family opinion) changed my perception from when I was 18, before I'd started and saw it as, oh I wouldn't want a baby hanging off my boob and those sorts of...When I was younger.** [W2 1.4].

The internet was a source of discourses about breastfeeding and motherhood that was raised by study participants.

I'd never heard of it before I got pregnant (infant feeding messages)... **on the internet, I'm always doing Google searches on**

this, that and the other....The Baby Centre's quite a big one that comes up, but anywhere that Google takes me to be quite honest. [W4 1.24].

I'm a member of I think every baby group online, kind of going in terms of like Cow & Gate. They send me varying things....I think because a lot of them are... the groups are milk companies, they always have the stance of, nothing will ever beat... however, when you choose to move on. I suppose... I mean, in particular, Cow & Gate send a lot of information through and it's not always been just about feeding, I've had kind of like DVD packs and booklets. Everything they send me, there's always the helpline that's available 24 hours if you want to speak to somebody. Everything. Absolutely everything. Pregnancy, feeding. That feels kind of quite nice in a way, because it doesn't feel... I suppose because they seem a bit more impartial, I genuinely believe that if you phoned up with a question about breastfeeding, they're not going to say, well I'd recommend you buy Cow & Gate instead. I think they would give you the genuine advice and I don't think there'd perhaps be so much of the pressure of health kind of background of... This is definitely going to be the best.....You know I think it might be more advice of, for me, rather than what the NHS say. [W6 1.31].

Conflicting messages from the media were also described by study participants. For example, breastfeeding was promoted through the inhibition of formula advertising for babies yet breastfeeding was not viewed on television. Formula companies were depicted as skilled at advertising their products despite the breast is best message.

As a mum, I think you get the impression that breastfeeding is the best. From the media as well, because they're not allowed to promote any formulas.....I've never seen anyone breastfeed on TV. [W2 1.32].

I don't watch soaps, but you know when you do catch them, they never would have a... or like adverts for other things, they never just have like sort of a woman sat on a park bench breastfeeding, or anything like that. So I actually think that outside of the intention or push for people to breast feed, there's very little actual support for breastfeeding to be honest....In society. [W4 1.27].

The media was credited with providing a plethora of information sources and messages by the following interviewee who viewed it as rapidly developing in tandem with the way that women's lives have similarly revolutionised in the past half a century.

There's just a lot more information (about infant feeding choices), therefore there's more to absorb, therefore it's for you to make your own mind up. I think probably 30 years ago, 50 years ago, you weren't... the media wasn't such a big influence on people's lives and if it was, certainly after the war it was still very much a propaganda type thing, so you believed what you were told, because if you didn't, you didn't want to be seen not to and obviously as the sort of years and like you know, women became more independent, the introduction of things like the pill gave women a greater freedom of choice. Then actually the media opened up a lot more and there's a freer press and people... now with things like the internet and everything, you know, you can... I could type anything into the internet and find an answer on it these days. That's where most people go for their sources of information, rather than to medical books or what have you. [W5 1.38].

Finally, celebrities were not viewed as promoting breastfeeding in any way by this participant.

I can't imagine any celebrity can breastfeed their child more than two weeks, because they're all back at work and super thin and you

know, they never seem to have this. Like did they ever have a child you know? [W3 1.36].

Women recounted several conflicting messages garnered from society including the breastfeeding is superior message **“Yeah it was pro breastfeeding”** [W2 1.33]. Yet this contrasted with the perception that breastfeeding in public was not always acceptable, particularly in relation to social class.

I think more people are doing the initiation. But I think it's still... I think there are still lots of qualms about it....just you're still hearing stories of people being... like breastfeeding mums are being asked to leave restaurants.....Yeah, being told that they shouldn't be doing it. Like locally even..... Like there's been in the paper, a couple of things and I think that's just really bad. Yeah I still don't think it's that acceptable but there are places you can go in **and all of those yummy mummy sort of places where some are very pro feeding. I was never asked to stop, anywhere. But yeah, I suppose you know places that are a little bit more breastfeeding friendly.**
[W2 1.34]

Yeah, well I suppose I notice a lot more bottle feeding than breastfeeding. I mean I suppose I go to quite a lot of baby group type things and so then you see a bit more breastfeeding, but if I was just out in public, ie going to the supermarket, I would say there was probably slightly more people that I would notice bottle feeding and maybe that is because of... you know, the breast feeders hide themselves away. [W4 1.37].

A perceived lack of balance present in the current infant feeding dialogues by healthcare professionals was critiqued by the following

study participant and associated with the institutions whose vested interests include perpetuating the unbalanced discourse.

Yeah and obviously if you're (healthcare professional) presenting any type of... not argument, but information, it should be a balanced view....And so why is it that certain bits of information are being...clearly left out? Is it because you know, they don't want women to perhaps know this and yeah there are going to be women out there who don't have access to a lot of information or choose not to find out, or actually aren't sort of academically enough...that they would...Yeah, the ability to question. [W5 1.40]..... I think that's obviously because all of our ante-natal classes and obviously our midwifery services are funded by the NHS and the government tell the NHS that this is better for women than that because this is what the World Health Organisation tell us, so you must make these women, or encourage these women to breast feed and by doing that, the only way you can do it is to only give them the information about breastfeeding, which is wrong because women will make up their own mind. [W5 1.41].

Several participants expressed views about the government setting pro breastfeeding policy. The following interviewee approved of their agenda.

Yeah. So they obviously do... and the way... obviously the government must set out... it must come from the government, like how the ante-natal classes and stuff are run, and what's perceived. Which I think's right. Absolutely, you know. [W3 1.39].

Yet other participants were more questioning about government motives for IFP.

Well certainly the national policy is definitely you know, pro breastfeeding as well. I mean they (government) advocate that you should. ...They'll save money probably. [W4 1.35]

Yeah I think probably that they've identified that... they've probably done countless amounts of studies on how many babies, and their health, depending on how they're fed, and they've probably identified that babies who are bottle fed have more types of early illnesses in early childhood. So in the way to drive down the healthcare bill, it's better that women are breastfeeding, it's better for their baby. That's fine. But it's not that... that can't work for everybody and I think that's what's... you know...[W5 1.43].

I suppose it would be interesting to know and like the research has been done on it, at what point have they been like checking the development of these babies health... how far into their lives have they looked to kind of...The whole lifespan of somebody. [W6 1.40].

The following participant was particularly well informed about government policy, although she was not a healthcare professional.

I think probably it's probably more now that it's a more government driven target to encourage women to breast feed, because health organisations say that's the best thing. But when they look at... health organisations look at statistics of world breastfeeding, they're looking at across huge amounts of developing countries where they don't have potable water, so they can't really use formula, so breastfeeding is potentially the only way of them giving their baby clean food in a way. So perhaps those statistics are somewhat distorted. I think in England, I mean most... out of all the... my friends who've had a baby in the last year, of which there are four, only one of them has breast fed full-time. [W5 1.19].

You know there was a government target to achieve and quite honestly (Interviewer: What do you think of that government target?) I

think I would like to know why there is such a drive for women to breast feed? What is that? Where has that come from? Is it really working? Is all these groups that they set up, these breastfeeding picnics you can go on locally, to encourage you to feed your baby and not feel ashamed to feed in public. [W5 1.65].

Dialogues encountered around healthcare professionals were also conflicting with some women reporting that they were not always supportive to infant feeding choices.

They (community midwives) were brilliant....but I know that like my sister-in-law lives in ** and some of the people she's seen are like, horrendous you know. She's just had a second one actually and they're just not supportive. Or they tell her she shouldn't be doing... or she's doing it wrong, or she's... you know, and she's on her second child now. Well it's probably more the health visitor isn't it, because after the... you know, 10 days after the baby's born, you don't see the midwife again do you. [W3 1.9].**

Two other friends have tried and haven't been successful with it and have gone on to formula, but have felt quite guilty about doing so, and said they didn't feel very well supported by their midwife.....because of that. [W5 1.21].

She (friend) has discussed it with her (midwife) and she said, the choice is completely yours, I will support you in whatever you do and I'm not going to make you do one thing or the other. [W5 1.36].

I think everything has its place you know and advice changes over the years. (Interviewer: So why do you think some of your peers have felt bad about not breastfeeding successfully?) Because of the way that their midwife has made them feel.... They said, at the time when they're quite emotional. Yeah, I mean I think every woman wants

to be able to feed their child how they're ideally supposed to, in inverted commas, because that's how your body is designed and if that doesn't work out you probably feel like a bit of a failure.

(Interviewer: Do you think they do feel like failures, your friends?) **Not now, no.** [W5 1.44].

The exclusive breastfeeding message from healthcare professionals was a dominant discourse that manifested in several ways regarding the dialogues of motherhood and infant feeding. They were not particularly welcomed or recounted as helpful by any participant in the study.

Because she's (antenatal teacher) like you know, it's not... it's never... people say it hurts, it doesn't. I'm thinking well... That's not everyone's experience and actually I think I'd probably have got more from it if you'd said, you know what, actually at times it is going to be difficult and rather than...[W6 1.10]... I think she does really believe what she says. I think possibly that she's very clearly in her head perhaps got what the benefits of it are and whatever little problems there were, the benefits kind of perhaps outweighed the problems. So maybe... I suppose it could be like seeing as like what we've heard about childbirth, you know, at the time it's pretty horrendous, but afterwards because you kind of forget... You forget how bad. So possibly... Yeah, I suppose. I do genuinely believe that she wanted to try and... be positive. Talk it up. But I suppose... I just don't think... that is how it is. [W6 1.11]

I mean I don't know. I mean I've got this ante-natal class, it's next week, where it's all breastfeeding, so it will be interesting to see how much they push it. I remember when I had (Boy 1) they wouldn't... they didn't even explain about bottles or how you would make a bottle or anything like that. It was... they had a whole class on breastfeeding, and then they don't tell people anything about doing... so in that sense... Yeah, because like obviously it's

been six years since I did the first ones, so whether or not... Whether they still have the same... I mean I guess it's probably still the same because when you see the list of what the classes are, one is breastfeeding. [W3 1.37].

Yeah, and they said you know, if you breast... if you bottle feed your baby they'll get gastroenteritis all the time because of the chemicals that are in the milk and you'll have a poorly baby because you're not getting any nutrients and it was just very one sided really, which is a shame, but I can understand that it's... they're being paid to encourage women to breast feed. But equally, if they were being paid by formula milk producing companies to give the talk, then they would be saying something completely different. It was a bit one sided. [W5 1.35].

So again, why is the choice... whilst the choice is yours about feeding your baby, why is it so heavily weighted towards breastfeeding? I think probably just because you know, statistically or health wise, feeding your baby with your breast milk probably makes them a healthier child, but you know, I don't know really. [W5 1.61].

I think the interesting thing is that bottle feeding doesn't seem to have really been touched upon (by healthcare professionals)....At all. I feel okay, because I think I've got a bit of knowledge from friends around me and like I said my auntie and I did work with her for a short amount of time and I was at college and things in the same room, so I've kind of... I've got a bit of an understanding. But I mean, that to me, that whole range of different teats and like, it seems to be a bigger minefield in a way, than breastfeeding does. But they don't seem to... want to share it with you as much....I'd say it's... yeah, I'd say it's perhaps like 80/20, rather than 50/50. [W6 1.25].

The next section of this chapter deals with the themes arising during Interview 2: Making the journey

5.3.2 Interview 2: Making the Journey

5.3.2.1 Theme 4: Being with the Reality of Infant Feeding

The following significant statements recount aspects of women *Being with the Reality of Infant Feeding* on their journeys. A high proportion of these statements relate to reflections about infant feeding in the light of their experiences. Some women recounted how their expectations of breastfeeding did not match the reality.

I kind of didn't expect her to be feeding as much as she did... It's hard to figure out what made it that way, was it me because I'd never done it before, so I'm thinking the next time round when I have another baby, will I feed it differently, and will it have a different pattern. I was thinking, feeding her on demand, but then again, it was difficult to tell when she was feeding and when she was just seeking comfort, because even when she was feeding, she would constantly stop for a break, even when she was younger. Now she has a bottle she will feed constantly, for a whole half of bottle, then she'll stop to be burped and then she'll drink the rest of it...I don't know, it's hard to imagine if it's better for her to be on bottles, because in my head, I thought breastfeeding was better, but she seems to be happier on bottles. But I think maybe that's just because of the way she's changed; I think it was probably the right time for both of us. [W1 1.17].

Just the lack of sleep (unexpected) there wasn't really...I expected it to be hard work but I didn't expect it to be as hard work and as I said, I hadn't comprehended the fact that I couldn't have a single

break. I couldn't have a single break from him.....So I think that was the thing and I think, it's an awful word to use, but I was very jealous of my close friend **, who when breastfeeding had dried up and there were nights when her mum and mother-in-law would take her baby for the whole night. [W6 6.32].**

Other participants evaluated what they might change 'next time around' in the light of their infant feeding journeys.

I still think breastfeeding is the best thing to do to begin with, yeah...and I'll be doing it again.....but the only thing I'd do differently was give them a dummy from an earlier age, because I think that would make a big difference. [W1 1.36].

I still think I would... I would still try again, to do exactly what I've done this time but I wouldn't beat myself up as much about the combination or us using the bottle. I think with... knowing now... I always knew there was the pressure before but knowing the feel of the actual pressure....yeah, I think the pressure that's put on me in some ways outweighs the benefits, for him. Because an unhappy mum is an exhausted and it's not going to help him. No and I suppose that is really what I wanted the health visitor to say. [W6 6.36].

The subject of healthcare professional involvement and women's infant feeding journeys was raised in that light of participant's experiences.

If you ever talk to a healthcare professional about it, they always sort of ask you gingerly, have you decided how you're going to feed your baby? Then if you say, breastfeeding, they're like, okay that's good. They seem... and they give you a lot of support with it. Whereas if you were to say, I'm going to bottle feed, they almost sort of leave you to deal with it on your own. I think there's a lot

more support for breastfeeding mums because they want you to do it and they think it's the best thing for your baby....I didn't feel pressured at all. But I think... I think there is pressure, yeah. [W1 1.40].

So she (health visitor) said he might just want to suck, have you considered a dummy....at which point I cried on the phone to her and said that I hadn't planned on using one, and I was a bit worried about using one. She said look...it's not going to be like that, if he wants to suck he can't be on you 24/7 you need to think of it as just something that's going to help you and help him for the minute and we can look at how we're going to wean him off it, with time.....I suppose there's perhaps I've had a misconception of actually what it's for....I suppose I just thought it was a way of keeping them quiet.....I was also worried (using a dummy) that there was the risk that he wouldn't feed as well, because they said it can mess up your feeding, so I was a bit concerned that it would....So I was a bit kind of, oh no am I going to damage this wonderful breastfeeding with the dummy but actually he was fine. [W6 6.10].

Exhaustion was a common experience of mothers on their infant feeding journeys.

So I was kind of really relieved of a small break even though it wasn't feeds where I was actually sleeping. It just meant I suppose psychologically it was a rest. ...And I think up until that point even with kind of... when I was trying to... the breastfeeding group, I don't think it was kind of always appreciated, it was always, always breast is best, breast is best, breast is best and I'm thinking, yeah, breast is best for him, however some nights I was kind of on my knees thinking I am absolutely exhausted, I am trying to eat well, trying to drink loads, I'm constantly hungry because I'm a milk

machine and it did feel kind of a bit... [W6 6.17].

One woman on her infant feeding journey encountered the phenomenon of government intervention in the sale and promotion of infant formula and reflected on this as a strategy for breastfeeding promotion.

I mean I can still go and buy the milk but why not give you (supermarket) points, I mean is (supermarket) points really going to stop you? I think... perhaps they think this might influence your choice, I mean why do it if they don't think it's going to? I think it might influence a very, very, very minute... but any kind of sane person is not going to say I'm not going to breastfeed my baby because I'm going to miss out on (supermarket) points. [W6 6.45].

Finally, one woman felt aggrieved as she had no choice but to stop breastfeeding one month post-partum, owing to the medication she was taking following the sudden onset of an unexpected illness **“I had to stop breastfeeding....So it was really upsetting”** [W2 2.1]. She went on to describe her conflicting experiences **“I had to kind of be sensible and say, the main thing is that I'm here for them, not that I'm breastfeeding”** [W2 2.6]. These included an acknowledgement that breastfeeding had been difficult, despite her commitment to it.

It was stressful towards the end when he just wanted to be on me all the time....and I had to do (sibling) dinners and lunches, and play...and you feel sorry for them as well because they haven't had that kind of... ..nice breastfeeding, because you are kind of doing other things while they're on....But, once he went onto the bottle....he was just the most happiest, contented baby. I could put him down. He'd then go for four hours. (Interviewer: So how do you feel now?) Not bothered. [W2 2.7]

The change in infant feeding method led her to reassess her views and reflect upon infant feeding generally.

I wasn't against formula because I do think, you know, it's everyone's choice. I wasn't against formula, I was just for breastfeeding....But I'm probably more now... you know that, maybe the understanding that maybe yeah, breast isn't right for all babies and that some babies are better on the formula. [W2 2.11]

5.3.2.2 Theme 5: Regaining Selfhood

All women participants engaged in some narrative that rationalised their infant feeding decisions in relation to their not wanting to continue exclusively breastfeeding. They recounted experiences that lead up to changing their views and used them to explain their subsequent behaviour.

This participant did not like her daughter's behaviour when breastfeeding as she got older, causing her to revise her position on breastfeeding.

Before I put her on to bottles, one of the reasons that made me do it was because I found her playing around a lot when I was trying to feed her. She'd be putting it in her mouth, spitting it out, laughing at me, rubbing her face all over me and just playing and I thought... Well I was thinking, stop messing around, you should be eating. She can't do that in public, because people are going to see me... and I thought, it's not really appropriate. It's fine when she's just feeding, but if she's just playing, then that's not really what I wanted her to be doing. [W1 1.8].

As theme four illustrates, several women related how emotionally difficult and tiring they found the experience of breastfeeding and as a result, for one woman formula feeding seemed the only answer to redress her fatigue.

I know she's still a baby, but... There's things I have to do and places I have to go...Yeah. I think I was getting a bit down...Yeah, I was just finding things really intense and struggling and it's draining...Being like the sole carer, because that's what I was because she wanted me to be....So I was tired and I was drained....Yeah, it was difficult...W1 1.13. It (breastfeeding) was emotionally and physically very draining....It's very hard...I was here all day on my own and then my boyfriend would come home about six in the evening and only hold her for like 15, 20 minutes, then she'd want to be fed for the whole evening, then go to bed.
[W1 1.19].

Certain experiences generated points in women's infant feeding journeys where they made key decisions to stop exclusively breastfeeding. These episodes varied in character. For example, the following mother felt exhausted and overwhelmed.

I just think I wanted to feel sane again, because it's so hard and emotionally I felt so, so exhausted. I could barely think or have a conversation with anybody. I remember I'd been rocking her to sleep for about an hour and feeding her and putting her down, then she woke up again, and I think I'd done it twice, so I'd been up there for about two hours with her and then my boyfriend comes up just as I settled her and starts asking if I'm okay and wakes her up. I just thought oh my goodness, so I said, 'you can rock her to sleep, I'm going for a walk'. I went and rang my sister and I was saying, I'm really struggling, I don't know if I can... like I physically couldn't rock her for two hours and then when he woke her up

again, I just thought oh my goodness, it's never ending. So I think I felt like I hit a wall, so I rang my sister and calmed down. But I was trying to talk to her about how I could make things better, because I was struggling and I talked about maybe trying her on bottles and it was an idea and I felt confident with that. I thought at least then someone else can give her a bottle, and it was my sanity...Because I definitely needed a break...Because my boyfriend has breaks all the time, he goes to work and then he goes out sometimes. [W1 1.27].

This woman felt bottle feeding would be easier because her baby was a 'snacky breast feeder'.

I think I thought it might be a bit easier to sort of... you know, that she would naturally... it would fill her up more, she would naturally fall into a four hour pattern. [W5 5.25].

In complete contrast to the above, one mother who was experiencing breastfeeding her third baby decided she would continue with her exclusive breastfeeding despite thinking previously she would have introduced mixed feeding by this point.

I don't feel the need to do that (mixed feeding) at the moment because she's just... you know she's easy enough. If she was constantly feeding off me or...[W3 3.5].

Work commitments were an incentive to make a key decision about infant feeding for the following participant who decided to introduce expressed breast milk to her baby.

I had to go into... well on a course for work last week so I was asking lots of questions about expressing and that kind of thing because I knew that I was going to have to do that for going in for this day last Thursday.... we tried him with expressed milk from a

bottle for the first time and he was like a different baby taking it. Yeah, I personally think it was the consistent flow that he preferred. [W6 6.15].

This led her to substitute formula feeding for expressed breast milk because she felt unable to produce enough milk to satisfy her baby.

I started doing the expressing on the Saturday night and I was trying my hardest to keep expressing, to keep up because we decided that we were going to try and express all the time and feed him by the bottle, but I wasn't making enough to keep up with his demand, so in my head at that point I kind of thought well if I can't express enough, and I'm expressing it all the time, then maybe I haven't been making enough anyway to satisfy him when he has been feeding. So on the Sunday evening we decided, I'd had the formula here from the beginning, that we were going to try...him on a bottle of formula to see if that would give me kind of a bit more time to make enough to feed him and he wolfed it down. [W6 6.18].

5.3.2.3 Theme 6: Seeking Companions

A small section of the dialogues appeared to relate to women recounting themselves 'seeking companions' on their infant feeding journeys. This mainly occurred when key decision making processes were underway that were contrary to exclusive breastfeeding expectations. Alternatively, 'seeking companions' also appeared to reflect a sharing or exchange of infant feeding experiences concerning an aspect of infant feeding that may be contrary to IFP but which did not necessarily constitute a 'key decision' in an infant feeding journey. For example:

I've had quite a lot of advice of you know, like a couple of sort of

friends have said oh, why don't you try changing her milk, so I did and it has... it's had some good, positive and some negative effects. [W5 5.42].

Well I still think she's been as sick on the Formula Brand A, to the Formula Brand B, and she's getting lots of little milk spots. But I don't know that she wouldn't be getting all that if I was still on Formula Brand B. I only went with Formula Brand B because that's what we used in hospital and that's what my friends had been using and we are all quite happy with it. [W5 5.43].

I went along to (the breastfeeding group) there was another lady there that went to our parent craft classes ...she was combining, she was doing some formula feeds and some breastfeeds ...and I was asking lots of questions about how that was going, was he taking it okay and she said yeah, fine. She also said that she had the problem of him using her as a dummy and she'd used the dummy (pacifier) as well, so it was kind of like a mirrored story in that sense. [W6 6.14].

I thought about it and a friend said that a friend of hers had done it, because I tried to do some research on the internet to see if it was okay for both milks to go into his tummy at the same time, because I didn't want to....ring the health visitor about it. I didn't feel I could ring the health visitor about it and...*Have you been honest with the health visitor now?* **No, she doesn't know.... A friend had said that a friend of hers had done that, that they had breast fed and then topped up and it was absolutely fine. [W6 6.24].**

Similarly, but more in relation to the key decision aspects of infant feeding journeys the following recounts how a woman turned towards a friend for support, following a troublesome and unsatisfactory experience at a clinic with a Health Visitor (HV).

She (HV) was saying don't express, keep breastfeeding, I didn't even mention to her, I couldn't mention to her that I'd got him on to

formula, I was combination feeding at that point.....Because I didn't even feel she would entertain the fact that I'd given him a bottle. No, she didn't want to know about the bottle, she just... she kind of... I suppose it kind of felt as if I was taking the easy option, which it wasn't an easy option because expressing was another period of time in my life that I needed to find and I did kind of leave clinic and burst into tears. I just felt like I knew what was kind of best and she just didn't... she wasn't letting me... I suppose I felt it was kind of like a bit of a cry for help and I went there asking for her advice and I suppose as well it didn't help with it being baby clinic. You know it's this open room and other mums are there and I'm trying to talk... I appreciate it's not a confidential situation; I wasn't expecting it to be. It was difficult in the clinic and I suppose I felt a bit embarrassed as well because I knew it wasn't confidential and I wasn't expecting it to be, however, she kind of made me seem and feel a little bit...It was in front... I'm not sure if I was tired and hormonal, which I suppose you're bound to be if you're a new mum, and took it the wrong way... But I did feel like kind of... that was the thing, it didn't help as well that she'd already opened the conversation with me arriving saying, what are you doing here, your appointment tomorrow is with the doctor, which I knew it was, but it said in the letter that you're meant to get them weighed beforehand and I know she said it wasn't necessary when she'd saw me the week before, but I wanted to because I was interested because of the expressing, to see whether it had made much of a difference. So I think it was just a whole emotional kind of thing, I came back and I phoned a friend and I know that her milk had stopped about two weeks in and she said, look they just try and push you to do this and it's perfectly normal, it can happen that you aren't making enough, don't kind of worry about it, just do what you think is right. [W6 6.19].

I don't think she (HV) perhaps understood what she was saying...The impact of what she was saying. When I first met her she was like a breath of fresh air because she was very, a spade's a spade, really easy to talk to, very matter of fact. As time's gone on there have been times where I haven't wanted that, but when I was trying to talk to her about the feeding I didn't want matter of fact, I wanted her to listen to me and be a bit more kind of understanding I suppose and that I think... I wanted her to... I suppose what I wanted was her to be the balance between the friend and the health visitor and I suppose she was the health visitor. I don't think she understood the fact that the way she said it wasn't really what I needed. And I think if she realised I'd got upset, she'd probably be mortified. [W6 6.48].

The woman's experiences above were in contrast to those with her Doctor, whom she perceived had a completely different attitude to that of her Health Visitor.

I went to see the doctor for my check and she was completely different to ...the health visitor...I spoke and I could speak to her, and she'd said that it's whatever you feel is best for you and best for him. She said quite a lot of women do the combination feeding it's absolutely fine. Her concern was actually the fact that at that point I was breastfeeding, expressing and bottling some of mine and giving him formula, that is a lot, you are going to make yourself exhausted and I actually felt that she was...understood and was listening and I felt I could talk to her because she hadn't put this wall up to start with that meant I couldn't talk to her and I spoke to her. [W6 6.22].

The following significant statement is a poignant illustration of the delicate balance between a woman exerting her sense of agency with infant feeding yet needing her partner's reassurance and 'companionship'.

I think it's always been my decision, I think...I think I found my own path; the thing that I found a little bit... influenced since I've had him is (Partner)... I suppose it's another person that's added pressure, not that he's meant to add pressure and not that he's anyway added pressure but that when we started to express and he was saying he prefers it, it was like some comfort and reassurance that he felt the same thing and I knew when I wasn't expressing enough that we were going to have to top up with formula but I couldn't say it and then he said it, and then he said it for me, which sounds really silly....I needed him to say...I needed him to say we're going to need to top up with formula aren't we and that made it okay because I wasn't raising it. (Interviewer: Why did you feel like you couldn't raise it with him?) I don't know, I think I probably felt like I'd perhaps failed a little bit. But I needed him to say....it was okayThat's all I wanted to hear. [W 6.46]

Finally, the perceived lack of 'companionship' between this mother and her health visitor on her infant feeding journey had detrimental consequences for their communication around infant feeding advice.

And I think perhaps that's the thing I've struggled with (not telling the health visitor about formula feeding). I think a lot of my friends... well, all my friends are like professionals and I suppose yeah, we can have a really relaxed way of talking to each other but we mutually respect each other, I think that's the thing that perhaps I kind of came away and thought she doesn't appreciate. You know I have... I look after 30 children a day, I have meetings with professionals, you know I'm a very capable person, you know I just need you to listen to me and take what I'm saying is actually happening, the truth, I'm not, and this sounds awful, I'm not like a 15 year old girl that's a first time mum and perhaps not understanding what's happening, I'm not trying to get out of

breastfeeding, I want to, and the thing that she said, which I... she said 'you're happy with feeding, still feeding aren't you?' And I said 'yes of course I'm still happy to feed', and then she said, 'did you go to the breastfeeding support group' as if... and I just felt like saying..... what did you think going to the group was going to do, like fill my boobs with more milk for me? I just...Yeah, I just felt like she was saying, if I was going to the group which only ran every other week and then there was a gap of every three weeks wasn't my instant answer of getting him happy and fed. So I think, yes, it will be interesting if I have got the courage to tell her....Because I had... we had a lot of questions about him being so sick and I haven't felt like I could ring her, and I was ringing her, not all the time, perhaps once every week and a half and I had a genuine... when I had a genuine question and I just haven't really felt that I could kind of speak to her since. So I suppose now the doctor is the port of call. [W6 6.49].

5.3.3 Interview 3: Six Months' Later

The interviews at six months post-partum yielded virtually no data relating to the study aims and objectives, as they contained practically identical answers to the interview guide as those questions in Interview two. Moreover, they were very quickly answered and the women then went on to discuss other issues relating to their infants namely sleep patterns and food solid introduction techniques. As a result, this data is not included in this chapter. Perhaps a useful modification of this study design might be to include the third interview at four months post-partum.

Summary

All women planning their infant feeding journeys expressed a commitment to breastfeeding that varied from high levels of commitment to a more laissez faire approach. Despite an evidently broad range of stances, breastfeeding was important to all participants and they did not want to 'fail' to achieve their goal with some participants implying accomplishment would lead to a sense of achievement.

Breastfeeding was frequently characterised as 'natural' by women adopting their stance on infant feeding methods although realism about the solitary aspects of, and commitment required for breastfeeding were also common. Breastfeeding was frequently positioned as superior to bottle feeding.

All women sought to justify or explain their ideas about how they might experience breastfeeding and these were garnered from multiple sources. Information from healthcare professionals was frequently viewed as biased towards the breastfeeding policy agendas, generating conflict and defensive stances in some women. Participants drew from wide sources of information when assessing their knowledge of infant feeding, especially recounting previous experiences of themselves (or others) to explain their opinions. Other ideas arose from how they imagined they might feel, or how they had felt previously, in certain circumstances.

A sense of apprehension and potential embarrassment was expressed by all women when they considered breastfeeding away from home. One participant explored her uncomfortable feelings when imagining herself feeding with her extended family present. References to the sexualisation of breasts in society were made by some interviewees, which lead them to envisage that their public breastfeeding behaviours would be discrete.

Expectations about how breastfeeding might establish were varied. Some women were relatively cautious about how easy they imagined breastfeeding might be for them and others had a clear expectation that they might encounter difficulty with breastfeeding. Realistic views about how breastfeeding might be experienced included words such as 'difficult' 'demanding', 'painful' and 'tiring'. These perceptions were offered as a rationalisation to buffer against expectations that might not be accomplished. Yet one participant expressed resilience, viewing these difficulties as challenges to be overcome.

The idea that breastfeeding infants could be directed was expressed by several participants. Introducing bottles, containing expressed milk or formula, was viewed as a solution to 'manage babies' and include partners in infant feeding activity, or organise lifestyles. Mixed feeding was also an issue appraised in relation to the exclusive breastfeeding element of current policy which was viewed by some participants as inflexible and a somewhat unhelpful dominant discourse of midwives and health visitors. Most participants explored and accepted mixed feeding as a viable option, despite current policy agendas, although one participant appeared to experience a sense of conflict about her stance. Some recounted dialogues of infant feeding and motherhood that included dishonest behaviour being perpetuated in front of midwives and health visitors. This behaviour was rationalised by the self-identification of a sense of pressure upon women, to maintain a façade of successful, exclusive breastfeeding.

Rationalising the introduction of bottles by some interviewees was also viewed as important to offset exhaustion and sole responsibility for infant feeding. This was articulated by women who had already experienced breastfeeding as well as women expecting their first child. However, one interviewee expressed an expectation that breastfeeding would be a good way to calm their baby, by reference to their previous experience. However, she also acknowledged that this conferred the position as comforter of the infant exclusively upon her. This issue was

viewed negatively by all participants considering the possibility that they might be the only person from whom their infant could derive such solace.

The concept of support was part of the views women held about their likely success at breastfeeding and did not appear to be directly attributed to healthcare professionals. The extent to which infant feeding information from internet sources is nowadays available, to rationalise views of infant feeding, was also revealed some study participants who appeared to welcome it as a resource and access much of their information from this domain.

Most women expressed views that midwives were not supportive towards their infant feeding decision making around stopping breastfeeding and several women described a disconnect between the rhetoric of policy suggesting 'choice' or that breastfeeding was easy. Dialogues encountered from healthcare professionals were also conflicting with regards to information about breastfeeding. Some women reported that healthcare professionals were not always supportive of infant feeding choices *per se* due to a perceptible lack of balance evident the professionals' discourses. One study participant associated current policy with the institutions (WHO) whose 'vested' interests include perpetuating the unbalanced discourse –this woman was not a healthcare professional (W5).

Dialogues about family and peer opinions of infant feeding were varied and not particularly evident in the interview data of pregnant women relating to 'planning the journey'. However, once babies were born, family, friends and peers were the dominant source of support for women undertaking their infant feeding journeys. Accessing these figures for validation about infant feeding decisions was identified in the data as women 'seeking companions' along their pathway. Notably one participant felt comfortable accessing her Doctor who validated her infant feeding decision making. At the same time, she avoided her

health visitor, freely acknowledging she felt unable to be honest with her about her mixed infant feeding decisions. This study participant was a professional woman and her behaviour mirrored that articulated by midwife participants in the study (chapter 4).

In terms of infant feeding support, study participants did not appear to express any clear notions of what they wanted from healthcare professionals beyond 'companionship' on their journeys without IFP agendas. Some 'companions' were not always sought as a means of rationalising decisions -many women simply struck their own balance with their infant feeding journeys although their decisions not to exclusively breast feed clearly created a sense of failure and conflict in most participants. However, when women did feel they needed support and validation, 'companions' were the people they sought and felt more accepted by, as opposed to their perceptions that the 'pro breastfeeding' remit of midwives and health visitors inherently disapproved of participants' infant feeding decision making that was contrary to IFP.

Conflicting messages from the media were appraised by some study participants. Whilst breastfeeding was promoted through the inhibition of formula advertising for babies, it was noted as not readily appearing on television. Formula companies were depicted as skilled at advertising their products despite the 'breast is best' message. The internet media was credited with providing a plethora of information sources and messages and welcomed by all women who mentioned it as a source of information about infant feeding.

Finally, despite women expressing their nervousness about how difficult breastfeeding might be most participants, including those with prior experience, were unprepared for how tired and demanding their infant feeding journeys as 'sole feeder' were. This led to less commitment expressed for the notion of exclusive breastfeeding future infants. During the phase of experiencing infant feeding, all women were compelled to rationalise their infant feeding decisions that represented

not following their infant feeding journey plans of exclusive breastfeeding intentions. In the majority of participants, these discourses were ardent and were often accompanied by feelings of distress in common with other studies. Clearly the women were uncomfortable with their decision making processes that were in conflict with current IFP, undertaking 'identity work' to justify the reasons for their decisions (see chapters 2 and 6).

Table 4: Women/Significant Statements and Formulated Meanings

Reference	Cluster	Significant Statement and Formulated Meaning
4 W6 6.4	Theme 4 Being with the Reality of Infant Feeding	I suppose to start with I was a little unsure of how often he should be feeding because he was delivered at 10 past six in the evening, so luckily ##### could stay a little bit longer and we were put in a side room to start with, so he was able to stay until midnight, so in that time I'd say he probably fed twice and then when I kind of was left I wasn't really sure how often I should be feeding,
Formulated Meaning		Mother reflected on how unsure she felt feeding breastfeeding her baby in the first few hours after birth
9 W6 6.9	Theme 4 Being with the Reality of Infant Feeding	No, he was about every three hours which wasn't too bad at all and, it's difficult to think, I think that was kind of continued until probably he was about four weeks and then I was finding his feeding time went up dramatically. It went up to about 45 minutes to an hour. Now I wasn't convinced he was feeding properly the whole time so I spoke to the health visitor and she said he might be using you as a dummy because he seemed to, as well, as well as feeding for longer at a time, if I'd fed him and I thought he was fed he would then cry as if he was still hungry and be acting like he was still hungry. But I said I've just fed him so I don't think he can be hungry.
Formulated meaning		Mother experienced baby increasing feeding and sought advice but she did not think the baby was hungry
10 W6 6.10	Theme 4 Being with the Reality of Infant Feeding	So she said he might just want to suck, have you considered a dummy.....at which point I cried on the phone to her and said that I hadn't planned on using one, and I was a bit worried about using one. She said look...I think speech and language, and working in school, I was a bit...And it kind of being in his mouth forever, and she said it's not going to be like that, if he wants to suck he can't be on you 24/7 you need to think of it as just something that's going to help you and help him for the minute and we can look at how we're going to wean him off it, with time some children in my class coming in still having them and them being sort of four and five and just thinking yikes.... Once I got passed it and it was helping, it was kind of... it was fine.
Formulated meaning		Mother was given advice to use a pacifier because baby wanted to suckle a lot. She was resistant at first but then followed the advice and found it effective.

Chapter 6: Discussion

6.1 Introduction

This thesis explores the discourses of women traversing their infant feeding journeys and healthcare professionals (HCPs) negotiating Infant Feeding Policy (IFP) within current maternity services in England throughout 2012-2013. The expressions and discourses collectively replicate their experience and perceptions -in essence their 'life-world' (Husserl 1980, Koch 1995). Despite the individuality inherent within each personal journey, the process of analysing dominant discourses enables a contextual picture of phenomena to emerge from the sum of each part. In essence, a gestalt actualises from this method, derived from the landscape that shaped the portrayed 'life worlds'. The purpose of this chapter is to revisit that landscape in the light of the collective participants' experiences, to try to understand what their views and perspectives reveal about the impact of that terrain.

Foucault (1970 xv) acknowledges the complexity inherent in understanding discourse, advocating an approach that incorporates multiple 'levels' and 'methods' thereby eschewing an exclusive focus upon the phenomenological position of conferring **“absolute priority to the observing subject”** (1970 xv). Hence, this chapter adopts a similar approach of exploring participants' views in conjunction with the contextual analyses presented in the thesis literature review and any additional research further identified that relates to the issues under discussion.

This discussion chapter will commence this integrative aim by firstly restating the purpose of the study and the research question. The main body assesses how the dominant discourses and key findings from the discourses inform that question by reference to what participants reveal. It gauges the study findings in relation to existing knowledge

and whether they confirm or expand the literature discussed in Chapters 1 and 2, or any additionally identified studies. Dialogues evaluated as providing a new or unique contribution to research are identified throughout.

The study findings in the main body address firstly topics arising from *The Emotion Work of Compliance* and the *Discourses of Self-Determination* themes identified in the study. These topics include Governance and Autonomy, issues that are incorporated into this discussion in relation to how the thesis discourses inform the context of IFP within a framework of Foucault's philosophical explorations of power, knowledge and governmentality (Foucault 1980, Foucault 2001). This approach is useful because political (or state) control is the principal feature of the current landscape of health and healthcare system policy (Foucault 1982, Hunter 2013a). The current status of women is also a recurring subject within which related elements of the discussion are undertaken as women still occupy an inherently marginalised role in society due to persistent gender inequalities (UN:CEDAW 2011, Bank 2013). This phenomenon persists despite societal discourses of feminism and the intentions of successive legislative reform. It may substantially be attributed to the global persistence of patriarchal dominance (Figs 1970) which has reigned since recorded history and is especially linked in western societies to the legacy of the industrial revolution and more recently the conquest of capitalism (Lasch and Lasch-Quinn 1997).

The discussion process ends with a conclusion chapter consisting of suggestions as to how the thesis may be interpreted with the aim of optimising maternity services in relation to IFP.

PURPOSE OF THE RESEARCH

This thesis commenced by posing the question:

What are Mothers' and Healthcare Professionals' experiences of infant feeding within the current policy context and culture of Healthcare in England?

The study aimed to:

Explore the impact of contemporary infant feeding discourse and practice on the infant feeding experiences and decisions of women

Use the results to inform future health policy and maternity services about ways to optimise the experiences of women relating to infant feeding.

6.2 Governance and Autonomy

This section of the discussion is best understood by synthesising and expanding upon previous references to these topics located earlier in the thesis. The literature review in chapters 2 and 3 demonstrate that the fervid UK reform of the NHS has created a culture in maternity services where neoliberal governmentality dominates all approach to NHS policy. This confers a culture where ill health is viewed as the consequence of individual lifestyles or 'risky' behaviours (Beck 1992) thereby obviating any state responsibility for health. As a result, a culture has been generated that seeks to compensate for risks through calculation, legislation and policy. However, such a culture often links causality to health risk factors regardless **“of the social and material context of these health behaviours”** (Crimson 2009: 183). Moreover, tension arises between the neoliberal agenda of a government that seeks to diminish the interventionist role in the life of individuals, whilst still acknowledging that the state requires engagement with the

consequences that a risk society faces.

Governance is an incarnation of Foucault's concept of 'neoliberal governmentality' (Foucault 2010) and the thesis findings are substantially linked to the consequences of UK healthcare governance. The dominant discourses illuminate the impact of the mechanisms of governance in relation to IFP, upon both the women accessing maternity services and the healthcare practitioners that provide such services.

As previously suggested, 'governance' is both a rapidly evolving concept and practice in recent history with general consensus that effective governance is an essential requirement for a stable economy between academics, policymakers, governments and budget holding organisations (Kaufmann and Kraay 2008). The origins of Governance are illuminated by Foucault's writing on Governmentality (Foucault 2002: 207). He refers to the establishment of the 'Art of Government' occurring with the introduction of economy into political practice during the 16th century and the notion of good government becoming correlated with economic government (Foucault 2002: 220). Since that time, government in western society has assumed a pre-eminence of power over all other forms of power such as sovereignty, or discipline etc. As a result, the administrative state is now 'governmentalized' having evolved into a culture characterised by the apparatus of the state and the associated array of '*savoirs*' or 'ways of knowing' (Foucault 1972). By extension, current maternity services are part of a healthcare system that has acquired such 'authoritative discourses' and sources of knowledge.

The 'apparatus' and '*savoirs*' of governance have a long, complex history which in turn contributes to the notion that contemporary governance is problematic to define (Chhotray and Stoker 2009). In 2007 the World Bank updated its definition of governance to:

...the manner in which public officials and institutions

acquire and exercise the authority to shape public policy and provide public goods and services (Bank 2007).

Crinson distinguishes constructs of governance from regulation and defines governance in a healthcare setting as:

...an analytical construct that is utilised to describe the processes associated with the relationship of authority existing between the state, the public/health service users, and the health and welfare professions entrusted with the implementation of policies that impact upon the lives of these citizens (Crinson 2009: 115).

In view of this identification of governance as the *relationship of authority*, when trying to understand the reality of governance in current maternity services it is helpful to explore the issue of power and it is important to appreciate that the English healthcare system (NHS) was incepted within a governing culture that viewed the purpose of medicine as performing a social ‘welfare’ function (Foucault 2002, Szreter 2007). It replaced the centuries old ‘Poor Law’⁵⁴ that was **“aimed at controlling the needy social classes”** (Foucault 2002:154). This underlying intention still exerts an influence upon one purpose of healthcare services today, as contemporary health priorities remain firmly located in social (and predominantly financial) inequalities.

To return to power and consider midwives as potential mechanisms of governmentality, Foucault highlights an important issue relating to power when he writes in the forward to *Anti-Oedipus* (1972 Deleuze and Guattari):

The strategic adversary is fascism...not only historical fascism, the fascism of Hitler and Mussolini –which was able to mobilize and use the desire of the masses so effectively – but also the fascism in us all, in our heads and in our

⁵⁴ A series of Laws that dealt with Paupers in society 1546-1948

everyday behaviour, the fascism that causes us to love power, to desire the very thing that dominates and exploits us.

(Foucault 2002: 106)

These words encapsulate the complexity inherent within the interplay of power relationships. The data categorised in the *Discourses of Self-Determination* and *The Emotion Work of Compliance* themes within this thesis illustrates how Midwives, Healthcare Professionals and Women accessing maternity services are privy to these dynamics in relation to how they negotiate IFP. This point is considered in the thesis conclusion.

Governance today has a broad remit yet the measurement of governance has become an increasingly sophisticated reductionist process, incorporating the collection of multiple types of empirical data for the purpose of measurement and comparison. Despite the complexity inherent in a focus upon specificity to measure expansive issues, governance is a culturally dominant feature of capitalist societies and measurement indicators are increasingly aggregated, and generally perceived as correlated, with precise aspects of governance (Kaufmann and Kraay 2008, DH 2012). As the preceding literature review suggests, and these thesis findings confirm, breastfeeding rates are now firmly established as a composite component of public health governance in the UK and this can be problematic, as identified in the discourses discussed below.

6.3 Governance Mechanisms: The Healthcare System, Maternity Services, Public Health and ‘The Evidence Authorities’.

The literature review discussed⁵⁵ the general changes in the NHS healthcare system since 2000 and the above suggests that general

⁵⁵ See chapter2

health policy reform is attributable to governance. All healthcare practitioners in this study recounted both their experiences of the unremitting NHS reform agenda and the concomitant increase in health related policy as overwhelming and this data is new in relation to Midwives and Heads of Midwifery. Maternity services were shown to have been significantly redesigned, under the guise of neoliberal governmentality which incorporates burgeoning public health agendas arising from a culture saturated with the discourses of risk.

In terms of the mechanisms of governance, the study findings illuminate how the role of midwives has been profoundly altered as a result of health policy especially concerning service redesign and extensive use of maternity support workers. In relation to IFP, postnatal breastfeeding support services have been shown to be effectively 'outsourced' from midwives to MSWs and volunteer services.

Contemporary maternity service provision is portrayed by the study findings as highly bureaucratic mostly due to governance policy and associated performance indicators that have also shaped midwifery practice. The findings support previous research questioning the veracity and efficacy of targets in relation to breastfeeding rates. New insights were also gained from maternity HCPs concerning opinion about the lack of practicality in general NHS performance targets. This included the perception that targets were useful, but they lacked holism and were 'blunt, reactive political tools' in terms of performance and measurement of healthcare services.

The mechanisms of governance, in relation to 'the evidence authorities' such as NICE, CNST and the UNICEF BFI were subject to much comment by HCPs. In common with other research findings (Battersby 2006a, Furber and Thomson 2008), conflict was identified between the role of the midwife and the promotion of exclusive breastfeeding as dictated by current IFP. The debate about the extent of the role of health promotion for midwives aside (Byrom and Symon 2011), clinical

autonomy was portrayed as compromised by the study discourses that revealed unique and specific criticism of certain prescriptive aspects relating to BFI policy. Particular practices currently forbidden under the 'ten steps' were deemed appropriate by HCPs in certain situations. They include: handling breasts, use of dummies/nipple shields, mixed feeding techniques to deal with painful breastfeeding and infant dehydration. The rise of infant weight and jaundice policies in relation to IFP generated new findings. These policies were viewed as problematic because they inhibited some midwives from exercising clinical autonomy and judgement regarding these conditions. Several participants also offered opinion about the rise of frenotomy in association with IFP, with criticism drawn to the fact that as a method it remains unevaluated and infant feeding support workers -who lack professional training, regularly identify tongue ties in babies and recommend the procedure. A recent systematic review of frenotomy concluded that it was effective at providing long-term breastfeeding benefits in approximately half the procedures undertaken but this was largely drawn from the subjective experiences of mothers. Accordingly, assessment and evaluation of the procedure remains distinctly under evaluated with regards to high quality evidence (Finigan and Long 2013).

As a result of increased governance mechanisms, some practitioners experienced frustration and confusion from the impact of the BFI upon their clinical practice. However, highly experienced Midwives seemed less affected by constraints of policy in their practice and their stance was more concordant with the Art of Midwifery. These findings are a new contribution with respect to clinical autonomy and IFP.

The governance mechanism of public health initiatives in relation to promoting breastfeeding was not directly questioned by HCPs. However, this study uniquely reveals that in comparison, breastfeeding was not viewed in the same sphere as: obesity, domestic violence, substance misuse, mental health issues, poverty and smoking. The literature

review identifying legitimate concerns about the veracity of the evidence base underpinning breastfeeding promotion was not directly questioned in the discourses of the HCPs although it was raised by some women participants. This reflects just how dominant the discourse of 'breast is best' has become in maternity service provision and midwifery academia. Lack of questioning of the BFI is also surprising because most midwives in the study revealed some level of conflict between the reality of their clinical experience and the dictates of the 'ten steps'. Moreover, some HCPs were also aware of high quality studies suggesting that use of dummies had no negative impact on breastfeeding rates (Jaafar, Jahanfar et al. 2011).

This study also uniquely reveals new insights concerning maternity service HCPs and governmentality. These include that fact that although all midwives may be viewed as representatives of the dominant healthcare culture most of them (across the strata of the hierarchy of midwives) felt unable to exercise political agency and influence this landscape in any overarching significant way. This was attributed to the relatively small role of midwives within healthcare services and lack of support from the RCM and academia. Whilst this does suggest the power imbalance referred to at the beginning of this section is simply reflected by these discourses, it also reveals ennui in HCPs when contemplating the current state of maternity services. In this interpretation, their discourses reveal that current mechanisms of governance, including IFP, demand acquiescence from HCPs. Accordingly, policy critique is not perceived as possible in the current policy landscape.

6.4 Ways of Knowing: Just another paradigm?

Foucault's 'Archaeology of Knowledge' above and midwives unique reflections concerning previous breastfeeding practices (now firmly consigned to history) remind us of the 'culture and practice'

components of healthcare services. Belief that ‘evidence based policy’ bestows certainty in practice by negating the impact of culture and routine is merely the creation of a new paradigm. This implicit acknowledgement by HCP participants was evident in their discourses welcoming and questioning certain aspects of evidence based healthcare policy, but also their expressions of value relating to anecdotal midwifery experience and knowledge. The significance of this for the current evidence base relating to IFP is that these concepts apply to the current context of IFP related ‘knowledge’.

However, the ‘Evidence Authorities’ in general were respected with no particular distinction made between their reliability as sources of information. They were portrayed as a somewhat convenient resource of ‘knowledge’ although in fact the quality of any evidence presented was deemed the most important aspect of any research findings by the majority of HCP study participants. Whilst not without any criticism, including allegations of nepotism and lack of meritocracy in review panel members, NICE were portrayed in the discourses as the most prominent ‘evidence authority’. Several interviewees were desirous for NICE to be more explicitly involved in breastfeeding guidance and IFP, feeling unable to criticise the BFI due to a lack of ‘evidence authority endorsed’ support for their views. UNICEF’s BFI was specifically appraised by several participants in the study, with the equilibrium of evidence it presented being questioned.

The next section considers the consequences and experiences of IFP

CONSEQUENCES AND EXPERIENCES OF IFP

6.5 Midwives: Hesitancy and Commitment

In general, the study findings relating to the experiences of IFP were largely unique owing to the design of the study, except where indicated below. The issue of reorganisation of maternity healthcare services in

the NHS was commented upon by midwives and views were mixed about policy induced changes, notably in relation to the extended role of MSWs. Negative comments related to the notion of the midwifery profession becoming marginalised in comparison with the nursing profession and that traditional midwifery roles were increasingly performed by MSWs. The study findings support previous research where midwives identified that NHS service redesign diminished both job satisfaction and the traditional role of the midwife (Prowse and Prowse 2008). Positive discourses of MSWs relating specifically to IFP suggest these workers were considered a vital component of postnatal support services, especially in relation to breastfeeding support. Accordingly, they were respected and especially viewed as a welcome remedy to the issue of diminished postnatal midwifery staffing resources.

IFP was viewed positively by all HCP study participants but not without some criticism of the impact this policy had upon maternity services. The cost of the BFI was an issue for all Heads of Midwifery. Additionally, the governance mechanisms associated with IFP were viewed as having an adverse effect on the Art of Midwifery. These included: the tick box mentality of IFP being viewed as reductionist and prescriptive policy compromising clinical autonomy to the ultimate detriment of clinical skills. Most HCPs viewed IFP impacting upon women by creating pressure to breastfeed and in common with other findings they reported significant levels of dishonesty from women regarding the self-reporting of their breastfeeding status (Lee 2011). Midwives perceptions of dishonesty correlated with women's discourses about their experience of infant feeding (see below).

Also in common with other research findings, midwives experienced mixed feelings about the impact of IFP on the care of women. 'Rooming in' was specifically mentioned by a large proportion of interviewees as a worthy component of the BFI. Despite concerns about clinical autonomy, evaluations about BFI were contradictory with prescriptive

elements valued as providing ‘evidenced based certainty’ in clinical practice. Moreover, ‘conflicting advice’ about breastfeeding was also perceived as stubbornly persisting in current maternity services, creating dilemmas for midwives concerning advice they gave women (Furber and Thomson 2006, Furber and Thomson 2008). This phenomenon was rationalised by several HCPs as being due to what midwives with their own infant feeding experiences bring to their postnatal care of women.

In further consideration of the impact of IFP on women, some HCP participants suggested that IFP generates an expectation that women will initiate breastfeeding because they want to be ‘seen to be trying’ yet when women first access maternity services they have in fact already chosen a preferred infant feeding method (Dyson L, Renfrew M et al. 2006). Additionally, current IFP was viewed as impacting negatively upon women by creating a ‘perfect picture’ of breastfeeding that belies the reality of how difficult establishing and conducting exclusive breastfeeding can be. These views resonated with women’s discourses (see below). In common with previous studies discussed in chapter 2, many HCP participants cited women experiencing pain when initiating breastfeeding, despite the rhetoric of the BFI, and viewed this as the principle factor causing breastfeeding cessation.

Discourses about society featured prominently in the evaluations of the efficacy of current IFP by midwives, being viewed as more important than IFP in terms of encouraging breastfeeding. Similarly influential were partners, grandmothers and friends who were described as readily advocating bottle feeding to women when problems arose.

Views about the static rates for breastfeeding duration were rationalised in relation to women exercising their autonomy with mothers’ pre-existing views suggested as impacting upon infant feeding decisions. In this sense, mothers’ opinions, and their sense of agency, were identified by several study participants as connected to their personal

backgrounds and peer group relationships.

The decisional autonomy of women not wanting to breastfeed was viewed as compromised to some extent by current IFP. Similarly, whilst IFP was thought to have led to increased initiation rates it was regarded as perhaps impacting upon women's volition in relation to their decision making. Some participants suggested IFP overtly effected maternal autonomy, questioning the efficacy of 'coercive' feeding policy. Furthermore, some HCPs that identified current interpretation of IFP results in women experiencing infant feeding information as being incongruent with the manner of other information presented to women accessing maternity services i.e. interpretation of BFI does not promote the 'choice' policy agenda.

Some midwives were more confident about how in practice they promoted maternal autonomy with regards to IFP yet there was inconsistency regarding their conceptual understanding of maternal autonomy in that breastfeeding promotion was considered paramount and not incongruous with the notion of promoting autonomy in women. Additionally, other midwives appeared to explicitly support the compromise of maternal autonomy and rationalised their stance by their perceived superiority of breastfeeding as an infant feeding method.

In complete contrast to the above, some midwives were clear about their role supporting women in maternity services, believing that women need midwives to respond to their decisions and unequivocally support them in their individual decision making processes about feeding or any other issues. This mirrored a key finding of the interview data from women, that they were 'seeking companions' on their infant feeding journeys (see below).

Reflections concerning the impact of current policy upon the decisional autonomy of women were also evident in conflicting views expressed of policy as on the one hand constraining women and on the other, having no impact at all. This concept of IFP exerting pressure on women to

breast feed was perceived by HCPs as influential upon women undecided about infant feeding method –but this view was not supported by women in the study (see below). Whilst this study’s findings suggest HCPs believe they can influence women’s infant feeding decisions, the interviews with women below imply that the midwifery profession believes it has more power over women’s infant feeding decision making processes than it actually has. This is because the interviews with women suggest they embark on their individual infant feeding journeys and ‘seek companions’. A recent study by the NCT supports these assertions by calling for a:

...shift in focus from seeking to influence initial feeding decisions, towards supporting mothers through their feeding journeys, enabling and protecting decisions to breastfeed as one aspect of ongoing support. (Trickey and Newburn 2014: 73).

6.6 Women: Do They Fall or Are They Pushed?

All women participants planning their infant feeding journeys adopted a stance that expressed a sense of obligation towards breastfeeding. This varied from high levels of commitment to a more laissez faire approach. Yet despite this fairly broad range of stances, the women implied that breastfeeding was important to them and that they did not want to ‘fail’ to achieve their goal. This finding echoes other research notably in relation to women’s expectations about breastfeeding (Murphy 2004, Marshall, Godfrey et al. 2007) and was highlighted in the literature review in relation to the ‘identity work’ of mothers (Lee 2008). In a similar vein, breastfeeding was frequently positioned as superior to bottle feeding (Carter 1995, Knaak 2005).

In common with other research findings, all women experienced significant pressure from current IFP owing to a perceived expectation

that they would breastfeed (Lee and Bristow 2009). This was acknowledged as at odds with the concept of promoting choice and some participants reported experiencing a bullying culture in maternity services concerning breastfeeding that supports existing research (Cairney, Alder et al. 2006, Battersby 2006a) and the most recent maternity services survey by the Care Quality Commission (CQC 2013). The study findings additionally generated new insights suggesting that health visitors were also likely to be perceived as strong advocates of breastfeeding, in line with government health policy goals and the recent maternity services survey.

The most upsetting part though, was that midwives and health visitors make you feel bullied into breastfeeding... I was desperate to breastfeed during my pregnancy, and I was devastated when I couldn't, but the comments and the way you are made to feel guilty is totally unacceptable. (CQC 2013: 30).

All women formulated a vision where they sought to justify or explain their ideas about how they might experience breastfeeding. Sometimes they considered their knowledge of feeding or recounted previous experiences of themselves (or others) to explain their opinions. Other ideas were garnered from how they imagined they might feel, or how they had felt previously, in certain circumstances. A sense of apprehension and potential embarrassment was expressed by all women when they considered breastfeeding away from home. References to the sexualisation of breasts in society were made by some interviewees, which lead to their envisaging anticipated breastfeeding behaviours that were discrete, and did not antagonise people in public. These factors have been identified in existing research as similarly impacting upon breastfeeding (Dyson, Renfrew et al. 2010).

The women's forecasting as to how breastfeeding might establish were varied. Some women were relatively cautious about how easy they

imagined breastfeeding might be and others expected to encounter difficulty with breastfeeding. 'Realistic' views included words such as 'difficult' 'demanding', 'painful' and 'tiring'. These perceptions were offered not as a defeatist attitude but more as a rationalisation to buffer against expectations that might not be accomplished.

Women processing the dialogues of infant feeding explored mixed feeding in relation to the exclusive breastfeeding element of current IFP. This topic was viewed as an 'inflexible' and dominant discourse of midwives and health visitors. Most women explored and accepted mixed feeding as a viable option, despite current policy agendas, although one participant appeared to experience a sense of conflict about her stance. Notably, women sought information from elsewhere about mixed feeding techniques, feeling unable to source information from HCPs due to current pro-exclusive breastfeeding IFP.

When planning the journey, rationalising the introduction of bottles by some interviewees was viewed as important to deal with exhaustion and needing a break from the sole responsibility for infant feeding. This was articulated by experienced mothers as well as women expecting their first child. One interviewee expressed an expectation that breastfeeding would be a good way to calm their baby by reference to their previous experience. However, this conferred the position as carer of the infant exclusively on the mother and was a matter that was viewed negatively by all participants. In relation to these issues, women being with the reality of breastfeeding were largely supported by their expectations; there were many expressions relating to how exhausted and difficult women found breastfeeding to be.

Whilst making their infant feeding journey most women expressed views that midwives and health visitors were not supportive towards their infant feeding decisions concerning stopping exclusive breastfeeding. Discourses relating to infant feeding and motherhood included dishonest behaviour being perpetuated in front of midwives and health

visitors. This behaviour was rationalised by the identification of a sense of pressure upon women, to maintain the façade of successful, exclusive breastfeeding.

Several women described incongruity of experience in relation to the rhetoric of policy promoting ‘choice’ or suggesting that breastfeeding was easy. Dialogues encountered around healthcare professionals were also conflicting with regards to information about breastfeeding. Some women reported that healthcare professionals were not always supportive of infant feeding choices *per se* due to a perceptible lack of balance evident in the professionals’ general discourses. One study participant associated current policy with institutions (WHO) whose ‘vested’ interests include perpetuating the unbalanced discourse –this woman was not a healthcare professional.

Dialogues about family and peer opinions of infant feeding were varied and not particularly evident in the interview data of pregnant women relating to ‘planning the journey’. However, once babies were born, family, friends and peers were the dominant source of support, as women sought to regain their sense of self-hood when undertaking their infant feeding pathways. Accessing these figures for validation about infant feeding decisions was identified in the data as what I term women ‘seeking companions’ along the way. These ‘companions’ were not always sought to facilitate decisions, many women simply struck their own balance with their path. However, after their decision-making or when women did feel they needed support, these were the people they accessed apparently because they felt intrinsically accepted by them. This contrasted with perceptions that the ‘pro breastfeeding’ remit of HCPs meant they inherently disapproved of women’s infant feeding decision-making processes. To some extent these findings echo a very recent study suggesting that:

..women turned to those most likely to confirm or resolve their decisions and maintain their confidence as mothers

(McInnes, Hoddinott et al. 2013: 1).

The internet was credited with providing a plethora of information sources and messages welcomed by all women who mentioned it as a source of knowledge about infant feeding. The extent to which such information is nowadays available to support personal views of infant feeding was also revealed by some study participants who appeared to welcome it as a resource and access it regularly.

Chapter 7: Conclusion and Recommendations

The discussion recounts how the findings of this study reveal the infant feeding experiences of mothers and healthcare professionals and suggests how they relate to the current policy context and culture of healthcare in England. It demonstrates that women, and healthcare professionals, are perpetually subjected to a variety of cultural influences that coalesce into the current context of infant feeding. It is this context that impacts upon the infant feeding experiences of women and healthcare professionals alike.

However, women and healthcare professionals are not passive constituents of cultural influences, despite the constraints that the current context of infant feeding inevitably places upon experiences of infant feeding. The literature review for this thesis demonstrates that significant components of health policy are not arbitrary. In fact they are the result of distinctive and identifiable practices within three spheres of: government, healthcare services and healthcare professions. As a result, healthcare practitioners and midwives are in a position to engage with and influence the culture of health policy in these regions.

This study also suggests that midwives need to reflect upon how they exercise their power because they profoundly influence the infant feeding experiences, but perhaps not decisions, of women. As healthcare professionals they 'co-create' with healthcare institutions the context of maternity service provision. The discussion incorporated the study findings into Foucault's analyses of power and governmentality highlighting how healthcare professions become affected by these phenomena. In so doing, it is demonstrated that some midwives position themselves against women by subjugating the 'Art of Midwifery' to the 'Art of Governance' through becoming instruments of policy as opposed to being 'with women'. This has parallels with debates relating to the medicalization of childbirth yet arguably extends that concept further to highlight that political power, or governmentalisation of the

care of women, is as equally detrimental to women's autonomy and sense of agency as the midwifery vs medical conflict familiar in midwifery discourses.

To optimise future maternity services for women, this conclusion will propose what the research findings suggest is the optimum approach for IFP. In so doing, it will attempt to distil from the discussion what the study findings primarily convey about the present experiences of infant feeding for the participants and advocate realistic alternatives to improve the current situation.

With regard to the theme of governance, the literature review and study findings imply that midwives occupy a diminished role in government and maternity services policy generation. Yet they are the key healthcare professionals that pregnant women and mothers are exposed to in the NHS thus they exert a profound influence upon women's experiences of maternity services. For this reason, raising the profile of midwives in government health policy generation is highly desirable to enhance the experiences of women as midwives can 'expertly' inform government about issues relating to infant feeding (and other aspects of maternity care). If midwives are to constructively inform government, in a complex and changing health policy landscape, a certain amount of political science analysis needs to be incorporated into the way the profession conducts itself. For such an approach to be effective, the midwifery profession would need to acquire a sense of political agency, something the dominant discourses presented here suggest is cohesively lacking in the profession, and certainly in relation to IFP. This pitch is not an ideological proposition it is a necessity, because if the midwifery profession fails to proactively engage in political processes, neither it, nor the unique artistic expertise and knowledge it possesses will be taken into account by governance agents and policy generators (Hunter 2003, Stoker 2006) . Increased political agency and profile of midwives enhances the context of midwifery service provision and ultimately benefits both women and midwives.

To encourage political engagement in midwives a two pronged approach could be adopted. Firstly, if political science and sociology were to become a more prominent feature in the education programs for midwives it may enlighten midwives and lead to the generation of debate about the governance of maternity services. Secondly, the creation of an entity may be useful that combines perhaps a sector of the RCM with midwifery (and healthcare) practitioners and affiliated parties across multidisciplinary academia. Collectively, this could deliver an effective political lobbying solution for midwives (and associated healthcare practitioners) to expertly influence policy with the aim of optimising maternity services for women.

If the above were to happen, the political and social situation of midwives could ascend in prominence for the profession in tandem with the profile of health and maternity issues for women, as a consequence of an increased midwifery profile in politics. The remit of such a body could include: monitoring health and healthcare systems policy, proactively lobbying government, appraising the impact of policy on women and informing midwives of the terrain that influences the context of their role and practice. This collaborative body could provide a literal and/or virtual forum for the rational debate of key governance issues affecting midwives and women accessing services. The findings of this thesis in relation to IFP and the contribution it makes to understanding the impact of governance upon healthcare systems for women and the midwifery profession is an example of the type of research that could contribute to such a body.

In further support of the above, this study clearly demonstrates that once questions are asked of Women, Midwives and Heads of Midwifery they generate a process of thinking and philosophising that contributes significantly to the debate about maternity service provision. This practice could be cohesively encouraged by the creation of a hub and by regular academic consultation with clinical practitioners and leading healthcare professionals in maternity service provision. Women could

perhaps contribute to this entity by working in conjunction with the PALS⁵⁶ service in the NHS. In summary, such an organisation might provide a distinctive influence for the midwifery profession, and women accessing maternity services, to inform the complexity of political processes and health policy. This might lead to an improvement in the infant feeding experiences of women and other health matters for which they access healthcare services. The findings of this study suggest the current governance focus upon healthcare services relate to many policy targets including breastfeeding and yet exclude swathes of significant female health issues that are politically not identified as important goals for health policy. Healthcare system policy that is influenced by women and related healthcare professionals can only be optimal due to the holistic approach it engenders towards services.

Through the analysis of current infant feeding experiences of women and healthcare professionals this study illustrates that the landscape of public health policy and maternity services provision is complex terrain. The literature review highlights that sociologists, and to a lesser extent political scientists, have made valuable contributions to this territory by their critiques of the paradigm of neoliberalism and the risk society in relation to public health (Culpitt 1999, Furedi 2008, Crinson 2009, Lee and Bristow 2009). Almost certainly these disciplines occupy crucial positions to inform health policy debates and it is suggested they should be regularly engaged with by prominent figures in the midwifery profession (and other healthcare professionals) to enhance practitioner understanding of the political and social constructs of healthcare service provision. To a certain extent, creation of the entity outlined above would address this issue. However, additionally healthcare professional and midwifery academia could engage in a collaborative research agenda that incorporates sociologists, political scientists and women with the aim of optimising health policy and maternity services for women.

⁵⁶ 'Patient Advice and Liaison Service'.

With further regard to academia, the dominant discourses of the Heads of Midwifery in this study reveal a palpable sense of frustration at their perceived lack of engagement with midwifery academia in maternity services policy debates and the arena of governance. Their expressions of estrangement were further compounded by their sense of alienation from politicians and macro governance institutions. These findings are an important new contribution to research. Perhaps by their very nature, services relating to women are complex and incline towards polarised views, owing to the marginalised status of women in society. Cohesion between academia in midwifery and practitioners is highly desirable and holds the real potential to improve the profession of midwifery and by extension the maternity service experiences of women. As outlined above, the creation of a body to address this relationship deficit is one method of addressing the issue but others that may be equally effective could simply include regular communication between academia, practising midwives and HoMs through open agenda meetings in local NHS trusts.

With regard to women and public health promotion, decisions to cease breastfeeding are often fraught (Redshaw and Henderson 2012) and as existing literature suggests may be associated with the onset of post-natal depression (Donaldson-Myles 2011). The thesis findings support existing knowledge by revealing that women still experience a plethora of negative feelings. They remain heavily enrolled in the 'breast is best' construct and endlessly position themselves or rationalise their infant feeding decisions in relation to their breastfeeding status (Lee 2011). The significance of this for midwives and healthcare professionals is the impact they have on women's lifeworlds relating to infant feeding decisions. Recent research supports this thesis findings that midwives affect women's experiences of infant feeding but not their decisions (McInnes, Hoddinott et al. 2013). As a result, to optimise the care of women, midwives need to be acutely aware of the negative emotional impact that pro-breastfeeding agendas may have on the experiences of

women making infant feeding decisions. This is increasingly relevant in the context of rising awareness of the extensive incidence of postnatal depression that arguably is itself becoming a public health issue.

In addition to the above, breastfeeding is ostensibly promoted on the basis that it confers significant health benefits to mothers and infants. The literature review reveals that this 'risk-based' message is the overriding rationale for breastfeeding promotion in the current context of IFP and both women and midwives are heavily enrolled in that principle. However, the review also shows that reasonable doubt is cast on the rationale for breastfeeding promotion in relation to the evidence base. It is unclear why, and highly undesirable that, this matter has been most lucidly⁵⁷ raised by a sociologist (Wolf 2011) and not the midwifery profession *per se*. Moreover, the media have started to report her findings and commence cogent debate about the 'breast is best' message (Wolf 2013).

The thesis findings provide new knowledge that extends understanding of the views of midwives and women relating to current IFP. Some of these opinions are also sceptical of the health claims associated with breastfeeding promotion, despite the current context of policy being totally saturated with positive reinforcement of the public health message and the lack of rational debate about this issue by healthcare professionals. Maintaining a position of implicit dismissal of alternatives to breastfeeding appears to alienate women accessing maternity services and arguably diminishes the status of healthcare professionals. This has parallels with other research findings (McInnes and Chambers 2008).

The above leads to consideration of the tension inherent in 'the emotion work of compliance', between the role of the midwife vs that of health promotion as a component of the role (Thomson, Dykes et al. 2013).

⁵⁷ See Heinig, M. J. (2007). "The Burden of Proof: A Commentary on "Is Breast Really Best: Risk and Total Motherhood in the National Breastfeeding Awareness Campaign"." Journal of Human Lactation **23**(4): 374-376.

This is not a new conundrum as the literature review identified and it is set to continue due to the prominence of 'neoliberal governmentality' underlying the current context of healthcare service provision. As a consequence of this fact, there is an increasing expectation that healthcare professionals' roles will incorporate public health promotion in accordance with government health policy priorities. Yet in relation to IFP, this thesis supports existing research suggesting that midwives and women exhibit 'deviance' and deceptive behaviour in relation to breastfeeding (Murphy 1999, Cairney, Alder et al. 2006, Furber and Thomson 2008, Heinig, Ishii et al. 2009, Lee and Bristow 2009).

The 'evidence' for health promotion clearly demonstrates that for 'lifestyle issues' it is to date a largely ineffective strategy for improving the health of populations. The thesis findings endorse this assertion and support the fact that despite a decade of particularly focussed IFP, exclusive breastfeeding duration rates remain relatively static. Given that (as above) IFP is interpreted as creating pressure on women (Lee 2011, Schmied, Beake et al. 2011) and as the next paragraph illustrates -compromises autonomy, then perpetuating IFP in the face of inefficacy is a potentially harmful strategy and somewhat dubious at best. However, if statistically insignificant outcomes are consistently achieved in relation to the aim of the policy then perhaps at least this policy requires urgent debate and might benefit from revision.

In conclusion concerning the study findings relating to the autonomy of midwives, healthcare professionals and women there are several issues worthy of further exploration. Firstly, why is it that current IFP and the BFI is a taboo topic for midwives to critique and engage with in a rational debate? The new research findings this study generates include a sufficient number of valid queries about the efficacy of, and evidence base supporting 'the ten steps' to warrant a coherent analysis of those issues. The existing breastfeeding evidence base in relation to government policy is also questionable from these findings, in common with other opinion (Balint 2009). The 'evidence authorities' have created

the cultural expectation of acquiescence by healthcare professionals in the form of deference to their publications and other 'powerful actors' in healthcare service provision have similar expectations. As these findings demonstrate, it is highly significant that even midwives who occupy the most senior roles in the clinical hierarchy are inhibited and 'nervous' about engaging in critique of evidence authorities such as the BFI 'industry'. Yet as existing literature shows, and these findings further support, evidence authorities and 'powerful actors' are an inherent part of the system of governance therefore they too require objective scrutiny. Otherwise midwives and other healthcare professionals assume a passive role as 'instruments of policy' as opposed to equal partners in care agendas.

These study findings also provide support to substantiate the assertion that healthcare professional clinical autonomy and maternal autonomy are connected to issues relating to governance. The omnipotence of the Government as an authority and the exercise of power it yields in relation to healthcare governance, professional governance and the pursuit of policy goals lessen the autonomy of both the midwifery profession and women, contrary to the rhetoric of choice pervading current provision of maternity services (Edwards 2005, Jomeen 2010). Therefore, in support of existing literature the role of the midwife is shown as curtailed by prescriptive policy such as the BFI, which in turn impacts upon women by diminishing maternal autonomy. In an extension of such existing research the incidental study findings presented here reveal that healthcare governance has increased dramatically in recent years through NHS reform policy, use of targets, CNST and healthcare system policy. Consequently governance dominates the current context of maternity services, entirely setting the agendas for maternity services and dictating the terms of service priorities.

As evidenced by other research (Prowse and Prowse 2008) and supported by this study's findings, over the past decade midwives roles

have receded in postnatal care and are increasingly outsourced to maternity care assistants and support workers, diminishing traditional roles of midwives. Over time, this issue will radically impact on the skills and direction of related healthcare professions, especially midwives. This study shows that whilst some midwives acknowledged this current context of service provision as perhaps being detrimental to the skills of their profession, most were so acculturated to the authority of the NHS that they positively welcomed the 'extra pair of hands' afforded by this development, despite it being forced upon the profession in an undemocratic manner and rationalised by government through simple deference to the prevailing paradigm of neoliberal governmentality. Moreover the current context of maternity services, and this research, support the suggestion that midwives have perhaps unwittingly handed over significant components of their post natal role particularly in relation to infant feeding, to other professionals without intra-professional discussion about the consequences of this phenomenon.

With further regard to the above, and the impact of current policy upon the experience of women, this study suggests that women appear to relate little to midwives during their infant feeding journeys, especially when 'regaining selfhood' and 'seeking companions' on their route. This finding is supported by recent research (McInnes, Hoddinott et al. 2013), but may also be due in this instance to women experiencing less contact with midwives in the current context of maternity service provision in addition to the contemporary pro-breastfeeding culture of maternity services. This former is detrimental to women's experiences of infant feeding, regardless of their method of choice, because midwives are experts in the 'Art' of postnatal care. Healthcare service governance through NHS reform policies effectively denies women the choice of accessing midwives to the degree that they may wish to do so.

A lack of rational critique of the current culture of healthcare service provision and IFP may undermine the unique status of the midwifery

profession because this study appears to suggest that some women experience a sense of alienation by the pro breastfeeding position adopted by midwives in current maternity services. Midwifing women on their mothering journey is a privilege that confers the responsibility to truly respect women's choices by placing them 'at the controls' of their decision making processes. A unique feature of this study's findings arose from the women turning away from healthcare professionals towards whoever supported their sense of agency in their infant feeding decisions. If midwives do not fulfil this role they lose the respect of women by trying to position themselves in a more powerful position of directing women as opposed to 'being with women'.

This leads to the overarching conclusion that women and healthcare professionals experiences of IFP imply there is a distinct lack of holism in the context of current maternity services because IFP appears to deny choice and promotes one stance towards infant feeding with no alternatives. Holism demands a women-centric orientation, not a policy centric approach. This includes placing mothers at the centre of their care decisions and paradoxically this position is a central premise of overarching government health policy. It is antithetical to the role of the midwife to compromise a woman's autonomy unless there are clear legal or clinical indications to do so. Government directed IFP should not enter into the category of acceptable subjugations of a woman's right to choose, regardless of the debate to be had about the scientific evidence base upon which such policy is predicated. Moreover, power relationships should not drive midwifery care practice either, they demean the profession and alienate women.

This study shows that neoliberal agendas diminish holism and are incongruous with the reality of significant stages and journeys in women's lives. An automatic default towards, and unquestioning acceptance of, the dominant paradigm is both injudicious and reductionist. This thesis suggests that Midwives do not overly influence women's decisions, but they certainly influence their experiences

especially in relation to how healthcare professionals implement policy. To optimise maternity services, people using or providing services must be listened to and midwives or healthcare professionals should not become overly inculcated with the culture of the prevailing healthcare system and government health policy agendas. This conclusion is supported by a recent study conducted using a similar qualitative approach to this thesis, namely being 'women-centred' in pursuit of understanding women's infant feeding journeys as opposed to policy-centric. A key message of that research was:

There is a need to shift the focus from seeking to influence initial feeding decisions, towards supporting mothers through their feeding journeys, enabling and protecting decisions to breastfeed as one aspect of ongoing support (Trickey and Newburn 2014: 73)

Finally, question arises from these findings as to why midwives generally tend to accept and not critique government policy. I believe the answer partly lies in the legacy of their historical (and arguably contemporary) inferior status in the maternity services when compared with medics over the past century (Heagerty , Donnison 1977, Donnison 1988). However, this study uniquely supports the notion that they also appear to lack information about the origins of the macro-context of health policy and tentatively suggests they perhaps feel powerless to engage in policy debate. This research may be regarded as a step towards increasing midwives' knowledge about the macro context of policy and may enhance confidence to engage with these vital issues.

This thesis categorically does not advocate that midwives stop promoting breastfeeding. Women who choose to breastfeed deserve, and should receive, the very best care to enable them to do so and these study findings entirely support existing literature by demonstrating that women lack adequate consistent support to breastfeed in financially stretched maternity services. There is a resounding lack of postnatal

resources to enable this to happen, despite the plethora of breastfeeding promoting policy which remains ineffective at changing breastfeeding rates, thus contributing to the experience of 'setting women and midwives up to fail' (Hannula, Kaunonen et al. 2008, Kaunonen, Hannula et al. 2012).

In summary, by answering the research question, this thesis concludes that there are many undesirable aspects to women and healthcare professionals' experiences of infant feeding. These adverse issues are related to the current context of current maternity services that in turn are influenced by identifiable spheres of policy. If healthcare professionals and midwives engage more in the rational process of critiquing policy, there is real potential to optimise experiences within maternity services for women and midwives especially in relation to IFP or indeed any other maternity services policy. In so doing, healthcare professionals will co-create the context of service provision, equalise the balance of power in their relationships with women and policy generators and thereby alter certain spheres of service provision. If they choose not to do so, the Art of Midwifery 'risks' becoming further 'confined' by the increasing neoliberal governmentality influence(s) upon the healthcare system it operates within, that still remain resoundingly unevaluated (Hunter 2013a). This will result in a maternity services journey that is detrimental to women and midwives whose life-worlds take place within this healthcare system of maternity service provision.

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List of Abbreviations

AC	Audit Commission
BFI	Baby Friendly Initiative
CHI	Commission for Health Improvement
DCSF	Department for Children, Schools and Families
DfES	Department for Education and Skills
DH	Department of Health
DHSS	Department of Health and Social Security
HCP	Healthcare Practitioner
HoM	Head of Midwifery
IFC	Infant Feeding Coordinator
IFP	Infant Feeding Policy
MCAs	Maternity Care Assistants
MSWs	Maternity Support Workers
MW	Midwife
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
ONS	Office for National Statistics
PSA	Public Service Agreement
SSCC	Sure Start Children Centres
WHO	World Health Organisation