

**Breastfeeding
and you:**
*A handbook for
antenatal
educators*

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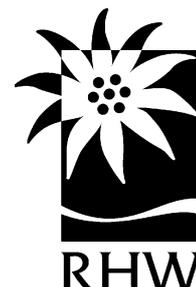
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Commonwealth Department of
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CONTENTS

Module 1: Introduction to the handbook	5
1. Aim of the handbook	6
2. Background information	7
3. How to use the handbook	8
4. The other resources in the package	10
5. Distribution of the resource package	11
6. The project team	12
7. References	12
Module 2: Preparing to breastfeed	13
1. Introduction	14
2. The realisation of pregnancy	14
3. The decision to breastfeed	15
4. The breasts in pregnancy	20
5. Your role as an educator	22
6. Conclusion	24
7. References	25
Module 3: The breastfeeding experience	27
1. Introduction	28
2. The breastfeeding relationship	29
3. How breastfeeding works	30
Chart: Influences on breastfeeding	31
4. Factors that influence breastfeeding	38
5. The benefits of breastfeeding	43
6. Your role as an educator	44
7. Conclusion	45
8. References	46
Module 4: Facilitating antenatal groups	47
1. Introduction	48
2. Antenatal group participants	48
3. Understanding antenatal groups	50
4. Factors that influence group functioning	51
5. Gaining confidence	54
6. Your role as an educator	55
7. Conclusion	56
8. References	56
Module 5: Planning antenatal strategies	57
1. Introduction	58
2. Assessing the participants' needs	58
3. Preparing session plans	60
4. Learning strategies	62
5. Obtaining feedback	68
6. Program/session evaluation	68
7. When you are in a hurry	69
8. Conclusion	70
9. References	70

Module 6: Resources for educators and participants	73
1. Introduction	74
2. How to use this module	75
3. Breastfeeding resources for educators	76
4. Antenatal education resources for educators	77
5. Health education resources for educators	77
6. Breastfeeding resources for participants	77
7. Breastfeeding resources for participants with languages other than English	78
8. Conclusion	78
Module 7: Breastfeeding and you: Preparing the way	79
1. Introduction	80
2. How to use the video	80
3. Facilitating a group discussion	81
4. Conclusion	84
Module 8: Breastfeeding-related learning strategies	85
1. Introduction	86
2. How to use the activities	86
3. Preparing to breastfeed	88
4. Learning to breastfeed	99
5. The reality of breastfeeding	103
6. Becoming a parent	107
7. Conclusion	110
Module 9: Handouts for participants	111
1. Introduction	112
2. How to use reference material	112
3. The handouts for participants	113
4. Conclusion	114
Module 10: Evaluating antenatal strategies	133
1. Introduction	134
2. Program evaluation	134
3. Program evaluation strategies	135
4. Self-evaluation	137
5. Peer review	138
6. Handbook and video evaluation	138
7. Conclusion	138
Evaluation hand-out	139
Module 11: Appendices	141
Appendix One – Project Advisory Committee	142
Appendix Two – The impact of migration on breastfeeding practices	143
Appendix Three – The Ten Steps to Successful Breastfeeding	146
Appendix Four – Still Best Commentary	147
Appendix Five – Strong Personalities Fact Sheet	149
Appendix Six – Program Planning Fact Sheet	151
Appendix Seven – Gaining and Maintaining the Attention of Participants	152
Appendix Eight – Connection and Pleasure, Disruption and Distress: Women’s Experience of Breastfeeding	153

Introduction to the handbook

CONTENTS

1.	Aim of the handbook	6
2.	Background information	7
3.	How to use the handbook	8
4.	The other resources in the package	10
5.	Distribution of the resource package	11
6.	The project team	12
7.	References	12

Before my life started properly, I was doing the usual mewling and sucking, which in my case occurred on a pair of huge, soft, black breasts. In the African tradition I continued to suckle for my first two and half years after which my Zulu wet nurse became my nanny. She was a person made for laughter, warmth and softness and she would clasp me to her breasts and stroke my golden curls with a hand so large it seemed to contain my whole head.¹

Welcome to *Breastfeeding and you: a handbook for antenatal educators*. This handbook is part of a resource package of research-based, innovative materials specifically designed for antenatal educators. The package aims to improve breastfeeding education in the antenatal period. It consists of:

- *Breastfeeding and you: a handbook for antenatal educators*
- *Breastfeeding and you: preparing the way* – a video for expectant parents and their families
- *Breastfeeding and you: preparing the way* promotional poster
- Breastfeeding handouts in community languages.

1. AIM OF THE HANDBOOK

The aim of this handbook is to:

- provide information and resources to antenatal educators and health professionals who inform and support women and men during the antenatal period;
- promote the use of educational resources that are based on recent biological and social research in breastfeeding and adult learning theory.

2. BACKGROUND INFORMATION

Breastfeeding is the unparalleled biological method of feeding infants and the Australian Government has placed it first in the Dietary Guidelines for Children and Adolescents.² Recently released Australian Bureau of Statistics figures³ indicate, however, that although a high percentage of women commence breastfeeding, there is a rapid decline in the numbers of women breastfeeding by the time the infant is six weeks of age. The initiation and duration rates amongst women from some non-English speaking background cultures are significantly lower.

In an attempt to increase breastfeeding rates for the year 2000 and beyond, the Commonwealth government has set a number of goals and targets⁴ and State governments have also been active in the promotion and support of breastfeeding. This Breastfeeding Education Resource Package is one example of the Commonwealth Government's commitment to breastfeeding.

Breastfeeding education in the antenatal period is common practice in most maternity units. Recent Australian research, however, shows that the education appears to emphasise the biology and physiology of the breastfeeding experience, and as such does not encourage parents to reflect on the individual, diverse and somewhat unpredictable nature of the experience.⁵ Parents could benefit from an awareness of the diversity of the breastfeeding experience, prior to the birth of their baby, and they should be encouraged to explore the nature of the physical and emotional involvement that occurs during breastfeeding. This wholistic approach should help parents achieve a more realistic and therefore less confronting or potentially disappointing breastfeeding experience.

The approach of this resource package is to combine the strengths of the biological model, already familiar to educators and health professionals, with the knowledge gained from recent social sciences research.

3. HOW TO USE THE HANDBOOK

For ease of use you will find that the handbook has been divided into two sections, with each section being divided into modules.

Section One is primarily professional development providing information on breastfeeding, adult learning, group facilitation and program planning. The modules in this section are:

- Module 1 Introduction to the handbook
- Module 2 Preparing to breastfeed
- Module 3 The breastfeeding experience
- Module 4 Facilitating antenatal groups
- Module 5 Planning antenatal strategies
- Module 6 Resources for educators and participants

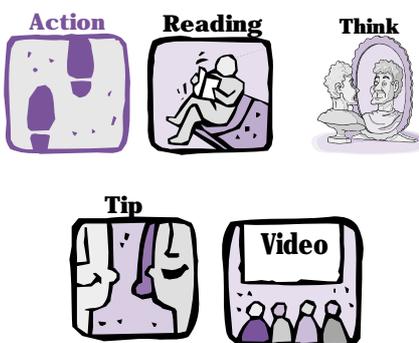
Section Two provides a range of activities and material that you may like to use in your antenatal programs/sessions. The activities are based on the principles of adult learning and each one covers a certain aspect of the breastfeeding experience. The modules in this section are:

- Module 7 Breastfeeding and you: preparing the way
- Module 8 Breastfeeding-related learning strategies
- Module 9 Handouts for participants
- Module 10 Evaluating antenatal strategies
- Module 11 Appendices

As you can see each module addresses a separate issue and although we have cross-referenced issues in the handbook, each module is self-contained. You can, therefore, select the modules that are of interest to you. The materials and strategies contained in this handbook have been designed to be helpful for experienced antenatal educators, as well as those who are relatively new to the role.

3.1 The icons in section one

The process of learning through acquiring knowledge and experience is similar to that of going on a journey, so you will find that the handbook has been designed to reflect the journey process. As you proceed through each module, there are think, action, reading, tip and video icons. We ask that you stop and follow the path that each icon takes you on. Although your progress to the end will be delayed through making these stops, as with any journey you embark on, the more preparation and experiences you have, the more success you will achieve. Professional development is important.



3.2 The language used in the handbook

The language used in this handbook is the language which the antenatal educators on the production team use in their work environments. It is language that is becoming more frequently used in the antenatal education arena, as it acknowledges the fact that the majority of the women and men who attend antenatal education programs are adults who like to be actively involved in their learning. For this reason you will find that we have used:

- sessions instead of classes;
- participants instead of clients;
- parents instead of couples;
- educator or facilitator instead of teacher.

3.3 Keeping a learning journal

Educational programs, sessions and strategies are the lifeblood of an educator and as we acknowledge in Module 5, each one is a unique journey that requires careful navigation. To enhance your growth as an educator, and hence your professional development, we recommend that you keep a learning journal to record important issues that arise in your programs/sessions.

The concept of a learning journal may be unfamiliar, so to help we have asked that you write your response to several of the professional development/‘icon’ activities in a notebook. This notebook can become your learning journal.

3.4 Handbook and video evaluation

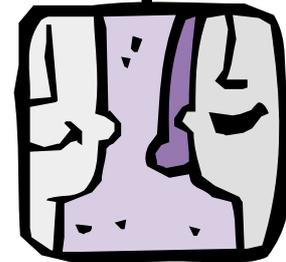
At the end of Module 10 you will find an evaluation questionnaire for the handbook and video. We ask that you complete it and return it to the address provided within 6 months of receiving this handbook.

Reading



For more information on learning journals please refer to the health education reference books listed in Module 6.

Tip



To increase the response to the evaluation questionnaire we suggest you write a reminder note in your diary now.

4. THE OTHER RESOURCES IN THE PACKAGE

4.1 *Breastfeeding and you: preparing the way* video



Please watch the video and think how you could use it in your program/session. Each scene requires thought and consideration, so you may like to show it in segments. In Module 7 we give suggestions on how to use the video. You may like to use them, or adapt them to your local community.

Breastfeeding and you: preparing the way is a video that emphasises the social, emotional and relationship issues surrounding the decision to breastfeed and how they can influence the experience. It differs from other breastfeeding videos you may have seen or used as it gives viewers a sense of the joy and closeness that breastfeeding can offer, but also of the ambivalence and uncertainty that women and men can experience. The video can be used for an antenatal group, in an antenatal clinic, antenatal ward or by expectant parents in their home environment.

In the video we follow the journey of Anna, and her partner Adam, as they explore what breastfeeding means for them during the pregnancy. In talking with their friends, Anna and Adam discover that breastfeeding may not 'come naturally' and that support provided by their families and friends will be invaluable. Anna also learns that there are community resources she will be able to draw on in the early weeks and months of breastfeeding. In the final scene we see Elsa, a new mother, breastfeeding her day-old baby, Gabrielle.

4.2 *Breastfeeding and you: preparing the way* promotional poster

The poster, which promotes breastfeeding and the video, is for display in obstetricians' waiting rooms and antenatal areas in health facilities. It will encourage women to borrow and view the video in their home environment.

4.3 Breastfeeding handouts in community languages

Breastfeeding handouts in community languages have been included in Module 9 for copying and distribution to women and their families. In addition to these handouts we have included, in Module 6, a list of organisations you can contact for resources in other languages.

5. DISTRIBUTION OF THE RESOURCE PACKAGE

The resource package has been distributed to an estimated 3,000 public and private sector antenatal and parenting educators working in maternity units across Australia. An additional 2,000 videos and posters have been produced and distributed to practicing obstetricians.

More information about this breastfeeding resource package can be ordered from:

Centre for Family Health and Midwifery,
University of Technology, Sydney
PO Box 123, Broadway NSW 2007
Telephone 61-2 9514 2977
Fax 61-2 9514 1678

6. THE PROJECT TEAM

The Family Health Coalition is a group of professionals from:

- Family Health Research Unit
- Royal Hospital for Women, Randwick
- Centre for Community Welfare Training
- University of Technology, Sydney

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7. REFERENCES

- 1 Courtenay B. The power of one. Australia: William Heinemann, 1989:1.
- 2 NHMRC. Dietary guidelines for children and adolescents. Canberra: AGPS, 1995.
- 3 Australian Bureau of Statistics. Breastfeeding data from the 1995 national health survey. Canberra: AGPS, 1995.
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- 5 Schmied V. Blurring the boundaries. Breastfeeding as discursive construction and embodied experience. Unpublished doctoral thesis. University of Technology, Sydney, 1998

Preparing to breastfeed

CONTENTS

1.	Introduction	14
2.	The realisation of pregnancy	14
3.	The decision to breastfeed	15
4.	The breasts in pregnancy	20
5.	Your role as an educator	22
6.	Conclusion	24
7.	References	25

1. INTRODUCTION

Pregnancy heralds a major life change for women and men. It is a unique journey, bringing experiences that may be comfortable and enjoyable for some, difficult and complex for others. As an antenatal educator you have the opportunity to accompany many women and men as they begin their journey.

Antenatal program participants come from diverse backgrounds so it is important that you understand their needs and concerns, and recognise and acknowledge the way they feel about situations they encounter. Infant feeding is one such situation. In this module we will explore when and why infant feeding decisions are made, and how you as an educator can prepare women and men for the breastfeeding experience.

As with the other modules in this section, the information provided is an overview. To adapt it to your local area and hence the participants in your programs, we recommend that you undertake the activities surrounding the icons.

1.1 Learning outcomes

Upon completion of this module you should be able to:

- describe when the decision to breastfeed is made;
- discuss the factors that influence the decision;
- identify the breast changes that women experience in pregnancy;
- identify the breastfeeding issues that interest expectant parents;
- describe strategies that an antenatal educator can use to address these issues.

2. THE REALISATION OF PREGNANCY

For many women breast changes signify the first signs of pregnancy. Tingling, sensitive, full, tender breasts are often the first bodily changes noticed by newly pregnant women. If, however, the woman is not expecting to be pregnant she may mistakenly think she is about to menstruate. The breast changes and feelings are similar to those experienced before a woman menstruates, although they are stronger or more noticeable.

These changing sensations and perception of the breasts, in combination with tiredness, nausea, vomiting, differing thoughts about the pregnancy and a fear of miscarriage, may prevent many women and men in the early weeks from truly 'connecting' with the baby. It does not, however, prevent them

from investing considerably in the health of their unborn. Australian couples are having fewer children than a generation ago and they expect their children to be healthy. For this reason most women regularly attend antenatal visits, they alter their eating patterns, quit smoking, consume less or no alcohol and generally do all in their power to ensure the health of their baby.

As the weeks progress and life begins to stabilise, you will find that women and men start to build an image about what it is to be a 'good' mother and a 'good' father. They reflect on their own upbringing, they look at their families and friends and they begin to formulate their own ideas of what they 'will' and 'won't' do. Some women tie their decision and ability to breastfeed to their desire to be a 'good' mother. They see breastfeeding as something that is not only healthier for their baby, but also important to their identity as a mother.^{1,2}

3. THE DECISION TO BREASTFEED

3.1 An historical perspective

For centuries, women's confidence in their ability to breastfeed has been influenced by prevailing cultural attitudes and the availability of viable alternatives.³ In pre-industrial societies most women breastfed or their babies were wet-nursed, although alternatives such as gruel, paps, rice or barley water were available. The alternatives, however, generally had a deleterious effect on the baby.⁴

The industrial revolution, with its associated urbanisation, brought a major change to this situation. The prospect of employment in the emerging industries meant families moved from rural areas to the cities.⁵ Women entered an uncaring workforce, traditional family networks disintegrated, wet nurses became scarce and Foundling Hospitals were established to care for the large number of abandoned babies. This created a need to find a viable alternative to human milk.

The first marketed cow's milk-based formula was patented in 1867 by the German chemist Von Leibig.⁶ The commercial success of this formula spawned a host of other human milk substitutes. In the early 1900s a Swiss merchant, Henri Nestlé, marketed a 'scientifically prepared' substitute by combining sugar and wheat flour cooked in malt with cow's milk. Nestlé advertised his product as 'scientifically correct so as to leave nothing to be desired' and he directed his marketing at mothers as he insisted 'mothers will do my publicity for me'.⁷

A thriving dairy industry in Australia, New Zealand, Europe and North America post World War II led to the next phase in the development of a truly commercial alternate method of infant feeding. The excess cow's milk was used to make infant formula. Multinational corporations, ranging from food to pharmaceutical companies, became involved and by the mid 1950s infant formulas, bottles and teats were freely available from the corner store, supermarkets and pharmacies.⁸ Formula feeding symbolised the modern world of progress.

The modernisation of infant feeding paralleled rigid hospital practices at this time. Strict feeding schedules and the separation of mother and baby in the immediate postnatal period were common. These influences, coupled with the loss of traditional family networks, resulted in a worldwide decline in breastfeeding rates and during the 20th century an all time historical low was reached.⁹

The dramatic reversal of the trend to formula feeding happened in the 1970s when women sought to regain control of their childbirth and parenting experiences. Women were not happy with the medical control of breastfeeding and they were frustrated by the lack of support and encouragement given to women wishing to breastfeed. Peer support networks began to emerge and they gained support and recognition within the community. For example, the Nursing Mothers' Association of Australia (NMAA) was formed in 1964 and grew from a dedicated group of 6 women to become a 17,000 strong grass roots group by 1988.¹⁰ Whilst these groups were initially treated with suspicion by the medical and nursing professions, women's confidence in learning about breastfeeding was, and still is, positively enhanced by mother to mother support outside the hospital.

In Australia today, breastfeeding initiation rates are relatively high compared with other western countries such as the United Kingdom and the United States of America. Duration rates, however, are low and cause concern as fewer than 50% of women in Australia breastfeed their infants beyond six months of age.¹¹

Many factors influence whether a woman will decide to breastfeed and for how long. Breastfeeding is viewed by many as the 'natural' way to feed a baby. However, it is a learned skill that requires support and cannot be understood in isolation from the social and cultural environment within which a woman makes her decision.

3.2 The decision today

Evidence now suggests that the majority of women have already decided, prior to conception, how they are going to feed their baby.^{12,13} It is a decision that is not always made in a planned, thoughtful, rational way, with many women not consciously weighing up the pros and cons of breastfeeding at a specific time. Rather, it seems to be a more subconscious decision. Breastfeeding is something that many women expect to do and so it is assumed or taken for granted by both the woman and her partner.

Interestingly, this commitment is not based on an understanding of what breastfeeding entails. So although the decision may have been made, as an educator you will find that as the pregnancy progresses and the baby becomes a reality, participants will begin to actively seek breastfeeding information. The characters Anna and Adam, in the video that accompanies this handbook, exemplify the concerns many women and men have and the process they undertake to formalise their decision.

3.3 Factors that influence the decision

While the timing of the decision to breastfeed is one factor found to be associated with the initiation and indeed the duration of breastfeeding, there are many others. As an antenatal educator you need to be aware that a wide variety of factors and experiences may influence a woman's decision to breastfeed. The participants in your antenatal groups will come from diverse backgrounds, so to be able to provide them with the information and support they require you need to be open to many beliefs and feelings about breastfeeding.

Most likely, from the accompanying activity, you have made a list of socio-cultural factors, as well as personal characteristics, that may influence a woman's decision to breastfeed. You may have included the following:

- **Age** – older women are more likely to initiate breastfeeding than younger women.¹¹
- **Socioeconomic status** – women who have attained a higher level of education and women who earn a higher income are more likely to initiate breastfeeding.^{14,15}
- **Support from partner, family and friends** – women are more likely to decide to breastfeed and to initiate breastfeeding if their partner is supportive, if their mother, other family members and friends have breastfed their infants and it was a positive experience. Women learn about

Think



Take a few minutes to consider the different ideas, attitudes and beliefs about breastfeeding that you encounter when you are facilitating antenatal groups.

Now list, in your notebook, the factors that you think influence a woman's decision to breastfeed.

breastfeeding from those around them and with low breastfeeding rates among some groups in the Australian community there are few role models for women.^{16,17}



Let us take a moment to think about the participants in your sessions. How old are they? What support do they have? Are they expecting more than one baby? Within the community where you live, what do you believe is the 'acceptable' length of time that a woman can breastfeed?

Do you have women or men who speak languages other than English in your sessions? If you do, from where do they come and what are the breastfeeding practices in their country of origin? What are the breastfeeding practices of these women in Australia? Is there a difference in their practices? If so, why does it exist?

If you do not know the answers to any of these questions, we recommend that you spend some time familiarising yourself with the breastfeeding practices in your local community. You may like to speak to a community elder, the women themselves, the health care providers and your multicultural communication department.

- **Cultural Background** – the decision to breastfeed is also influenced by the norms of the culture from which the woman and man originate.^{18,19,20} For example, indigenous Australians consider breastfeeding to be a normal activity that is not hidden and does not have sexual connotations, and in many Asian countries women breastfeed for one to two years. Immigration and dislocation can, however, have a profound influence on these norms. In Australia there are many immigrants from less developed areas, such as Vietnam, the Philippines, rural China and Korea. These women report that in their countries of origin women often breastfeed for one to two years, yet here in Australia they may not initiate breastfeeding or they breastfeed for a short time. These women state that breastfeeding is more difficult in Australia for three main reasons:

- they do not have the support they require to care for their infant and any other children they may have;
- they have to return to work soon after the birth of their baby; and
- they rarely see women breastfeeding in public, so there is an underlying belief that Australian women do not breastfeed.

In certain cultures, such as in New Guinea, the men make the decision to breastfeed. Men decide who shall be breastfed, by whom and for how long.²⁰ Similarly Morse and Harrison²¹ suggest that in western cultures there are powerful social forces that prescribe how long women may breastfeed. If a woman breastfeeds for longer than this period, then the lack of social acceptability, particularly breastfeeding in public, results in pressure to wean.²²

- **The image of the breast within society** – another influence on a woman's decision to breastfeed appears to be the way in which the female breast is viewed in her society. Some commentators believe that the preoccupation in western societies with breasts as objects of sexual desire and gratification is particularly influential in a woman's decision to breastfeed.^{23,24} Women appear to be concerned that their breasts will lose their sexual attractiveness if they breastfeed or that their partner may become jealous of the baby sucking at their breast.²⁵ Women living in contemporary western societies pay detailed attention to the appearance of their body, its control and function. The physiological changes that occur in relation to lactation may distress women, deterring them from initiating breastfeeding. For some

women there is also a general feeling of unease or even revulsion at the thought of breast milk leaking from their breasts.^{26,27}

- **The media and breastfeeding** – media images of the female breast are considered important in shaping our ideas about the breast and therefore women's comfort with breastfeeding.^{22,28} It is important to consider that the media also actively shapes our understanding about breastfeeding. Henderson's²⁹ recent examination of the Australian newspapers and magazines suggests that while articles present the message of 'breast is best', this message is frequently contradicted by images of breastfeeding. They suggest breastfeeding is difficult to do, requires patience, practice, time and is a battle, 'a war to be won' or a problem to be solved. She adds that in many instances women are presented as ignorant, ambivalent, needing support or failing to stay relaxed. In abandoning breastfeeding they are presented as 'endangering their babies'. Underlying many of the reports is the message that women require the assistance of health professionals to succeed at breastfeeding.

- **International marketing of infant formula and related products**

Researchers and commentators have identified that the marketing and supply of free and low-cost infant formula and related products has contributed to a rapid decline in breastfeeding this century and has promoted bottle feeding as the norm in western societies.^{23,30} In the early 1980s most of the international community adopted the World Health Organisation International Code of Marketing Breast Milk Substitutes (the WHO Code). The Code limits the promotion and supply of formulas to consumers in order to protect breastfeeding and assist in increasing initiation and duration rates. Despite the introduction of the Code, the continued aggressive marketing of infant formula by multinational companies cannot be underestimated.^{23,30,31}

The fact that there is a community accepted choice to breastfeeding also affects the decision on infant feeding. If there is no choice, for example in Papua New Guinea or some isolated areas of Australia, formula feeding does not occur and is not even considered as there is no substitute available. Is breastfeeding or formula feeding the more accepted method of infant feeding in your community?

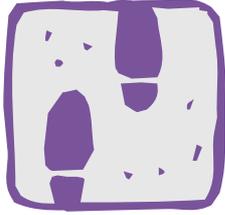
- **The medicalisation of breastfeeding**

It is argued that health professionals, particularly from the medical profession, have undermined women's confidence



For additional information on the impact of migration on infant feeding practices please read the article in Module 11.

Action



When you are next in your tearoom at work or a waiting room somewhere, have a look through various magazines. How are breasts portrayed? How are breasts described? What messages do you get from these images? Write your responses to these questions in your notebook.

A collage of a range of women with differing breast shapes, sizes and images can be a useful discussion trigger for your antenatal sessions. It can, however, create feelings of concern if the images are all of 'perfectly shaped' breasts, so make sure you include a range of images.

Now take a minute to think how easy it is for a woman to breastfeed in public within the community where you live. For example, do you see women breastfeeding in public, are there any stickers or posters on restaurants or shops stating 'Breastfeeding mothers welcome here'?

in their ability to breastfeed. For example, earlier this century the medical profession began to dictate the way in which women should breastfeed their infants, recommending that babies be fed on a rigid four-hourly schedule and for limited times. As we are now aware such practices compromise the initiation and maintenance of breastfeeding by hindering breast milk production. In addition, the widespread denigration of women and their bodies managed to convince women that a scientifically formulated product was superior to their own milk. As a consequence, women have come to view breastfeeding as problematic and a practice that requires continuous assistance and support of professionals.^{32,33}

4. THE BREASTS IN PREGNANCY

4.1 The physical changes

The feelings a woman experiences in her breasts are the first signs of the physical changes that occur in pregnancy and are most apparent in the first trimester. To be able to support women and answer their questions, you need to be aware of what the physical changes are.

The nipples begin to enlarge and become more erect, the areola darkens and may enlarge, and the Montgomery's Tubercles become more pronounced and noticeable. As the breasts enlarge, the skin becomes translucent and as the blood supply to the breast increases the veins become more prominent. These changes all indicate that the breast is undergoing a remarkable maturation to develop the milk-making cells and ductal system of the breast, in readiness for the infant to be nurtured after birth.

Inside the breast the adipose or fatty tissue, which has primarily been supporting the breast since puberty, decreases as the glandular tissue and the ductal system develops and matures in preparation for breastfeeding. Throughout pregnancy the breast tissue is under the influence of the hormones, oestrogen and progesterone. These are secreted by the placenta to stimulate the maturation of the milk-producing tissue.

Breast milk may be noticed from 16 weeks gestation and women need to be reassured that this is perfectly normal. Most women, however, will not notice any breast milk or colostrum until the third trimester.

As the pregnancy progresses breast changes become more evident. The responses to these changes may be similar to the responses to the pregnancy, in that they are often mixed and may range from joy and fascination to distress and dismay.

4.2 How these changes are perceived

As an antenatal educator, you need to be aware that some participants will regard their breasts and breastfeeding as a sensitive issue and so there will be a range of responses in any discussion that occurs in your sessions. For example, tightly crossed arms or hunched shoulders may indicate that a woman is uncomfortable with her breasts and the changes. Some will ask direct questions such as ‘My breasts are huge now – what will they be like when I start breastfeeding?’ or ‘My partner thinks they are wonderful – but he doesn’t have to carry them around. Will they get bigger?’ Similarly, women with smaller breasts may ask about their ability to produce enough breast milk.

In the second trimester many women become concerned about their ability to breastfeed, as they have heard that it is ‘hard’. In the third trimester men seek answers to more practical issues, such as ‘What can I do to help with breastfeeding?’ Whenever you can, capture opportunities and address issues as they arise, such as when you are asked direct questions or negative comments are made, as fears can become significant concerns if they are not dealt with as they occur.

In most communities in Australia breastfeeding is no longer seen as a ‘woman’s issue’. Men tend to ask fewer questions spontaneously than their female counterparts, but this should not be taken as an indication that they are not interested in the breast changes or breastfeeding. Adam and Max’s discussion in the garage scene in the video that accompanies this handbook, typifies conversation which occurs between men during a pregnancy.

4.3 Breast care during pregnancy

When you are discussing breastfeeding antenatally, it is important to recommend that each woman have her breasts checked by her caregiver, i.e. her midwife, general practitioner or obstetrician. The health worker frequently overlooks the need for this check, but it is an opportunity for them to answer any questions about breastfeeding that the woman has and to discuss issues such as:

- breast development during pregnancy
- the care of flat or inverted nipples
- previous breast injuries or surgery
- previous breastfeeding experiences.

If the woman has questions or problems that her caregiver and yourself have not been able to answer, you may wish to refer her to the local Nursing Mothers’ Association of Australia (NMAA) breastfeeding counsellor or a lactation consultant.



Anna and Adam's comments and questions in the video, *Breastfeeding and you: preparing the way*, are typical of those of women and men as they prepare for breastfeeding.

Please watch the video and use it in your sessions to stimulate discussion amongst the participants.

One question that women often ask is what they should do to prepare their breasts for breastfeeding. The simple answer is that there is no specific care necessary during the pregnancy. No creams, ointments, breast shells or nipple pullers have proven to make any difference to breastfeeding outcomes.

It is important that women be encouraged to increase their comfort and familiarity with their breasts as they change during the pregnancy. The more familiar and confident a woman is with her body and her breasts, the more likely she is to initiate breastfeeding and to breastfeed for longer.³⁴ Some women, however, do not find touching their breasts comfortable, so the issue should not be forced. Discovering a woman who is uncomfortable with her breasts should trigger concern for future breastfeeding issues.

5. YOUR ROLE AS AN EDUCATOR

Historically, antenatal education has been birth-focused and teacher-centred and educators have assumed that expectant parents would not be interested in postnatal issues until they have the baby in their arms. We know this is not true and, in fact, it should be questioned as to whether it ever was. It was more a case of professionals telling antenatal program participants what they thought they should know – participants were not allowed to make comments or ask questions.

'How will I know if the baby is getting enough?', 'How frequently will I have to feed my baby?', 'How will I know when things are going wrong?' and 'All my friends have had problems' are all common questions or comments. When women and men are given an opportunity to discuss parenting issues prior to the birth, you will find that infant feeding is one of their main interests. In fact, it seems that once the ambivalence and uncertainty of the first trimester is over, and the thought that they are having a baby becomes real, women in particular are receptive to and actively seek breastfeeding information, along with other information about their role as a parent.

So what is your role as an antenatal educator? As stated in Module 4, expectant parents are adults with interests, needs and concerns who learn more effectively if information is relevant and practical. Your role is to capture opportunities, as was mentioned above, and present new information in a very practical way, relating it to situations they are familiar with. This should enhance their interest and hence their ability to learn new concepts. These strategies, however, require a degree

of skill so we will now give you a few suggestions as to how to facilitate discussions on the topics covered in this module. Firstly, we will discuss how to facilitate a discussion on the attitudes and beliefs surrounding breastfeeding and then the physical or biological issues that require addressing during pregnancy.

5.1 Beliefs, attitudes and expectations surrounding breastfeeding

Many educators believe it is important for participants to discuss how they intend to breastfeed. This can, however, create rifts within a group and can alienate those who are not intending to breastfeed. In fact, women may say that they are going to breastfeed just so they are not ostracised.

For many women the decision to breastfeed is a subconscious decision that, as we mentioned earlier, is made without a recognition or consideration of the implications of the decision. Antenatal educators should, therefore, encourage women and men to explore their beliefs and attitudes, as well as their expectations surrounding breastfeeding. The process of exploration should highlight for parents the need to question whether the reality of the breastfeeding experience will meet their expectations.

There are many strategies you can use to facilitate a discussion on feelings, beliefs, attitudes and expectations surrounding breastfeeding. We have included several in Module 8, but with experience you should be able to develop your own. For example, if there is a woman in your group who has previously had a baby and is happy to share her story, you could ask her to describe how she felt breastfeeding amongst family and friends. To address the father's experience you may like to include a father of a breastfeeding infant, or have single gender group discussions with a male facilitator.

5.2 Preparing to breastfeed

In this module we have discussed the breast changes women experience when they are pregnant and the care required. You may wish to share this information with your group, particularly if you are facilitating a session early in pregnancy. Using visual aids, such as charts and breast models, would enhance a verbal presentation.

Discussing breast changes that occur in pregnancy and what they mean will assist women to become more aware of the physical capacity and potential of their breasts. Allow yourself to be available for women to privately discuss any concerns

Think



From your experience, do you find that women and men are interested in learning about breastfeeding before the birth? What have you based your answer on? What have women and men asked you about breastfeeding? What have they said about it? List their comments and questions in your notebook.

In Module 6 we have provided a comprehensive list of organisations, Internet sites and reference books which you and your participants may like to access. The list includes specialised resources, such as those of interest to women expecting more than one baby, young women and those in single sex relationships.

they may have regarding their breasts and their ability to breastfeed. It requires confidence and trust on the part of a woman to discuss these in a group setting, so you may find some women will require private discussion time. If the information they require is too specific or you are unsure of the answer, suggest that they discuss the matter with their midwife, obstetrician, general practitioner or a lactation consultant.

In addition to this factual information you may like to include a range of other activities, such as those in Module 8. Be creative and refer to Module 5 for ideas of how to integrate activities into your sessions.



The video, *Breastfeeding and you: preparing the way*, can be used to stimulate discussions on beliefs, attitudes and expectations surrounding breastfeeding.

Discussion triggers are provided in Module 7.

6. CONCLUSION

Congratulations, you have now completed Module 2 – Preparing to breastfeed. In this module we have explored:

- when the decision to breastfeed is made;
- the factors that influence the decision;
- the breast changes that women experience in pregnancy;
- the breastfeeding issues that interest expectant parents;
- the strategies that an antenatal educator can use to address these issues.

We hope this module has given you an understanding of how breastfeeding is perceived by women and men during a pregnancy and that you will be able to provide them with the information and support they require as they begin their journey.

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The breastfeeding experience

CONTENTS

1.	Introduction	28
2.	The breastfeeding relationship	29
3.	How breastfeeding works	30
	Chart: Influences on breastfeeding	31
4.	Factors that influence breastfeeding	38
5.	The benefits of breastfeeding	43
6.	Your role as an educator	44
7.	Conclusion	45
8.	References	46

1. INTRODUCTION

Breastfeeding is often regarded as a physiological process that begins with breast development early in pregnancy, is initiated with the birth of the baby and the placenta and is continued for as long as the woman and child wish. It is, however, a complex biological and emotional process, and is described by women as a powerful social, cultural and emotional experience.

As an antenatal educator you need to be aware of the mechanics of breastfeeding, but importantly you also need to be aware of the psychosocial and cultural factors that can influence the process. It is these factors that are less well understood and women and men may be reluctant to raise them in the company of others.

Mothers and babies instinctively 'know' how to breastfeed, as is evident from the fact that a healthy newborn placed on the mother's abdomen at the time of birth and left undisturbed will move slowly towards the mother's breast and search for the nipple.¹ This innate interaction, which is a newborn's survival mechanism, is seldomly seen in the developed world today. Breastfeeding, in this culture, is a skill that has to be learned and which is nurtured through the support of family and the community.

1.1 Learning outcomes

Upon completion of this module you should be able to:

- discuss how women and men describe their breastfeeding experience;
- discuss the diversity of the breastfeeding experience for those involved;
- describe how breastfeeding is initiated and maintained;
- identify factors that can influence the physiological process of breastfeeding;
- describe the role of an antenatal educator in preparing participants for the breastfeeding experience.

2. THE BREASTFEEDING RELATIONSHIP

Many educators describe a sense of satisfaction when women attending a reunion group are breastfeeding their infants. Alternatively, there can be feelings of frustration or disappointment when women have weaned their babies. But how do women feel themselves? What is their experience of breastfeeding?

In recent Australian and other research, women have described the powerful and varied responses that they have towards breastfeeding.² For many women, nourishing their infant is so emotionally consuming it is seen as central to and indeed shapes their experience of motherhood in the first three to six months following the birth. For example, comments such as 'it's a special kind of moment when you breastfeed, when you look up and then you look down and he's down there looking at you' and 'I suppose it's a bit of an ego trip. I like feeling that... I'm responsible for him... I feel really needed... crucial' are common. In the early postnatal weeks, however, you will find that many women entwine these comments with vivid descriptions of the demanding and intense nature of the experience.²

In the article by Schmied and Barclay² breastfeeding is described as an 'embodied' experience, the power of which amazed many of the women in the study. By describing breastfeeding in this way, one recognises the body as not just a physiological entity, but a sensual, emotional and social entity with conscious and unconscious needs and desires.

When you think about it, preparing women and men for breastfeeding should be equivalent to preparing them for the birth. Both are fundamentally physiological processes but over the years they have become somewhat medicalised and many women fear their consequences as they don't know what to expect.



The article by Schmied and Barclay² in Module 11 describes the breastfeeding experiences of a group of Australian women. When you read it, take note of the comments made by the women and also the themes that recur.

2.1 Your role as an educator

As antenatal educators it is important to give women and men the information they want about how breastfeeding works, but we should prepare them for the diversity of the experience as we do for the birth. Breastfeeding can be and is very enjoyable, even wondrous for some, but within our culture it requires commitment and some degree of perseverance and support. Participants need to realise that breastfeeding is not a 'badge of motherhood'. There are many ways to establish a relationship and intimacy with one's baby, as thousands of bottle feeding women have shown.

To prepare them more effectively for the reality of the breastfeeding experience, women and men can benefit from discussions with new parents. In addition, realistic, anticipatory guidance about breastfeeding is more helpful than focusing on its benefits. Australian women know the benefits, but they have difficulty predicting how they may experience breastfeeding.^{2,3,4}

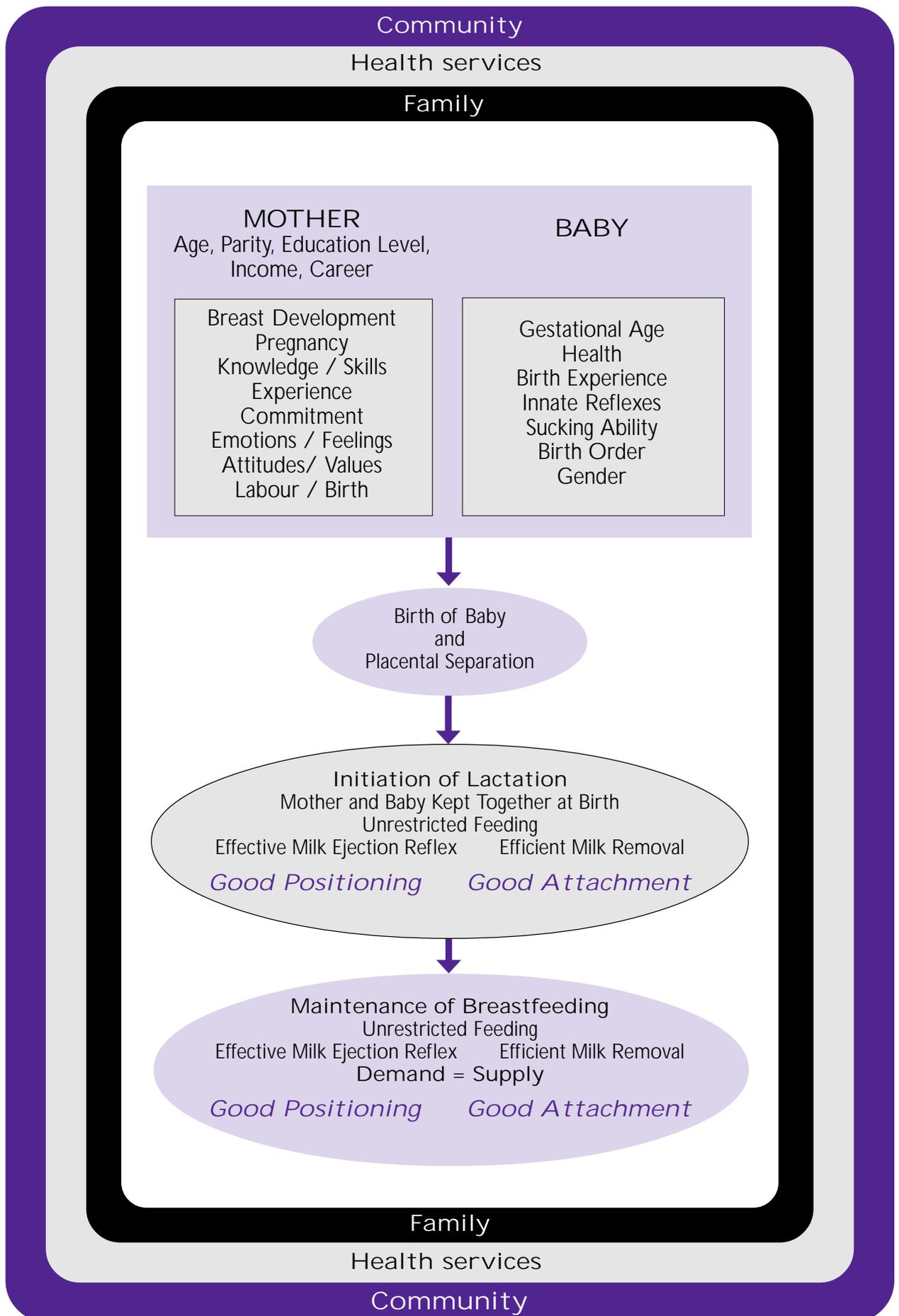
3. HOW BREASTFEEDING WORKS

3.1 The physiological process

There are many texts available that describe the biological and physiological processes of breastfeeding, as you will see from the reference list in Module 6. On the accompanying flowchart we have developed an overview of the physiological process and the factors that can enhance or disrupt it. You may like to use the flowchart in your antenatal sessions, as it places breastfeeding in the context in which the participants will experience it.

In addition to the flowchart you may like to use the accompanying graphics in your antenatal sessions. They demonstrate good positioning and attachment of the baby at the breast.

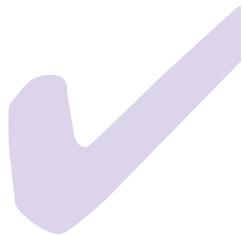
Influences on breastfeeding

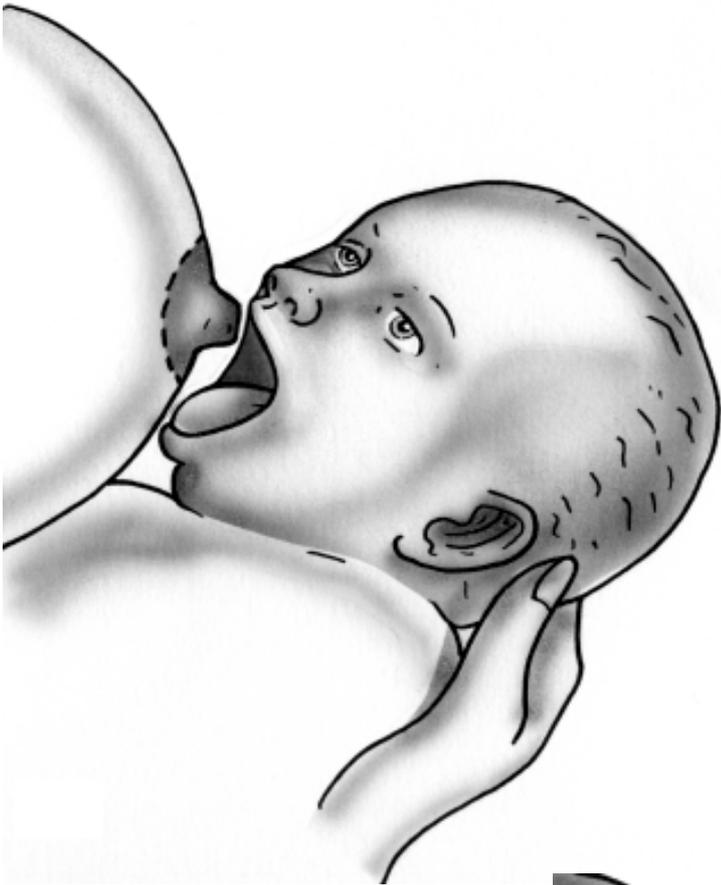


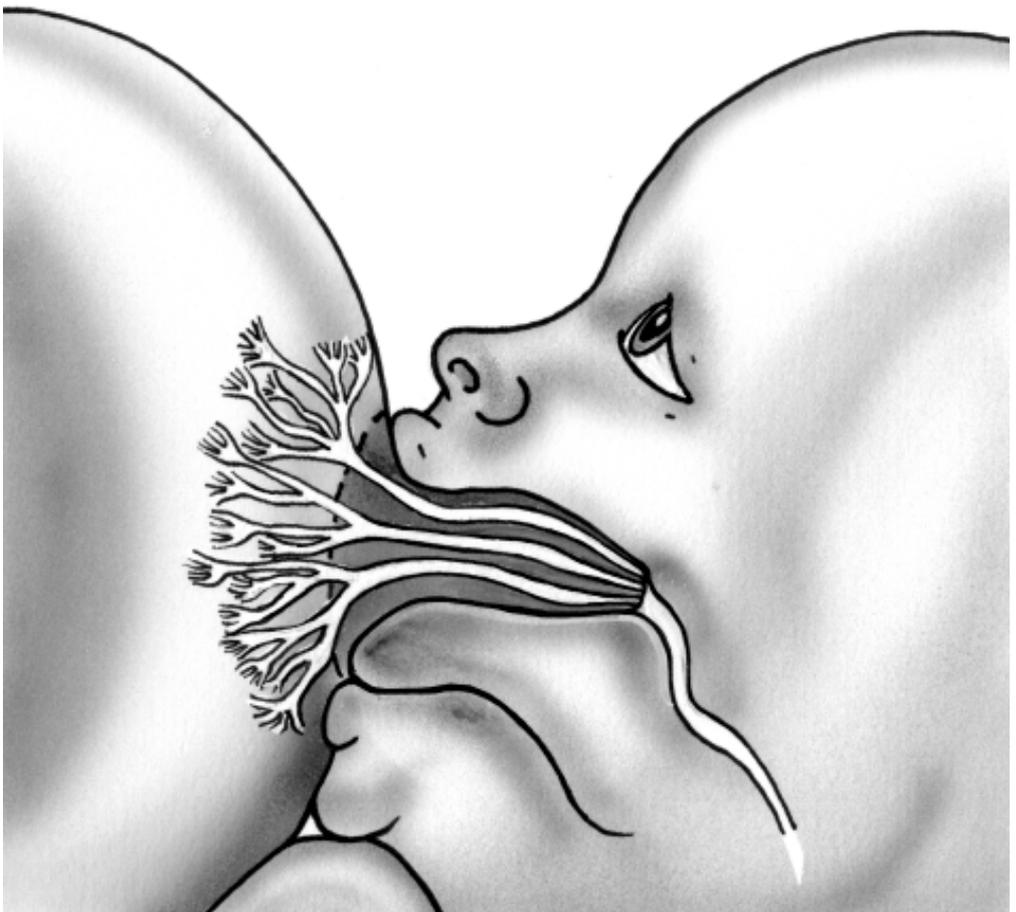
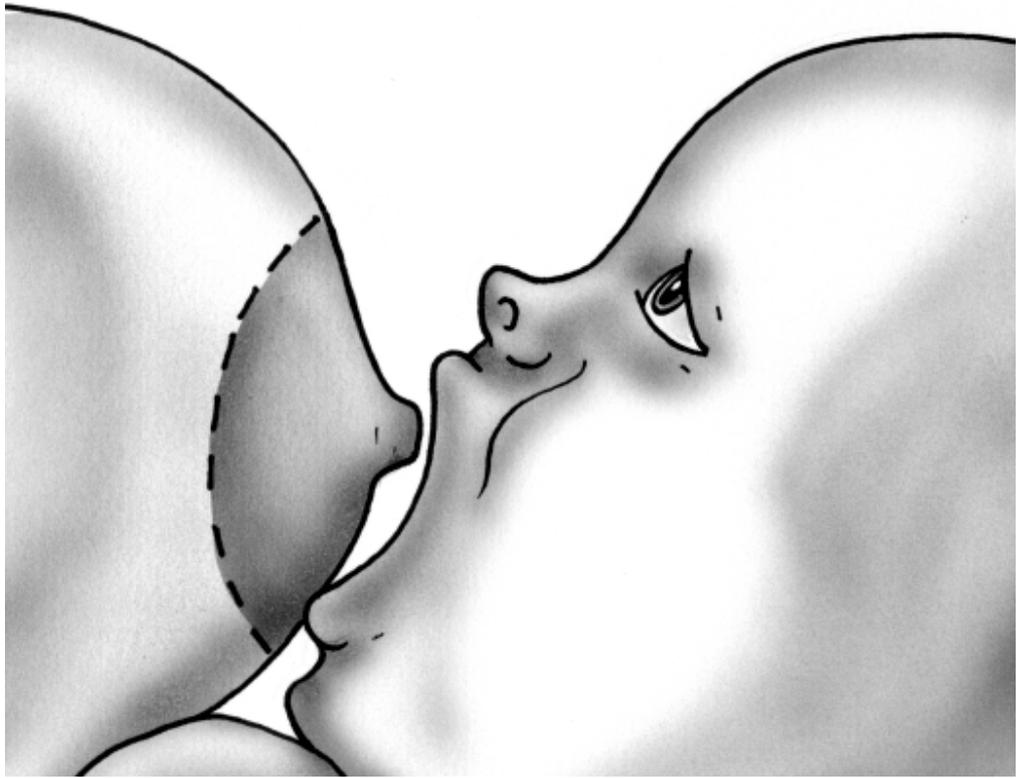
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Good support and comfort for mother and baby.







3.2 Breastfeeding in the initial postnatal period

The rapid nature and the complexity of changes that occur when breastfeeding begins can confuse and distress new mothers. To prepare participants for what is commonly described as a 'roller coaster ride', we have given you an overview of the sequence of events that are likely to occur in the first week of breastfeeding. You may like to share this information with your antenatal group, but remember that it is only an overview and does not allow for the individual differences that will occur. You can inform them of these changes either as an open discussion on their expectations of the first week, or through an activity such as the 'What If' cards in Module 8.

Postnatal Day 1-2: The mother and baby are quite sleepy and they need to rest and recover from the labour and birth.

- The time taken by the baby when it is breastfeeding will be minimal, as the protein and calorie-rich colostrum will meet its needs.
- The baby is well hydrated from being in the amniotic fluid with continual feeding from the placenta, so it will not require frequent feeds.

Postnatal Day 2-3: The baby will become wakeful and want to feed more frequently.

- The baby's thirst intensifies a few days after birth and this triggers the need to breastfeed more frequently.
- The mother's breast milk will change from colostrum to transitional milk with the volume of the milk slowly responding to the baby's needs.
- The mother's breasts may feel heavier with the veins being more obvious.
- As the baby feeds more frequently its stool and urine output will increase.

Postnatal Day 3-4: The baby may become unsettled, feeding more frequently and not wishing to be separated from its mother. The mother is often emotional with day 3 'blues' and in need of sleep and rest.

- The breasts become firm as the milk comes-in.
- The baby can be unsettled, requiring frequent feeds, just prior to the milk coming-in.
- Once the mature milk begins to flow, the baby tends to have bigger feeds and then a long sleep. This may cause temporary over-fullness in the breasts.
- Baby's stools change to transitional stools as the mature milk begins to be absorbed.

Postnatal Day 4-5: The baby settles with more controlled and predictable feeding.

- The breasts begin to supply mature breast milk and they soften as they start to meet the baby's needs.
- The baby's stools change to breast milk stools, which are yellow and soft. The baby has 6-8 wet nappies per day.

It is important to note that this pattern of feeding is potentially quite vulnerable and if for some reason one of the stages is interfered with, the whole situation can change. For example:

- poor positioning or attachment of the baby can delay the amount of sucking stimulation at the breast therefore delaying the milk coming-in. In addition, it increases the incidence of damaged nipples, venous and/or milk engorgement and ultimately physiological jaundice, as it delays the laxative effect of the breast milk.
- giving supplements, complements or pacifiers when the baby is unsettled on days 2-3 can delay the amount of sucking stimulation at the breast and thus delay the milk coming-in. They can increase the incidence of venous and/or milk engorgement and physiological jaundice as described above.
- pain-relieving drugs during labour can make the mother and baby sleepy for a longer period and can confuse the baby so its suck is not as active or coordinated.
- a postpartum haemorrhage due to retained placental products can continue to signal progesterone release, which inhibits prolactin from triggering the breasts to function. The increase in milk volume on days 3-4 will therefore be delayed.

Reading



In this section we have given you an overview of the physiological process and the factors that influence it.

For more specific information please refer to the breastfeeding reference books listed in Module 6.

4. FACTORS THAT INFLUENCE BREASTFEEDING

Think



As an antenatal educator you need to be aware of the specific factors in your local community that can influence the breastfeeding experience.

Take time to think about them and list, in your notebook, a few examples under the following headings: Physiological, Psychological, Social and Community Influences.

When reflecting on the physiological influences, you no doubt identified the important roles supportive posture of the mother, optimal positioning of the baby at the breast and an effective maternal milk ejection reflex, triggered by the release of oxytocin, play in maintaining breastfeeding. During the conditioning of the milk ejection reflex in the early postnatal weeks, the new mother is vulnerable to many influences. A supportive environment, consistent advice, being pain free and positive encouragement are all-important when the woman and baby are learning to breastfeed.

As mentioned earlier, you may like to use the flowchart and graphics in your sessions and we suggest that you allow time for women to learn and practise the skill of holding the baby for breastfeeding. When you do this you may like to include input on practical issues such as how to:

- identify good and poor attachment through observation of the shape of the breast and nipple on detachment;
- observe milk transfer by the changing suck or swallow pattern of the baby and relate this to the milk ejection reflex or maternal let-down, as it is described;
- hand express colostrum or breast milk;
- perform breast self-examination.

Using visual aids, such as the graphics in this handbook, enhances your presentation as does the use of baby dolls to practise positioning and attachment. In Module 8 you will find a range of activities to assist you in demonstrating these skills in your antenatal groups.

4.1 Support from partner, family and friends

Becoming a mother is a significant life change with many skills to be learned and situations to be negotiated. The early weeks, as mentioned previously, can be exhausting, confusing, even overwhelming if the new mother attempts to do everything by herself. Support from her partner, family and friends can greatly enhance the adjustment process and the success or otherwise of breastfeeding.^{5,6}

Through using reality-based activities, such as the video and the discussion triggers in Module 7, participants should gain an understanding of the roles of the mother, partner and the family in the breastfeeding experience.

4.2 Peer support

Peer support is one of the most important influences on the breastfeeding process, but its value is seldomly recognised by women and men before they have their baby. Peer support can increase their understanding and knowledge of the breastfeeding process, peer counsellors have been found to increase initiation and duration rates of breastfeeding and women welcome and appreciate breastfeeding support groups when they are offered.^{7,8} Peer support engenders a sense of personal empowerment to breastfeeding women, giving credibility and value to breastfeeding.⁹

Involving the parents of new babies in your antenatal program, as we describe in the *Reality of Breastfeeding* activity in Module 8, is one strategy you can use to emphasise the importance of peer support to your participants. Encouraging them to become members of their local Nursing Mothers' Association of Australia group is another.

4.3 Breastfeeding guidelines and policies

In an attempt to reduce confusion, health organisations, hospitals and community groups have developed recommendations, policies and procedures to promote, support and manage breastfeeding. As the basis of these guidelines, many have adopted the *Ten Steps to Successful Breastfeeding*,¹⁰ and the NH&MRC *Infant Feeding Guidelines for Health Workers*¹¹ as their breastfeeding policy. The *Ten Steps to Successful Breastfeeding* are the global standards developed by WHO/UNICEF for maternity services. You will find a copy of the *Ten Steps to Successful Breastfeeding* in Module 11.

It is important that you know your local maternity units, Early Childhood/Maternal and Child Health Centres and Nursing Mothers' Association of Australia policies on breastfeeding issues. Being proactive in this area can help to reduce the conflicting advice given by health professionals involved in the care of the mother, her baby and family.



Scenes 1-4 of the video *Breastfeeding and you: preparing the way* emphasise the importance of support from partner, family and friends in the early postnatal weeks.

As women and men during pregnancy frequently underestimate the importance of support, you may like to show the video in your program/session.



Do you know the breastfeeding guidelines and policies of the facilities your participants will be using? If not, you should arrange a meeting with the relevant staff as you need to be informed.

4.4 Australian breastfeeding goals and targets

Increasing breastfeeding rates is one of the Federal Government's stated health goals and targets. Encouraging the adoption of an accreditation process for maternity hospitals, called the *Baby Friendly Hospital Initiative* (BFHI), is one way of achieving this goal. The *Ten Steps to Successful Breastfeeding* mentioned above form the basis of this accreditation. As an educator you need to be aware of the your local community's involvement in this initiative.

The *Ottawa Charter*¹² is a document that has implications for antenatal educators. It is the World Health Organisation's guide for health promotion activities and it identifies five strategies that should be considered when planning a health education or health promotion activity. These strategies can easily be applied to the *Ten Steps to Successful Breastfeeding*, as is demonstrated in the articles by Croker¹³ and in Table One below.

Table One:

The Ottawa Charter and Breastfeeding Policy Relationship

Re-orientate Health Services	BFHI Accreditation
Strengthen Community Action	Step 10
Create Supportive Environments	Steps 6, 7, 8, 9
Build Healthy Public Policy	Step 1
Develop Personal Skills	Step 2 (Staff), Step 3, 4, 5 (Mothers)

4.5 Half-truths, myths and rules

The family and community in which the mother lives are major influences on breastfeeding practices. Practices have changed significantly over the years as we have moved from the rigid, prescriptive 'scientific' era of regulating and timing feeds, to the more flexible, unrestricted breastfeeding practices of today. Some of the early rules still linger and have been added to the pool of myths surrounding breastfeeding. With breastfeeding being a relationship that the mother and baby 'grow' themselves, with patterns and rules to suit themselves, other 'rules' are always likely to develop. These all have the potential to create confusion for new parents.

As an antenatal educator, you will find that women and men ask you an amazing range of questions and they pass quite unexpected comments. You will find that sometimes the comments completely stump you. If you are uncertain as to how to address their breastfeeding concerns or questions, you should ask them why they asked the question or passed the comment. Sometimes they have misinterpreted or misunderstood a family comment or experience, so they need to gain more information about the situation to be able to put it into context. If they remain concerned and you don't know the answer, you should refer them to their caregiver or a lactation consultant.

4.6 Conflicting advice

As with any skill we learn, our 'introduction' to it can have an enormous impact on the outcome. New parents are on an emotional roller coaster so they are receptive to all information and are vulnerable in their aim to be 'perfect parents'. Comments such as 'every midwife had a different way of showing me how to breastfeed' and 'everyone tells me something different' are unfortunately quite common in the early postnatal weeks.

There are strategies you can use to prepare women and men for the varied advice they may encounter. Probably one of the most effective is encouraging them to discuss the breastfeeding experience with friends or family who have a newborn. Attending a coffee morning, such as those run by the Nursing Mothers' Association of Australia, is another way of making them familiar with the reality of the experience.

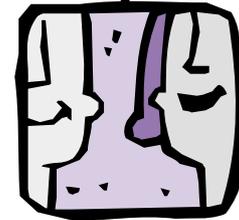
Throughout this module we have emphasised that the breastfeeding experience is a very individual one for everyone involved, rather like the birth. Therefore, as an educator you need to familiarise yourself not only with how women perceive breastfeeding but also the effect it has on their partner and their relationship. Speaking to men at your antenatal program reunions can be very enlightening and useful, as the information they give you can be shared with the participants in your future programs.

Think



Within your local community and even amongst health professionals you will find there are many half-truths, myths and rules about breastfeeding that can impinge on a woman's breastfeeding experience. For example, 'Don't wake a sleeping baby' and 'There is "only" colostrum in the first few days, it won't be enough for the baby'. What are other half-truths, myths and rules you have been told? From where do they originate in your community and how are they defined?

Tip



Myths, half-truths and rules can have quite an effect on breastfeeding, so it can be useful to incorporate them in your session or program. For example, you could:

- address them as a specific learning activity. See Module 8 for an example of how to do this;
- address them as they arise;
- offer a special program for the significant other/s or cultural leader/s if they are the instigators of the myths;
- invite the significant other/s, for example the grandparent/s or cultural leader/s, to your antenatal session or program to discuss current breastfeeding practice;
- provide your participants with a list of useful resources, such as the NMAA *Especially for Grandparents* booklet.

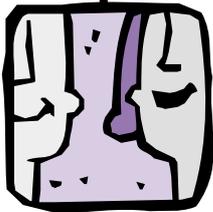
Think



Take a few moments to reflect on antenatal program reunions that you have attended. Record, in point form, the answers to the following questions in your notebook.

- How have the women and men described the breastfeeding experience in hospital?
- How have they described their experience at home?
- Did the men's description of the experience differ from that of the women? If yes, how was the experience different for them?
- What enhanced the breastfeeding experience for them?
- What hindered their experience?

Tip



Differing language and conflicting advice are commonplace and are problems that new parents confront. What activities can you think of to prepare them for these occurrences?

An example of a simple activity is to ask all participants *How do you bake a chocolate cake?* The outcome could be many and varied – ingredients, methods, timing etc. – but the result will be a chocolate cake.

4.7 The spoken and written word

The language surrounding breastfeeding can have a powerful effect on families. Words such as tits, boobs, sagging breasts, leaking breasts, inverted nipples, flat nipples have negative connotations, often offend, and can denigrate women. Even mentioning 'successful' in relation to breastfeeding automatically implies that the opposite equals 'failure'. Think about the words you use and try to rephrase them to be positive, descriptive and enhancing.

As an educator you also need to be familiar with the colloquial expressions used by your clientele and adjust your vocabulary accordingly. For example, if you are facilitating a group of young women, terms such as 'boobs' may be acceptable. This also applies to groups with participants who speak languages other than English, as the word 'breasts' in some cultures is not acceptable.

The spoken and written words you use should not only be consistent, they should be correct. Just think of the following examples and the impact they can have.

Example A: The local hospital's breastfeeding handout tells mothers of premature babies to express their milk every four hours. If the women are told verbally by staff to express six times in 24 hours, confusion is the likely outcome as the mother has been given two different types of information. Use the same language – be consistent.

Example B: The breastfeeding resource book your participants are using has incorrect pictures of attachment and positioning. The verbal description of the correct way could be diluted by their 'vision', as visuals have a stronger impact on learning than words.

Preparing parents for mixed messages and conflicting advice during the antenatal and postnatal period can assist them to filter the information they receive. This will empower them to verify the information they are receiving and accept or reject it.

5. THE BENEFITS OF BREASTFEEDING

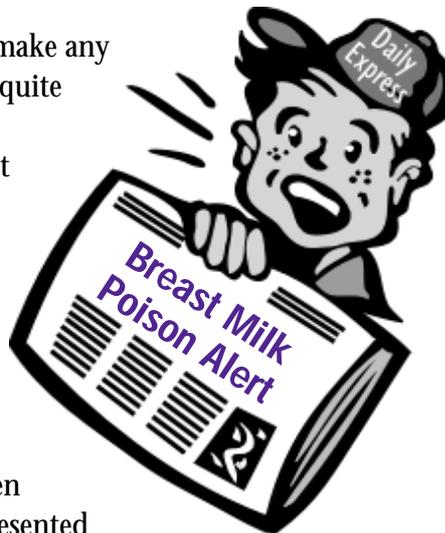
There are many advantages to mother, baby and society when women breastfeed exclusively for at least the first six months. Health benefits continue with the duration of breastfeeding and beyond. These advantages are well supported by research¹⁴ and apply in both developed and undeveloped countries. As we stated earlier, most women know the benefits as they are readily available in professional and lay breastfeeding journals, books and the Internet.

5.1 The media and breastfeeding

The advantages of breastfeeding can be sensationalised by the media, which frequently creates unnecessary concern and guilt for parents. As an educator it is your responsibility to remain in touch and up-to-date with the latest information, research, products and what the media is telling the community about breastfeeding. If you have heard about but don't know the details of an important, recently published article or book, it is advisable to find out more, as you are likely to be asked questions about it by one of your participants.

Two examples of newspaper headlines that are alarmist and inaccurate, or partly so, are:

This headline would make any breastfeeding mother quite concerned, as the last thing they would want to do would be to poison their baby. However, when you read the commentary of the article in Module 11, you will see how facts have been misinterpreted and presented as a simplistic alarmist headline.



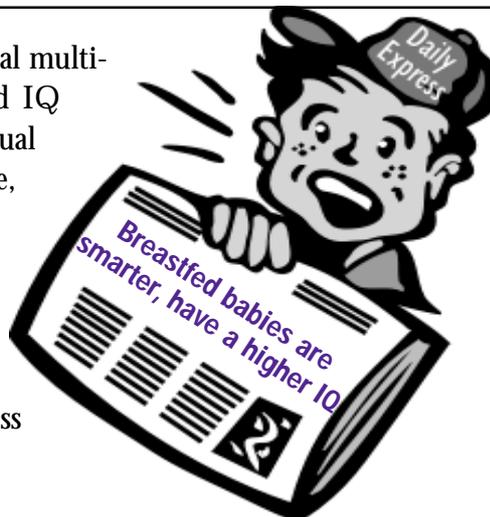
Think



On week three of your antenatal program Brett and Shona arrive brimming with the latest research relating to breastfeeding that was aired on the early evening TV news.

As the room becomes electrified with this news, you realise that it is full of half-truths. How would you deal with this situation?

This information, though based on excellent, longitudinal multi-centred studies, compares early feeding methods and IQ outcomes. It places less emphasis on the verbal and visual interaction between parents and their babies over time, which makes an important contribution to IQ. If you breastfed your baby and kept it in a black box, it would not have a very high IQ. The research, however, can encourage and support mothers who breastfeed their neurologically compromised babies, when there is pressure from others to bottle feed because it is seen as less time consuming.



The amount of information available to the public today is overwhelming. The media, the Internet and a plethora of breastfeeding publications are accessible. Keeping up-to-date as an antenatal educator need not take a great deal of time or effort if you know the key resources to access. In Australia the primary resource for information about breastfeeding is the Lactation Resource Centre. For contact details please refer to Module 6.

6. YOUR ROLE AS AN EDUCATOR

Through this module we have given you a number of ideas as to how you can prepare your participants for their breastfeeding experience. Please review these suggestions and refer to the activities we have provided in Module 8. Above all please remember that antenatal breastfeeding education should be balanced, non-judgmental and it should:

- allow the participants to explore the issues that are of importance to them and encourage them to consider the implications of their infant feeding decisions;
- provide the participants with an understanding of how the mother, baby and the breast interact physiologically and emotionally, and the factors that can influence this interaction;
- introduce the skills that are required for a positive breastfeeding experience;
- emphasise the importance of a postnatal support network. Participants should be encouraged to plan the support that will assist them practically as the woman and baby establish their breastfeeding relationship;
- acknowledge the cultural and social context within which the learning occurs.

7. CONCLUSION

Congratulations, you have now completed Module 3 – The breastfeeding experience. In this module we have explored:

- how women and men describe their breastfeeding experience;
- the diversity of the breastfeeding experience for those involved;
- how breastfeeding is initiated and maintained;
- factors that influence the physiology of breastfeeding;
- the role of an antenatal educator in preparing participants for the breastfeeding experience.

We hope this module has given you an understanding of the breastfeeding experience and how you can prepare women and men for the reality and the individual nature of the experience.

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Facilitating antenatal groups

CONTENTS

1.	Introduction	48
2.	Antenatal group participants	48
3.	Understanding antenatal groups.....	50
4.	Factors that influence group functioning.....	51
5.	Gaining confidence	54
6.	Your role as an educator	55
7.	Conclusion	56
8.	References	56

1. INTRODUCTION

Just as the pregnant woman develops physically and emotionally through her pregnancy and parenting experience, your role as an antenatal educator changes as you gain experience and insight. The knowledge and skills you develop have the potential to transform you from the tentative, inflexible beginner, to the creative, adaptable, experienced facilitator.

Facilitating a group is a skill that develops over time and, in fact, continues to develop even when you think you are experienced. This module is simply to get you started – it is not a comprehensive guide, rather it highlights the vital information we all require as antenatal educators.

1.1 Learning outcomes

Upon completion of this module you should be able to:

- identify the characteristics of antenatal group participants;
- describe factors that can affect the functioning of antenatal groups;
- identify areas for your own professional development as an educator.

2. ANTENATAL GROUP PARTICIPANTS

As an antenatal educator you mainly work with motivated, enthusiastic adults who already have a wealth of knowledge, so the approach required is quite different from that which you may have experienced at school, college or university. Take a few moments to consider this difference and as you do think about groups you have facilitated, people you have taught and groups you have participated in as an adult. Now write your responses to the trigger statements, in the accompanying activity, in your notebook.

Adults have knowledge, they have experience and they have values and attitudes that they like to have respected. Understanding the special qualities of antenatal group participants should both reward and challenge you as a developing educator.

Antenatal group participants:

- **have specific learning needs.** You may think you know why they are attending your program or session, but it is worthwhile checking the specific needs of the group. They may be different from those that you expected.

- **bring knowledge and experience to any learning situation.** Sometimes you can feel as though they know more than you do, but in most situations the knowledge they have is fragmented or incomplete. Agenda setting and questioning are techniques you can use to gauge the level of the group. Respect their knowledge and when it is appropriate use their comments as a springboard for further group discussion.
- **are stimulated by variety.** Adults hear what they want to hear, see what they want to see, and pay attention to whatever is relevant, interesting or stimulating. Providing a range of relevant learning strategies within a session sustains interest. For example, within a one-hour session you could begin with a 10-minute icebreaker, then a 15-minute mini lecture or demonstration and conclude with a 35-minute small group discussion with some large group feedback.
- **expect their dignity to be respected.** No one likes to look stupid, foolish or 'exposed' in front of other people. To prevent this from occurring, try to create an atmosphere that is informal, relaxed and non-judgemental. For example, when the group is using dolls to practise positioning and attachment, do not single out participants who are incorrect, but rather make suggestions on how it should be done to the group as a whole.
- **value their independence.** When adults are treated as if they are dependent beings, their pride feels attacked and their self-respect is undermined. Adults do not appreciate people talking down to them or treating them as children.
- **have strong feelings about learning situations.** Some don't like being lectured to, some hate role-plays, others hate butchers paper or group discussions. Provide a range of learning strategies, make them relevant and be aware of the terms that you use. For example, talking about 'classes' could remind participants of school, so you may like to refer to 'programs' or 'sessions'.
- **like to understand what they are expected to do.** Adults can worry about keeping pace with the demands made upon them. At the beginning of each activity outline the purpose, the timing and the feedback mechanism for the activity.
- **need time to unwind.** Adults can come to a learning situation with 'things on their mind', for example, today's worries, family problems and decisions to be made at work. Greet each person warmly and help him or her to relax by playing background music and offering refreshments. It is a good idea to begin each session with a group activity, such as an icebreaker.
- **have attitudes and beliefs.** Firmly established attitudes and

Think



In a learning situation:

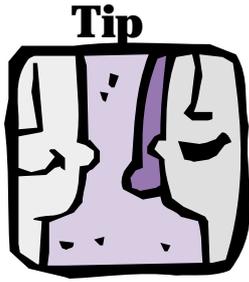
adults are

adults like

adults need

adults hate

To enhance their learning I can



There are several ways to discover participants' learning needs, or 'agenda set'. At the beginning of a program/session you could:

1. ask each participant to introduce themselves and state two things they could gain from the program. Although many educators use this method, it may not give a true indication of their learning needs. Participants tend to repeat what others have said and it lacks anonymity, so participants rarely raise sensitive topics;
2. give each participant a piece of paper and ask them to write down three things they could gain from the program. For example, specific topics they would like covered, questions they would like answered or how they wish to feel by the end of the program. Responses can be read to the group or transferred to butchers paper for reference during the program;
3. divide them into groups of 4-6 people, mixed or single gender. Ask each group to write on butchers paper their expectations, needs, and the questions they would like answered during the program. This information is then fed back to the whole group and referred to throughout the program.

beliefs can slow any changes you propose. To help participants deal with change, allow them time to explore and discover how the new way of behaving or thinking can be more productive than the old. It is only when results can be seen that attitudes and behaviour will change. Incorporating decision-making and problem-solving activities, as well as group discussions, in your sessions should help in this regard.

- **have an inner strength.** Encourage participants to trust their own judgements and find solutions to their problems. Decision-making activities in a group learning situation can assist in this regard.

3. UNDERSTANDING ANTENATAL GROUPS

Many people think that a group is a collection of people who have come together for a particular reason. A purposeful group is much more than that – it is an entity with its own physical form, its own personality, its own potential and its own limitations. As the educator you are a part of the group.

When you begin as an educator it can often feel as though the group and yourself are separate entities. You are the expert and they are your pupils. You stand in front of the group and you teach them everything you want them to know. As you gain confidence in the subject matter being covered and your people management skills improve you begin to relax. Eventually you realise that you do in fact become a part of the group to a greater or lesser extent – you may become an acquaintance, a friend, and a sounding board for their ideas. Allowing this to happen, or 'letting go' as it is often called, can be awesome as you may feel as though people won't learn anything if you don't actually tell them. **REMEMBER** – adults have knowledge, they have experience and above all they like to participate in their learning. Relax and enjoy the process.

As mentioned earlier, groups have a physical form and they have their own potential. They can be open or closed, formal or informal, structured or unstructured, time limited or ongoing, productive or unproductive. The purpose of the group and the qualities of the group participants normally predetermine the physical form or structure of a group. For example, most antenatal education programs are closed and time-limited in order for the participants to have a chance to form a support network for themselves whilst they are gaining the knowledge and skills they require. The potential of the group primarily depends upon the skill of the educator or leader, who is now commonly referred to as the group facilitator.

Group facilitation is the art of guiding a group towards its goal. It is a process that is hard to describe and therefore difficult to teach, because it basically occurs as you gain experience and confidence. Watching others lead groups and facilitating your own are the most effective ways of becoming familiar with the process. An understanding of the factors that affect group functioning should enhance the process.

4. FACTORS THAT INFLUENCE GROUP FUNCTIONING

4.1 Style of leadership

A collection of people is not necessarily a group and a group is much more than the sum of its parts. It is through the medium of the group that its members are helped to move towards their goals. Thus one of your main roles as a group facilitator is to help the group develop, as far as it is capable, into what is described as a goal-directed, mutual-aid system.¹

A study of effective leader techniques found that it was not the methods used by leaders that were important, but rather the qualities and attributes of the leaders themselves.² Effective leaders were friendly, confident, organised, sensitive to group needs, had realistic expectations of the group and self, were creative and adaptable, had good time management skills and they knew their own limitations.

When you observe group leaders you will notice that they have particular qualities, but they also have what is described as their own leadership style. At one end of the continuum there are the autocrats who are task-focused, directive and they determine how and what the group will do. In the middle there are the democrats who are willing to share the leadership role when appropriate, they are task and group-centred and they have a changing role within the group. At the other end of the continuum there are the laissez-faire leaders who are non-directive, focused on the needs of the group and who allow the group members to decide how things will be done. No one style of leadership is correct, but rather the personality of the leader, the purpose of the group and their present level of functioning are factors that influence the style used in a particular situation. Being flexible is the key.

To be able to decide whether a group is functioning and developing as well as would be expected, you need to have a clear idea of what the group should be like, given its specific characteristics. You also need to know what the group members

Think



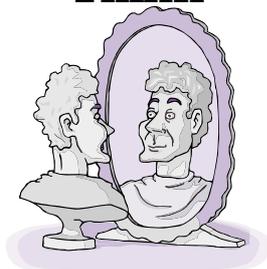
Take a minute to think about your role in an antenatal group and then answer the following questions in the notebook.

When you began life as an educator did you feel as though you were a part of the group?

For those of you with some experience, do you still feel the same way?

If your feelings have changed, why do you think this is so.

Think



Take a moment to think about a group learning situation you have experienced as an adult and that you enjoyed. Why did you enjoy it?

List, in your notebook, the qualities of the person leading the group that made the group enjoyable. What did they say, do and how did they act?

Now think about a group learning situation that you did not enjoy. List the things the leader said or did that made learning difficult for you.

Think about the qualities of the effective group leader and as you do so think about the factors that enhance adult learning – what are the similarities?

Finally, think about the qualities you recognised in the effective leader. Which of these qualities do you already possess? Which of the qualities require further development? How can you develop these qualities?

expect the group to be like. As mentioned earlier in this module, an assessment of the group needs, goals, or agenda setting should occur early in the life of the group.

4.2 Participant attributes

Age, sex, ethnicity, educational status, personality and health status are all qualities of group participants that can affect the functioning of the group, and while these characteristics cannot be changed, you as the facilitator need to be aware of them. We live in a multicultural society in contemporary Australia.

As we mentioned in Module 2, an important issue is that women of non-English speaking backgrounds do not always perceive that Australian women breastfeed. The antenatal group process can help dispel this perception. There are times when it can be helpful to have specific sessions for minority groups, such as when language or age is an issue, but in many situations multicultural groups can be very enriching. They break down barriers and can contribute to multicultural, postnatal support groups.

4.3 Group size, structure and stage of development

Group size and structure, the stage of group development, the physical environment, seating arrangements, your style of leadership and the roles participants play are other factors that can affect the functioning of your group, but they can be changed. So let us spend time examining each of these.

The size of the group can have a large effect on the amount of interaction. Educational theorists³ state that to establish a sense of cohesion and trust amongst the members in a group the maximum size of a group should be 8-12 participants. Experience demonstrates, however, that the most appropriate size depends upon the nature and type of the group. In the antenatal education arena, there are many situations when the total number of participants has to be 18-22, which is almost twice the recommended size. If this occurs in your sessions just remember that when you need active participation or interaction, your large group can be broken down into sub groups, either single or mixed gender, for group discussions.

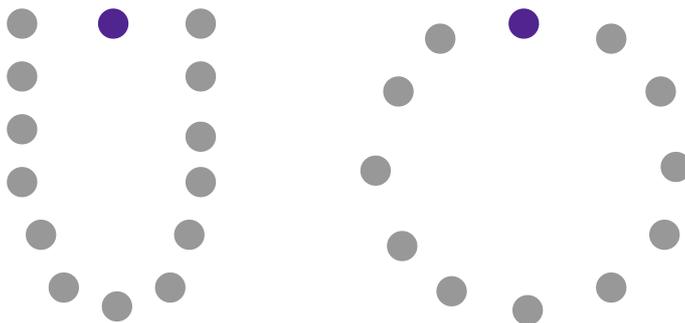
As mentioned earlier, the form or structure of a group can vary. To determine what is appropriate you should identify the purpose of the group, the resources that are available and investigate what works for others. For example, you may have heard that in another rural area they offer an ongoing support group for young expectant women at the local youth and community centre. If this concept interests you, contact the

educator involved and arrange a visit for yourself. As educators commonly say – why reinvent the wheel if you can replicate something that is working for a colleague. Just remember to check that the conditions and resources you have are similar to those of your colleague.

An effective educational group is dynamic and has what is described as a life cycle. We all know that a group has a beginning and an end, but few group facilitators realise that there are important stages in between that they can influence. Forming, storming, norming, performing, adjourning are the stages outlined by Tuckman.¹ Please familiarise yourself with this concept as the stages affect how your sessions work.

4.4 The physical environment

The ideal physical environment for a group should be well ventilated and lit, have free space, accessible toilets, refreshments available and minimal distractions. The seating arrangements in the room probably have the greatest effect on interaction. Just think about the following seating arrangements.



Which seating arrangements would enhance interaction between group participants? Most participants do not like talking to the back of a person's head, so these examples are the preferred arrangements.

Having a break in your session is another way of enhancing group interaction. It is a well-known fact that the concentration span of an adult is approximately 20 minutes, so providing a variety of learning strategies during your session and having a break can have a dramatic impact on the amount of learning that is achieved.

4.5 Strong personalities

One of the greatest concerns of a less experienced educator is how to deal with strong personalities in a group. Individuals occasionally assume roles within a group that are either an

Reading



For information on the qualities of effective group leaders, styles of leadership and co-leadership you may like to refer to the antenatal education reference books listed in Module 6.

Reading



For information on the stages of group development you may like to refer to the antenatal education reference books listed in Module 6.

exaggeration of their own personality or a reaction to the process they are experiencing or to a life issue they are dealing with. For example, if a woman is concerned about her ability to breastfeed because she has had breast reduction surgery, she may become a persistent questioner in the group. The know-it-all, the shy person, the passive resistant and the clown are just a few of the terms educators use to describe the roles individuals assume.



For more information on strong personalities please read the fact sheet in Module 11.

For information on how to deal with these different roles you may find it useful to refer to people management or leadership books, but before you do this stop and think about the possible reason for the behaviour. Many of the roles assumed by people are done so because of underlying insecurity, concern, and anxiety. When you think you understand the reason for the behaviour, you can then decide how to deal with it. Sometimes the simplest thing to do is to take the person aside, for example during the coffee break, and quietly ask them questions such as: 'From the questions that you have been asking I sense that you are concerned about..., is that correct?' or 'I appreciate your input – how are you feeling about...?'

4.6 Introducing new members

Adults are more likely to interact when they feel comfortable in the group. Some people develop a sense of trust in a very short time, whereas others can take hours or weeks. Using guest speakers or having participants coming and going from the group can impede this process. Guest speakers should be used only if they are the experts and can provide the group with information that you cannot provide. New members, late arrivals and early departures are all situations you can control. For example, you can get group agreements, sometimes called group rules, if you are troubled by persistent interruptions, but it is often easier to work these out with the group at the first session so they know what to expect.

5. GAINING CONFIDENCE

Being prepared, having an adequate knowledge base, feeling confident, self aware and honest and being supported by colleagues or friends are all required if you are to become an effective group facilitator. Group facilitation can be extremely rewarding, but it can be very isolating if you feel you are on your own. Is there anyone who can support you through this process of developing your skills and your confidence?

Whether or not support is available, professional development for group facilitators should involve a process called 'reflective practice'. Reflective practice is more than just learning from mistakes; it is reflecting upon what, why and how things were done and the outcomes that followed. It needs to take into consideration the positive and negative aspects of a situation.

Most educators state that they do reflect on their practice, but the majority do so by simply discussing the session verbally with their partner, peers or colleagues. Very few keep a reflective or learning journal, claiming that they don't have time or they believe that the discussion is enough. Such discussion is more likely to be a debriefing session, whereas reflection by writing allows you to debrief as well as problem solve. Maintaining a learning journal does not have to be an onerous affair; simple notes made at the time are sufficient, as long as you spend time later reviewing them. For more information on reflective writing and keeping a learning journal please refer to the reference list in Module 6.

6. YOUR ROLE AS AN EDUCATOR

Throughout this module we have emphasised that antenatal educators work primarily with adults who have specific needs, interests and concerns. They value their knowledge and their experience and they like to be actively involved in their learning.

As educators strive to give their participants the information they need to make their own decisions, it seems that many actually steer them on the course that they would choose themselves. For example, some educators tell participants that when returning to work they can continue to breastfeed if they have access to their baby or they can express and leave the milk to be given to the baby by its carer. Is this really giving the participants all the options that are available to them? No, there are other options, such as combining breast and formula feeding or weaning the baby. These may not be vocalised if the educator is a breastfeeding advocate. Personal opinions and using examples from your own infant feeding experience may give a one-sided view of a situation, so you need to consider their relevance and their consequences before they are used.

As an antenatal educator it is your responsibility to give participants the resources they require to make decisions. Sometimes this can put you in conflict with the policies of your employer. It is, therefore, important that you are familiar with the policies and practices of your institution and if you

Think



If you were told you had to facilitate a breastfeeding information session for expectant parents two hours from now, how would you feel? Do you feel prepared? Do you feel confident? How would you structure your session? What would you include in the session?

Now, take a few minutes to think about how you have gained the breastfeeding knowledge base you currently have. Does it come from work experiences, professional training, personal experience or from other sources?

Think



So, the group is waiting. You are ready to go. Take a few moments to describe how you feel.

What can you do or have you done to help you to relax?

are unsure of how to present information in a balanced way we recommend that you discuss the issue with your program coordinator or other antenatal educators.

Every time you facilitate a group you are likely to feel slightly apprehensive, in fact a small adrenaline surge is quite healthy as it heightens your senses and keeps you alert. However, if you find that your nerves are interfering with your ability to function then acknowledge that it is happening and seek assistance from the coordinator or an understanding colleague.

7. CONCLUSION

Congratulations, you have now completed Module 4 – Facilitating antenatal groups. In this module we have explored:

- the characteristics of antenatal group participants;
- the factors that can affect the functioning of antenatal groups;
- the areas for your own professional development as an educator.

Facilitating a group is a skill that develops over time and in fact continues to develop even when you think you are experienced. This module is simply to get you started. Now it's over to you. Good Luck and Bon Voyage.

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Planning antenatal strategies

CONTENTS

1. Introduction	58
2. Assessing the participants' needs	58
3. Preparing session plans	60
4. Learning strategies	62
5. Obtaining feedback	68
6. Program/session evaluation	68
7. When you are in a hurry	68
8. Conclusion	70
9. References	70
Breastfeeding: a skill to learn	71
Having a baby program outline	72
Birth and parenting in a nutshell	72

1. INTRODUCTION

Educational programs, sessions and strategies are the 'mark' of an educator; each one is a unique journey that requires careful navigation. As with any journey one embarks upon in life, planning is essential if the outcome is to be positive.

Antenatal educators in Australia mainly work within facilities that have education programs and strategies designed for expectant parents. For example, birth and parenting programs that run weekly late in pregnancy, weekend workshops and ongoing support groups. It is your responsibility to ensure that the programs and strategies have been designed to meet the needs of the participants.

1.1 Learning outcomes

Upon completion of this module you should be able to:

- describe how to assess participant needs;
- write a breastfeeding session plan;
- identify strategies that enhance expectant parents' learning;
- describe how feedback and evaluation can be obtained from participants.

2. ASSESSING THE PARTICIPANTS' NEEDS

An assessment of the participants' needs is important when planning any educational program/session. What do the participants really want? Do they want to know the practical aspects of how to breastfeed a newborn? Do they want to know what it really is 'like' to breastfeed? Do they want one session in their program dedicated to breastfeeding or would they prefer to have the information integrated through the program?

2.1 Agenda setting

In Module 4 we emphasised the importance of involving the participants in their learning and we suggested that one of the most effective ways of doing this was to undertake an agenda setting exercise at the beginning of the program/session. Agenda setting is, however, a fine-tuning exercise that gives you insights into what the participants in a specific group want from their program. It allows you to adapt your input to the participants' needs. It does not answer the more complex questions required by program planners. A comprehensive needs assessment is the only way to answer questions such as the final one posed in the paragraph above.

2.2 Needs assessment

A needs assessment is a process that identifies the reported needs of an individual or group. It can focus on a particular strategy, such as an educational program, but a needs assessment should also see the program within its wider social context. It provides a logical starting point for program development and it can be used as an ongoing process for keeping strategies on track. The main advantage of a needs assessment is that it enables activities, such as educational programs, to be guided by realistic data or information gathered from the people who participate.

The data required for a needs assessment comes from a number of sources. This is because human needs are ever changing and, as Bradshaw identified in 1972,¹ there are four different dimensions or types of need.

- Normative needs are the needs of a community as defined by an expert or a professional.
- Felt needs are what the community says it wants, for instance through a community survey.
- Expressed needs are those needs that have been expressed by the community. For example, names on a waiting list.
- Comparative needs arise when one community lacks services that are available in another, similar community.

Ideally data should be collected from:

- the target group or the learners;
- key informants or subject experts;
- demographic and statistical data;
- literature review.

The data collection methods in a needs assessment include surveys, in-depth interviews, focus groups and computerised record keeping. The aim is to provide a comprehensive picture of the target population and an understanding of the gaps that exist in current services or programs.

The antenatal program outlines and several of the strategies/activities provided in this handbook are based on the results of a needs assessment conducted by the principal author, Jane Svensson, in 1998/9 as part of her doctoral studies. Data was collected from women and men pre and post the birth experience, from caregivers and associated health professionals, from antenatal educators, demographic data and a review of health education and adult learning literature. The aim of the project was to develop educational strategies that were based on the needs of the participants, were grounded in adult learning theory and, more importantly, would prepare women and men for the birth experience as well as the early postnatal period.

Reading



For more information on the needs assessment process you may like to refer to the health education reference books listed in Module 6.

2.3 Quality improvement activities

Experience demonstrates that many educators believe that program planning is not their role, but rather that of the program coordinator. However, being actively involved in quality improvement activities, such as program evaluation surveys, is your responsibility and it is another way of assessing needs. In addition, as an educator, you are the person who has the most contact with the participants themselves so you have the unique opportunity to hear comments directly from them. The comments and feedback you receive at the 'coalface' provide the information coordinators need to ensure participants are receiving the information they require. Regular team meetings and an annual review of the programs and strategies provided by your facility are important if you and your programs are to meet the needs of the local community.

3. PREPARING SESSION PLANS

Planning is an essential ingredient in the overall program development process, but it is also required at all levels of the process. So prior to any session you are to facilitate, give some thought to what you plan to do, how you will do it and what you expect the outcomes to be. Writing aims and objectives and expanding them into session plans is time consuming, but this habit makes you think about the content and process of the session and the program as a whole.

Session plans are a guide – a tool to help you to get everything ready when you are preparing your session. They are basically a set of notes that list in a logical order what will happen during the session. They outline the:

- aims of the session;
- desired learning outcomes of the session;
- topics and issues to be covered;
- learning strategies to be used;
- time allowed for each strategy;
- resources that are required.

At the end of this module we have provided an example of a session plan and two program outlines that you may like to use. Read the session plan carefully and think – 'Does it have all the information I require to be able to facilitate the session?' You should be able to simply pick the plan up, together with your resources, and begin the session. When you write your own, don't be tempted to leave them half done. If you are sick and a colleague has to take over, they will need to use your plan as a guide.

Think



- What can you do to make the programs offered by your facility or hospital more appropriate for the women and men who attend?
- What can you do to ensure that the sessions you facilitate meet the needs of the participants?

Session plans may appear to be prescriptive, but unlike other plans that you may have used, they are only a guide. Adult learners learn more when the information they receive is relevant, so there are times when you should capture an opportunity, such as answering specific breastfeeding questions during a labour session, rather than strictly adhering to the plan. In addition you need to consider alternate strategies to achieve the same outcomes, as you may need them when, for example, the equipment fails to operate or is not available despite careful planning.

As you read through the example, provided at the end of this module, you will notice that:

- an **aim** is a statement that gives a general idea of what the session hopes to achieve. It provides a focus and a sense of direction without any details. It does not state how the outcomes will be achieved.
- **learning outcomes**, or objectives as they are sometimes known, state precisely what the participants will learn or achieve as a result of attending the session. They are the specific steps taken to achieve the aims of the session. They are usually prefaced by an opening statement such as 'by the end of this session participants should be able to' and they commence with an action verb. Action verbs are used so the outcome can be measured. A few examples you may like to use are identify, list, describe, demonstrate, and perform.
- **learning strategies** explain how the information will be presented. When determining the strategies you will use, keep the learning outcomes and the participants in your mind. If the outcome relates to a manual skill, the strategy used will be more effective if the participants have an opportunity to practise the skill.
- **time allocation** is an approximation. When planning sessions you should write a list of the topic areas that are very important and another of those that are to be covered only if time allows. Decide how you will present each topic and then allocate enough time for each to be covered effectively. As the session unfolds do not be surprised if your timing is unrealistic, as active learning strategies stimulate interest, interaction and participation, which all require time. If this happens refer to your 'must include' list and begin to prioritise the items you wish to include.

4. LEARNING STRATEGIES



For more information on program planning please read the fact sheet in Module 11.

The strategies or ways you impart information to a group are commonly called learning strategies and can be divided into two main groups, teacher-centred or learner-centred. Direct instruction, lectures and deductive teaching are teacher-centred strategies because the teacher controls what and how the students will learn. Discovery learning and inductive learning are learner-centred because they place a greater emphasis on the learner's role in the learning process.² With learner-centred strategies the teacher/educator sets the learning agenda or learning outcomes, but does not have direct control over what and how the participants learn.

When considering the strategies to use in your sessions, you need to have a clear idea of what you want the participants to be able to do as a result of attending the session. For example, if you want expectant parents to explore their feelings and concerns about breastfeeding, you could involve them in either a small or large group discussion so they can share their feelings, their concerns and gain support from each other. Peer support, as stated in Module 3, engenders a sense of personal empowerment and it gives credibility and value to individual ideas.

Learning strategies are not 'right' or 'wrong', but some are more effective than others in particular situations. You need to use a variety of strategies and decide when each one is likely to be more effective in meeting the needs of the group and the learning outcomes of the session. In addition, a range of strategies is required to accommodate the different learning styles of the participants. For example, a mini lecture followed by a group discussion with feedback and then a practical component on the same topic would serve the needs of visual, auditory and kinaesthetic learners. Enhancing these strategies with the use of a modulated voice, music, visual aids and bright colour will add vitality to your presentation.

In their quest to make sessions interesting educators can become so enthusiastic they try to integrate as many learning strategies into their programs as they can. This often creates a sense of confusion and can actually impede the learning process. Just think how the group would feel if you began the session with an icebreaker and then they went from one group discussion to another, then to a game and back to another small group discussion finishing with a video and then a problem-solving activity? Probably exhausted. The following guidelines should alleviate such problems.

4.1 Guidelines for the use of learning strategies

All strategies should:

- **have a purpose.** Learning strategies can be used to relay new information, to reinforce information already covered, stimulate discussion on a particular topic, increase confidence or enhance an individual's ability to make decisions. At times they can simply be used to lift energy levels or provide time for social interaction.
- **be clearly introduced or explained.** Adults will respond positively to a learner-centred strategy if it does not seem pointless or child-like and group members understand what they are going to do. Demonstrations may need to be given. Clear feedback instructions help to reduce anxiety.
- **have realistic time limits.** Learner-centred strategies frequently take longer than you anticipate because they stimulate interaction. Observe the group and decide whether interaction is more important than keeping to a strict time schedule.
- **have an appropriate closure.** For example you may need to follow a learner-centred strategy with a discussion to fill in the gaps or sort out misconceptions.

Strategies will be more effective if the materials required are prepared in advance and organisational details have been determined. Think of effective ways to distribute materials, such as cards, paper, pens etc and consider the amount of space the groups will occupy to complete a particular activity. Decide in advance the composition and size of sub-groups if you are using them and explain the type of feedback you expect from participants before they begin an activity.

4.2 Group discussions

As individuals we are involved in numerous verbal interactions with other people every day, but when placed in the learning environment the atmosphere is different. Triggering and sustaining a group discussion can be difficult. Thoughtful preparation, gaining experience with questioning techniques, trusting yourself and the ability of the group can help to overcome problems.

As you will discover in Module 8, there are many issues surrounding breastfeeding that lend themselves to a group discussion. Discussion is the art of cooperative thinking aloud, so it can be used as a part of the session, as a whole session or it can be carefully integrated with another learning strategy. It can involve the whole group or sub-groups and these can be mixed or single gender. You just need to know why a group

Think



Listed below are a number of strategies by which information can be communicated to a group. Tick the strategies you have used and think about the effect they have on the group. Which of them enhance group interaction? Which enhance group participation?

- Group discussions
- Demonstrations
- Role-plays
- Scenario cards
- Brainstorming ideas
- Buzz groups
- Case studies
- Lectures/talks
- Graffiti sheets
- Posters/charts
- Handouts
- Videos

All learning strategies have benefits and problems, so before returning to the text take a moment to think what these might be and when each strategy could be used. Write your ideas in your notebook.

discussion is the most appropriate strategy for covering the topic at the time and you need to be aware of the likely outcome of the discussion.

4.3 Questioning

Questions are an important component of a discussion, but questioning is a skill that has to be learned. For example, how many times have you shown a group a video, switched it off and then had very little response to the following question: 'Well how did you find the video?'

Prior to presenting a question to a group, you should prepare them. Give some background information on the topic if this is required and explain why you want their point of view or input. When you present the question, pose it, pause so they have time to think, and then restate the question. If necessary use a prompt, but do not give too much additional information as it may confuse the group.

Questions fall into two categories – closed or open. Closed questions require a limited response, such as 'yes' or 'no', and typically they have 'right' and 'wrong' answers. Open questions require thought and an organisation of knowledge and facts into an appropriate response. Unlike closed questions there are no right or wrong answers – rather they are the why, how and what questions.

When using questions to stimulate discussion and to maximise the number of participants who respond to the question, you may need to break the large group into sub-groups prior to the event. Your question/s can then be presented verbally, on trigger cards or on a graffiti sheet, as described later in this module. Whichever method you use, you should give the group an understanding of the type of feedback required at the end of the discussion. If the topic is controversial or sensitive it may not require feedback, but it will require a closure.

Closing a group discussion is extremely important as without an obvious conclusion participants can be left wondering why they undertook the strategy or they may come away with misconceptions or misinformation. Closure can consist of a summary or an evaluation of what has been discussed. It can include gathering feedback from the groups, asking participants for any final comments or questions and thanking them for their contributions.

For your own credibility it is important that you respond openly and honestly to any comments made in the closure of a group discussion. Occasionally comments and questions can take the discussion into areas that you are not familiar with. If

this happens and the participants want to know more about the issue, refer them to appropriate resources and they can do their own homework.

4.4 Spontaneous questions or comments

Spontaneous questions and comments are those that are asked or stated by the participants during a session. Although many educators respond to them immediately, they can be used to trigger a group discussion. For example, if a participant asks 'How long should I breastfeed?', it could be helpful to gain the input of the group. To do this you could refer the question back to the group by saying 'Well what do you all think – how long do you think you should breastfeed?'

This strategy can stimulate an active discussion but it should only be used when the input of the others would be beneficial. You can easily lose credibility if you never give a direct answer. However, be careful of giving an ill-informed or incorrect answer, as many of the questions you are asked have no right, wrong or specific solution. They need to be considered before being answered. For example, in response to the question above you could describe a range of six months to 2-3 years and the advantages and disadvantages of points across the range.

4.5 Graffiti sheets

Group discussions are an excellent way of gaining information and of sharing ideas and concerns. Beginning a discussion can, however, be difficult during the early part of a session if your group does not interact readily or when the response to a sensitive issue is required. Graffiti sheets can be useful in these situations as they provide input, through an anonymous means, from the participants, which is then fed back to the group.

Large pieces of butchers paper are required for graffiti sheets and thick marking pens for the writers. For a group of 20 people it is best to have 4-5 sheets placed around the room on tables or benches. Across the top of each sheet of paper write an open-ended statement for the participants to complete. Each sheet should have a different statement. Participants are asked to move around the room and to complete the statements as they like. They should **not** take time considering their response, they should **not** discuss it, they are **not** to read the other responses; they are just to write the first thing that comes to their mind. Graffiti sheets are an anonymous form of brainstorming.

When the participants begin to mingle and it appears that all their ideas have been listed, ask them to return to the large group for a discussion on the comments made. The most effective way of triggering a discussion from the comments is

Reading



For information on how to gain and maintain attention in a group please read the fact sheet in Module 11.

Think



During the closure of a group discussion one participant responds to your question in a totally unexpected way. For example, in small groups the participants have been discussing the benefits and problems of feeding according to need for the mother, baby and the family. The feedback from the groups suggests that feeding according to need is beneficial for all involved. Joanna, however, totally disagrees and states that 'feeding according to need is an absolutely ridiculous idea as you will just spoil the baby and make life difficult for yourself. You have to feed every four hours – there is no other way to do it'. How would you respond to this situation?

Should you disagree with Joanna and run the risk of being judgmental of mothers who find routine necessary and suitable for themselves and their baby? What should you do? Take a few moments to think about this situation and write a response in your notebook

for the feedback to be given by participants. If the educator takes the sheets the group may not respond and it can be tedious having one presenter. In Module 8 you will find several activities that use trigger questions to stimulate group discussion. You may like to use graffiti sheets instead of the suggested cards.

4.6 Models and visual aids

Models and visual aids, such as those provided in Module 3, can enhance a presentation, they support those who are predominantly visual learners and can be used to communicate information and trigger group discussion. Throughout this handbook we have given examples of how and when specific visual aids can be used, but there are many more. Be creative and discuss ideas with your colleagues.

4.7 Videos

Videos, such as the one that accompanies this handbook, can communicate information, reinforce issues already discussed and stimulate thoughts and discussion within a group. Most videos can be used at any stage in a session, such as the beginning, middle or end, but read the video jacket prior to use as it may give specific instructions. Some videos can be used in their entirety, but you will find many are divided into scenes/segments as they are long and very informative. For example, the video *Breastfeeding and you: preparing the way* has six scenes and each one can be used independently to trigger discussions in your sessions.

Prior to using any video you should become familiar with its content and think of how a group would respond to it. You should decide when in a program/session it will be shown and whether it will be shown from beginning to end, or in segments as described above. You may even like to discuss your ideas with your colleagues or have a 'dress rehearsal' with your friends.

Check the VCR and monitor and track the video prior to the session, give an overview of its contents before it is viewed and allow time for small or large group discussions and comments at the end. Presenting the group with trigger questions, such as those provided in Module 7, can encourage an active group discussion.

4.8 Reference material

Expectant parents may be receptive, but as with any learner they will only retain a small percentage of the information they acquire from any session they attend. To reinforce and increase

the retention of important information, as well as address issues you have been unable to cover, you should provide reference material, such as the handouts in Module 9.

Reference material can, however, be expensive to reproduce and may have a limited life span, so make sure that handouts and brochures are accurate, concise, up-to-date, meet the needs of the participants and do not contain unacceptable advertisements. In Module 6 we have listed Internet sites that provide a range of information for you and the participants.

4.9 Visualisations

Visualisation, sometimes referred to as guided imagery, is a technique that through the process of relaxation transposes an individual from their current environment to an imaginary or special place so they can become familiar with it. It is a way of allowing intuitive thoughts to be released and inner wisdom to be revealed. Goal-directed visualisations can be used for birth and parenting issues, but care must be taken. Visualisations have the potential to unlock suppressed inner thoughts and emotional reactions.

Prior to using a visualisation with a group or an individual we recommend that you **participate in at least one yourself**. Relaxation and visualisation are techniques that have to be learned and practised before they are used in an educational program/session. Visualisation may seem an ideal way of exposing expectant women and men to situations they may encounter, but through doing so you can unlock suppressed thoughts, cause a panic or anxiety attack or if the wording used is gender specific it can exclude participants in the group.

For a visualisation to be effective, the environment must be quiet, warm and conducive to relaxation, and the participants and the facilitator need to be relaxed themselves. The size of the group may vary, but if you are dealing with a sensitive issue or you have not used visualisation with a group before, we recommend that you have a maximum of 4–6 participants. They need to understand what the visualisation will involve and they need to be aware that they can **leave the room** at any time. Offering an alternative, such as a refreshment break or another group activity, is a good idea because people who do not want to participate will feel more comfortable if they know there is something else to do.

The choice of words used and the situation that is described should be relevant, appropriate and non-threatening to participants. For this reason when you begin to use the technique you may like to use a script.

5. OBTAINING FEEDBACK

In this module we have used the term 'feedback' several times in relation to learning strategies, such as group discussions. Feedback, in this context, is the small group's specific response to the questions or discussion triggers. Feedback can be obtained by:

- a spokesperson for each group reading listed points to the large group prior to the closure of the activity;
- pinning feedback sheets on the wall. Participants can mill around them and look at the points listed by other groups;
- using white boards to record the main points, but this tends to be a slow process;
- formal feedback may not be required.

The strategies in Module 8 use a range of feedback mechanisms, so if you are unsure of when it is required please refer to them.

6. PROGRAM/SESSION EVALUATION

Your program/session ends, the participants leave and you are left wondering 'What did they think of it?' Program evaluation is the process of measuring the outcome of an activity, a strategy, a session or a program. It does not have to be an arduous task and is an excellent way to check if the learning outcomes have been achieved.

There are several ways to evaluate an educational program/session. For example, questionnaires, telephone surveys or even dartboards can be used. The method chosen depends on factors such as the depth of information required, the type of group facilitated, the reason for the evaluation and the skills of those analysing the data. The main thing you need before undertaking an evaluation is a clear understanding of what you want it to achieve. For example, if you want to know whether the participants benefited from the group discussions, ask a question about the learning strategies used, rather than focusing on the content of the session. In Module 10 you will find examples of evaluation strategies that you may like to use in your sessions.

7. WHEN YOU ARE IN A HURRY

Throughout this handbook we have emphasised the importance of basing the content and structure of your programs/sessions on the needs of the participants. We have encouraged an exploration of your local community and, in particular, the specific needs of your target population, but we realise that the time and resources required to do this may be limited. We have, therefore, included an example of a session plan for an antenatal breastfeeding information session, and two examples of antenatal program outlines which integrate many of the breastfeeding strategies/activities presented in Section Two. Please use or adapt them as required.

7.1 Session plan for an antenatal breastfeeding information session

Session plans, as described earlier in this module, are a tool to help you to get everything ready when you are preparing your session. They are basically a set of notes that list in a logical order what will happen during the session. The example presented below is for an antenatal breastfeeding information session.

The session, entitled *Breastfeeding: A Skill to Learn*, is a two-hour session which can be presented as an independent session or can be integrated into an existing program. Although 2 hours on breastfeeding may seem a luxury many of you can not afford, the session plan has been included to provide an example of an educational session plan. We hope that you will use it as it is or adapt it to meet the needs of your target population.

The learning strategies identified in the plan are those presented in Modules 7 and 8. For ease of use we have simply given the title of the activity, rather than a description of how it will be implemented.

7.2 Antenatal program outlines

The two program outlines, as mentioned earlier in this module, have been designed by Jane Svensson and are based on the results of a needs assessment conducted in 1998/9. The research demonstrated that if parenting and related issues are entwined within an antenatal birth and parenting program, instead of being covered as separate entities, then the information is more likely to stimulate interest and be retained by the participant.

The *Having a Baby* program outline provides an example of how the activities presented in Modules 7 and 8 can be

Reading



For more information on specific learning strategies you may like to refer to antenatal education reference books listed in Module 6.

incorporated into a 7-week birth and parenting program. As many antenatal education programs being offered in Australia are of this duration, it was felt that this outline should be included. As models of care and the structure of programs change, you will need to adapt the outline to meet the needs of your local community.

Think



Do you have a reminder note in your diary for our handbook evaluation questionnaire? We made this suggestion in Module 1. The questionnaire is in Module 10.

For ease of use the breastfeeding and related activities have been identified by title and number. The topics and learning strategies for the remainder of the program have not been provided as we hope that our concept will be adapted to your current program.

The *Birth and Parenting in a Nutshell* program outline provides an example of how the activities presented in Modules 7 and 8 can be incorporated into a 2-day birth and parenting program. Condensed programs are becoming popular in Australia, even though it can be a challenge giving participants the information they require in a restricted time frame.

For ease of use the breastfeeding – related activities have been identified by title and number. The topics and learning strategies for the remainder of the program have not been provided as we hope that our concept will be adapted to your current program.

8. CONCLUSION

Congratulations, you have now completed Module 5 – Planning antenatal strategies. In this module we have explored:

- how to assess participant needs;
- writing a breastfeeding session plan;
- strategies that enhance learning expectant parents' learning;
- how feedback and evaluation can be obtained from participants.

Educational programs, sessions and strategies are the 'mark' of an educator; each one is a unique journey that requires careful navigation. As with any journey one embarks upon in life, planning is essential if the outcome is to be positive.

9. REFERENCES

- 1 Bradshaw J. The concept of social need. *New Society* March 30, 1972:641-643.
- 2 Killen R. *Effective teaching strategies: lessons from research and practice* (2nd edition). Australia: Social Science Press, 1998.

BREASTFEEDING: A SKILL TO LEARN

Aim of the session

This 2-hour session aims to give expectant parents an understanding of the breastfeeding process and how they can prepare for breastfeeding in the antenatal period.

Learning outcomes

By the end of the session participants should be able to:

- describe how family members can influence the infant feeding experience;
- discuss how breastfeeding is initiated and maintained;
- identify factors that can influence the physiological process of breastfeeding;
- identify community resources available to new parents.

Duration of Session 2 hours

Target Population Women and men in the third trimester of pregnancy

Materials Required Breast model, dolls, visual aids
Breastfeeding and you: preparing the way video
Breastfeeding handouts

Topic	Learning Strategy	Time	Resources
Creating a relaxed environment	Background music, name labels, refreshments	Prior to session	Tape recorder, tapes, pens labels, refreshments,
Introduction to the session	Welcome to the session and introduction of the facilitator. Overview of the session, housekeeping issues.	5	
Participant introductions	Each participant to state their name, when baby is due and one thing they would like to gain from the session.	10	
The role of family members	<i>A family feeding tree</i> – Activity 3.1 Module 8	15	Paper, pens
How breastfeeding begins	<i>How breastfeeding begins</i> – Activity 4.3 Module 8 Complement the description with the video as suggested in Activity 4.3	20	<i>Breastfeeding and you: Preparing the way</i> video Breast model, dolls, visual aids
Maintaining breastfeeding	<i>Oranges and breasts</i> – Activity 4.1 Module 8 <i>Breasts, nipples and sucking</i> – Activity 4.2 Module 8 <i>Breastfeeding according to need</i> – Activity 4.4	20	Oranges, cups, straws.
Break			
Breastfeeding experiences	<i>'What If' cards</i> – Activity 5.2 Module 8	30	<i>'What If' cards</i>
Postnatal support	<i>Community resources</i> – Activity 6.3 Module 8 <i>The 24-hour clock</i> – Activity 6.1 Module 8 to be discussed and completed at their leisure.	10	Prepared 'clocks'
Overview of the session	Summary of issues discussed and questions answered. Distribution of handouts	10	Breastfeeding handouts

Having a baby program outline

Session Number	Session Title	Breastfeeding activity to be incorporated
One	Approaching Birth	<i>A Family Feeding Tree</i> – Activity 3.1 Module 8 as homework
Two	Unraveling Labour	<i>Community Resources</i> – Activity 6.3 Module 8 as homework
Three	Labour Continues	Feedback from Activities 3.1 and 6.3
Four	Our Baby is Born	<i>The 24 Hour Clock</i> – Activity 6.1 Module 8
Five	Are we Prepared?	<i>My Needs Are</i> – Activity 6.2 Module 8 as icebreaker <i>Breastfeeding and you: preparing the way</i> video – Scene 1 Module 7 <i>Oranges and Breasts</i> – Activity 4.1 Module 8 <i>Breasts, Nipples and Sucking</i> – Activity 4.2 Module 8 <i>Breastfeeding According to Need</i> – Activity 4.4 <i>Breastfeeding and you: preparing the way</i> video – Scenes 3 and 4 Module 7
Six	Being a Mother/Father	<i>Reality of Breastfeeding</i> – Activity 5.1 Module 8
Seven	Our New Life	'What If' cards – Activity 5.2 Module 8 adapted to cover a range of birth and parenting issues

Birth and parenting in a nutshell

Session Number	Session Title	Breastfeeding activity to be incorporated
One	Unraveling Labour	<i>A Family Feeding Tree</i> – Activity 3.1 Module 8 as homework <i>Community Resources</i> – Activity 6.3 Module 8 as homework
Two	Being a Mother/Father	<i>Breastfeeding and you: preparing the way</i> video – Scene 1 Module 7 <i>Oranges and Breasts</i> – Activity 4.1 Module 8 <i>Breastfeeding According to Need</i> – Activity 4.4 <i>Breastfeeding and You</i> – Activity 3.5 Module 8

Resources for educators and participants

CONTENTS

1. Introduction	74
2. How to use this module	75
3. Breastfeeding resources for educators	76
4. Antenatal education resources for educators	77
5. Health education resources for educators	77
6. Breastfeeding resources for participants	77
7. Breastfeeding resources for participants with languages other than English	78
8. Conclusion	78

1. INTRODUCTION

The process of preparing for any major life change or journey usually includes gathering information and resources that may be required. As an educator you will be exposed to this process constantly and it will come from two angles. You will have your own learning needs to be met, but more importantly you will have the needs of the participants in your group/s.

The desire of women and men to accumulate information on an extensive range of health and lifestyle issues during pregnancy and in the postnatal period requires educators to be informed. Having up-to-date knowledge at your finger tips, being aware of your limitations and knowing where and how to access information/resources are essential skills for antenatal educators.

1.1 Learning outcomes

Upon completion of this module you should be able to:

- identify the resources that relate to your information needs as an educator working with a specific target population;
- describe how to access the resources required to maintain your own professional development as an educator;
- identify the resources that would be of interest to your target population.

2. HOW TO USE THIS MODULE

The resources listed in this module are of interest to antenatal educators, health professionals and participants. For ease of use they have been placed into five categories.

Resources and information needs are ever-changing and expanding. To keep the database current and specific to your needs you will need to check the list and add and delete items on a regular basis. This list is purely to get you started. As you read it another Internet site will have just been born!

The general reference books listed should be available in major bookshops or local libraries, but the specific resources for antenatal educators/health professionals may have to be obtained from a specialist bookshop. You could contact:

- A university or medical bookshop;
- The Feminist Bookshop in Sydney for Gay and Lesbian Parenting Books, ph (02) 9810 2666, fax (02) 9818 5745
- Specialist breastfeeding, childbirth and antenatal education bookshops. For example:

Merrily Merrily Enterprises Pty Ltd
PO Box 4500
Glen Iris, Vic 3146
Phone 1800 032 926 or (03) 9886 9399
Fax (03) 9886 9033
Email: merrily@vicnet.net.au
For all NMAA publications

CAPERS
P.O. Box 412 Red Hill QLD 4059
Tel: (07) 3369 9200 Fax: (07) 3369 9299
Email: capers@gil.com.au

ACE Graphics
P.O. Box 366 Camperdown NSW 1450
Tel: (02) 9660 5177 Fax: (02) 9660 5147
www.acegraphics.com.au

Most of these bookshops have mail order catalogues so accessing information, even in rural areas of Australia, should not be a problem.

3. BREASTFEEDING RESOURCES FOR EDUCATORS

3.1 Reference books/articles

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- Rice PL. Asian mothers, western birth. Victoria: Ausmed Publications, 1999.
- Walker M. A fresh look at the risks of artificial infant feeding. Journal of Human Lactation 1993;9(2):97-107.

3.2 Journals

- Breastfeeding Review – National Journal of NMAA, 3 issues per year
- Journal of Human Lactation – International Lactation Consultants Association Journal, 4 issues per year

3.3 Videos

- Babies of the Dreamtime – NSW Health
- Breastfeeding is Best Feeding (Teenage Mothers Talk About Breastfeeding) – NMAA Vic Branch C/- Mrs Pauline John (03) 9555 4061
- Breastfeeding Series by Chloe Fisher and Sally Inch
- Infant Cues: A Feeding Guide
- In tune with Breastfeeding
- A Guide for Successful Positioning
- Coping in the First Week
- Dealing with Problems
- Focus on Attachment
- Understanding Breastfeeding: Social and Emotional Aspects by Sheila Kissinger



For more information on the organisations and Internet sites listed in this section you may like to refer to the Lactation Resource Directory. The directory can be obtained from NMAA National Headquarters, PO Box 4000, Glen Iris, Victoria 3146. Ph (03) 9885 0855.

3.4 Organisations

- Nursing Mothers' Association of Australia (NMAA) – www.vicnet.net.au/~nmaa
- Australian Multiple Birth Association (AMBA) – www.amba.org.au
- Network of Australian Lactation Colleges (NALC) <http://home.connexus.net.au/~lizr/wlr/network.htm> There are colleges in NSW, Vic, Qld, SA, WA and Tasmania
- Australian Lactation Consultants Association (ALCA)
- International Lactation Consultants Association (ILCA) – www.ilca.org
- Australian College of Midwives – Administrators of BFHI, email: austmid@ozemail.com.au
- Dietitians Association of Australia, www.daa.asn.au

3.5 Additional Internet sites

- Australia's National Breastfeeding Strategy – www.health.gov.au/pubhlth/strateg/brfeed/
- Breastfeeding Topic of the Month, www.bftopics.org
- World Alliance for Breastfeeding Action (WABA) – www.elogica.com.br/waba
- Top Ten Breastfeeding Sites for Health Care Professionals and Parents <http://hecate.acofi.edu/biology/ARA/Lactation/TopTen.html>

4. ANTENATAL EDUCATION RESOURCES FOR EDUCATORS

4.1 Reference books

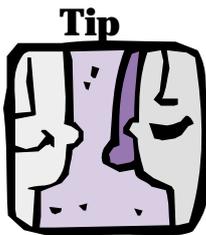
- Handfield B. *Thrown in at the deep end: a handbook for childbirth educators*. Melbourne: Handfield and Bell, 1996.
- Hunter D, Bailey A, Taylor. *The facilitation of groups*. Aldershot: Gower Publishing Limited, 1998.
- Hunter D, Bailey A, Taylor. *The zen of groups*. Aldershot: Gower Publishing Limited, 1992.
- Killen R. *Effective teaching strategies: lessons from research and practice (2nd edition)*. Australia: Social Science Press, 1998.
- Malouf D. *How to teach adults in a fun and exciting way*. Sydney: Business and Professional Publishing, 1994.
- Pratt R. *Games for childbirth educators: active learning strategies*. Brisbane: CopyRigth Publishing Company, 1998.
- Priest J, Schott J. *Leading antenatal classes*. Kent: Butterworth – Heinemann, 1991.
- Western Sydney Area Health Promotion Centre. *Group leadership*. Parramatta: State Health Publication, 1988.

4.2 Journals

- Interaction – National Association of Childbirth Educators journal – 4 issues per year.
- International Journal of Childbirth Education – International Childbirth Education Association journal – 4 issues per year.

4.3 Organisations

- National Association of Childbirth Educators (NACE) –
PO Box 31, Caulfield East, Victoria 3145,
www.nace.org.au
- International Association of Childbirth Educators (ICEA) – www.icea.org



Tip

To enhance your professional development and decrease the sense of isolation many antenatal educators experience, we suggest that you contact several of the organisations listed in this module. You may be surprised by the number of services available to antenatal educators and health professionals.

5. HEALTH EDUCATION RESOURCES FOR EDUCATORS

5.1 Reference books/articles

- Boud D, Keogh R, Walker D, eds. *Reflection: turning experience into learning*. London: Nichols Publishing Company, 1987.
- Hawe P, Degeling D, Hall J. *Evaluating health promotion*. Sydney: MacLennan and Petty, 1990.
- Holly M. *Keeping a personal-professional journal*. Victoria: Deakin University Press, 1987.
- Mager R. *Preparing instructional objectives*. London: Kogan Page, 1992.
- South Australian Community Health Research Unit. *Planning healthy communities: a guide to doing a community needs assessment*. Bedford Park: Flinders Press, 1991.

5.2 Internet sites

- Health Promotion on the Internet –
www.monash.edu.au/health/hprn/htm
- Theory Into Practice – www.gwu.edu/~tip

6. BREASTFEEDING RESOURCES FOR PARTICIPANTS

The number of resources available to participants is constantly increasing, and can be quite confusing. It can, therefore, be helpful to provide a suggested reading list during your program. In Module 9 we have prepared a list which you may like to distribute as a handout. The list below is an abbreviated version of the handout.

6.1 Reference books

- Cox S. *Breastfeeding I can do that*. Tasmania: TasLac, 1997.
- Nursing Mothers' Association of Australia. *Breastfeeding... naturally*. Melbourne: NMAA, 1996.
- Nursing Mothers' Association of Australia Booklets. Renfrew M, Fisher C, Arms S. *Bestfeeding: getting breastfeeding right for you*. USA: Celestial Arts, 1990.

6.2 Audio tapes

- Nursing Mothers' Association of Australia
- Breastfeeding... Right from the Start
 - Softly Softly

6.3 Organisations

- Nursing Mothers' Association of Australia
www.vicnet.net.au/~nmaa
- Australian Multiple Birth Association
www.amba.org.au

7. BREASTFEEDING RESOURCES FOR PARTICIPANTS WITH LANGUAGES OTHER THAN ENGLISH

The resources available in languages other than English vary from state to state and from hospital to hospital. Those listed below cover a range of breastfeeding issues and are accessible.

7.1 Brochures in Chinese, Arabic, Vietnamese and Korean

A copy of these resources is provided in Module 9 Successful Breastfeeding – NSW Multicultural Health Communication Service

7 helpful hints for learning to breastfeed – NMAA

7 helpful hints for solving breastfeeding problems

7.2 Brochures in other languages

Successful Breastfeeding – NSW Multicultural Health Communication Service

In addition to the languages listed above, this brochure is in Croatian, Italian, Macedonian, Portuguese, Russian, Spanish, Thai, Turkish.

7 helpful hints for learning to breastfeed – NMAA

7 helpful hints for solving breastfeeding problems – NMAA

In addition to the languages listed above, these brochures are in Turkish and Spanish.

7.3 Internet Site

Multicultural Communication –
www.mchs.health.nsw.gov.au
for additional multicultural resources.

8. CONCLUSION

Congratulations, you have now completed Module 6 – Resources for educators and participants. In this module we have explored:

- the resources that relate to your information needs as an educator working with a specific target population;
- how to access the resources required to maintain your own professional development as an educator;
- the resources that would be of interest to your target population.

Resources and information needs are ever changing and expanding so you need to keep your database current. This list is purely a basis from which to start.

Action



If the participants in your program speak a variety of languages other than English, you should contact your local multicultural communications department or other health care facilities. They may have resources you could use.

Breastfeeding and you: preparing the way

CONTENTS

1.	Introduction	80
2.	How to use the video	80
3.	Facilitating a group discussion	81
4.	Conclusion	84

1. INTRODUCTION

Breastfeeding may be perceived as being the 'natural way' to feed a baby, but in reality it is a powerful social, cultural and emotional experience which in contemporary society requires support and a certain degree of commitment. The complexity of the process and the diversity of the experience are frequently underestimated by women and men in the antenatal period, so you as an educator should encourage an exploration of their infant feeding decision.

Breastfeeding and you: preparing the way is a video which will facilitate this exploration, as it emphasises the social, emotional and relationship issues surrounding the decision to breastfeed and how they can influence the experience. It differs from other breastfeeding videos you may have seen or used as it gives viewers a sense of the joy and closeness that breastfeeding can offer, but also of the ambivalence and uncertainty that women can experience.

In the video we follow the journey of Anna and her partner Adam as they explore what breastfeeding means for them during the pregnancy. In talking with their friends, Anna and Adam discover that breastfeeding may not 'come naturally' and that support provided by their families and friends will be invaluable. Anna also learns that there are community resources she will be able to draw on in the early weeks and months of breastfeeding. In the final scene we see a new mother, Elsa, breastfeeding her day old baby, Gabrielle.

The video can be used for an antenatal group, in an antenatal clinic, antenatal ward or by expectant parents in their home environment.

1.1 Learning outcomes

Upon completion of this module you should be able to:

- identify the issues raised in each scene of the video;
- describe how you would use the video in an antenatal program/session;
- describe the impact the video and subsequent discussions will have on participants.

2. HOW TO USE THE VIDEO

The video is 30 minutes in length and is divided into six scenes. Scenes 1-5 are the journey taken by Anna and Adam as they prepare for the birth of their first baby. Scene 6 shows how the journey continues after the birth as we see Elsa breastfeeding Gabrielle.

The video can be shown in its entirety, however, we recommend that you show only one or two scenes at a time

because each scene requires thought and discussion. For example, if you facilitate a 6-7 week program you could show scene 1 in session 2, scenes 2 and 3 in session 4, scenes 4 and 5 in session 6 and scene 6 in the final session. The video jacket summarises the issues raised and provides trigger questions for women, partners and families who view the video independently of an antenatal session. Handouts for participants in antenatal programs are provided in Module 9.

2.1 Synopsis of the video

Scene 1: Anna and her mother-in-law, Elizabeth, talk about the arrival of a new baby. In response to Anna's questions Elizabeth shares her breastfeeding experience. Anna is six months pregnant in this scene.

Scene 2: Anna and Adam attend a barbecue hosted by their friends, Claire and Max. In the privacy of Claire's bedroom, Anna reveals her fears and concerns surrounding breastfeeding. Claire reassures Anna as she discusses her own experience.

Scene 3: Adam and Max discuss becoming fathers and the important role fathers play in supporting breastfeeding.

Scene 4: Anna discovers through Claire that friends are a source of wisdom and there is also support and encouragement available in the community.

Scene 5: On a lazy Sunday morning, as the birth approaches, Anna and Adam discover that together they are feeling more confident about their decision to breastfeed. They have gained useful advice from family and friends and they know they will have their support and a mutual commitment to the process.

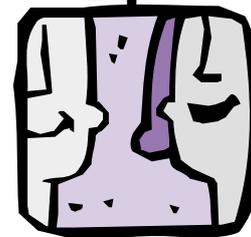
Scene 6: The journey of discovery about breastfeeding continues soon after birth with mother and baby learning together how to breastfeed. In the final scene we see a new mother, Elsa, breastfeeding her day old baby, Gabrielle. The interaction that occurs between each mother and baby is unique to them and very personal – not all women experience this the same way. The voice-over in this scene emphasises the importance of good positioning and attachment of the mother and the baby during a breastfeed.

3. FACILITATING A GROUP DISCUSSION

In Module 5 we described how you can stimulate a group discussion through the use of trigger questions. When you view this video you should be able to think of many questions you could use. If you want additional ideas you can refer to the questions listed below. They can be used:

- independently or in combination with others
- to stimulate large or small group discussions
- for mixed or single gender groups. The language used in

Tip



As an educator you will find that the amount of group discussion that ensues following a viewing of a video will vary. There are several reasons for this, but with careful planning, and following tips such as those listed below, you should be able to maximise a video's potential.

- The time at which you show the video, that is whether it is at the beginning, middle or end of the session, will affect the amount of discussion. There are times when a video can be used as an icebreaker, but in most situations you will find that it will stimulate more discussion if you give participants an overview of what they will see before they view the video and you allow time for discussion at the end.
- In your introduction to the video, rather than just describing what will be seen, ask the participants to look for a number of important points or ask them a couple of questions and at the end restate the questions to gather their response.

For example, before you show scene 3 you could say, 'In this scene you will see Adam and Max discussing the partner's role in breastfeeding. Take note of what Max did to help Claire when she was breastfeeding'. At the end of the scene you could ask the group, 'What did Max do to help Claire when she was breastfeeding?'



Before you show the video, *Breastfeeding and you: preparing the way*, to women or men we suggest you watch it and read the handouts in Module 9.

You can then decide how to use these resources in your program.

most questions is not gender specific and can be adapted if it is inappropriate.

To complement the information presented in the video you may like to give participants a copy of the handouts provided in Module 9.

3.1 Trigger questions for each scene of the video

Scene One

- Anna dislikes the way everyone is preoccupied by her appearance – no one seems to be interested in how she feels. **For women:** How do other people relate to you now? How have you managed their reactions?
For partners: Does your partner feel like Anna? How do other people relate to her now that she is pregnant? How do people relate to you?
- When describing how she felt as a new mother, Elizabeth says, 'On more than one occasion I felt completely lost'. Have you asked your mother or any family members how they felt when they were a new parent? If yes, how did she/they describe the experience? How did their description make you feel? What can you do to prepare yourself for the experience?
- Anna asks Elizabeth how she fed her children. How were you fed as a baby? Was it by breast or did your mother use an infant formula? Why did your mother choose that method? **Note:** If participants do not know, encourage them to find out.
- Has your mother given you any advice on what you should do? If yes, what advice has she given?
- What have family and friends told you about breastfeeding?
- Do your family and friends know how you intend to feed your baby? How do they feel about your decision?
- Elizabeth says, 'There will always be someone to help you Anna'. Do you think you will need help feeding your baby? If yes, what kind of help will you need and who will provide it?

Scene Two

- Anna is concerned that breastfeeding won't be suitable for her – she is worried about breastfeeding in public and about the effect it will have on her relationship with Adam. How do you feel about breastfeeding? What concerns you?
- Many women think, like Anna, that they will know what to do. 'Isn't that what being a mother is – you know, "instinct" and... well... you know.' What do you think about Anna's comment? Is 'mothering' instinctive? What have you heard?
- Claire responds to the issue of mothering/breastfeeding being instinctive. She says 'I didn't know. Well I knew the mechanics of it – but I didn't know how it would all go'. How does this comment make you feel? What can you do

to prepare yourself for the breastfeeding experience?

- Before you have your baby, who can you talk to if you have concerns about breastfeeding?
- What resources are available to the breastfeeding family in your local community?

Scene Three

- Have you discussed the role of a father with other men/friends? How did they respond? Have you asked them about their experience as a new father? If yes, how have they described the experience? Did they give you any advice/tips?
- Max says, 'The first time especially I remember feeling a bit like the proverbial third wheel on a bike'. Why would he have felt like that? What, if anything, could he have done to lessen that feeling?
- Adam wonders how he can help Anna when she is breastfeeding and Max gives suggestions.
For women: What would you like your partner to do when you are breastfeeding? Have you discussed this with him/her? What plans, if any, have you made?
For men: What could you do when your partner is breastfeeding? Have you discussed this with her? What plans, if any, have you made?

Scene Four

- Claire says, 'She gave me all these hints about how to settle Sascha down first, before I'd sit down to feed Jamie – worked like a dream. We're a mine of information ya know'. What do you think about Claire's comment? Will friends be a help or a hindrance? Why do you feel that way? What sort of help could you ask family and friends to provide you with?
- Have you thought about where you/your partner will breastfeed? Where do you think you/she will feel comfortable breastfeeding? Have you discussed this?

Scene Five

- Anna says, 'You see I wanted you to think I had the whole thing you know sorted out. I mean I am a mother, and I'm supposed to have all this figured out and...'
For women: Why does Anna feel this way? Is it a realistic feeling? How do you feel about becoming a mother? Have you shared these thoughts with your partner, family or friends?
For partners: Why does Anna feel this way? Is it a realistic feeling? How do you feel about becoming a father? Have you shared these thoughts with your partner/family or friends?
- Anna thought she would have to give up breastfeeding when she returned to work, but 'having talked through the options

Think



Some of the questions in this section are open, some are closed. Think about the amount of discussion they will stimulate and adapt them as required.

it seems like you can do all sorts of things...’ What do you hope to do when you return to work? What are the options available to you?

- Adam says, ‘If you decide to breastfeed, well... it’s important work. I reckon that’s where I can come into my own.’

For partners: What will you do when your partner is breastfeeding? How can you prepare for the experience?

For women: What would you like your partner to do when you are breastfeeding? Have you discussed his/her role?

Think



Think about the antenatal programs you facilitate. Watch the video, *Breastfeeding and you: preparing the way*, and develop trigger questions which may be more relevant to your participants.

For example, if you are working with young mothers scene 2 offers opportunities to explore lack of readiness, body image, the importance of friendship and the community resources they can draw on. Create questions that enable an exploration of these issues.

Scene Six

In the final scene Elsa breastfeeds her day old baby, Gabrielle. The interaction between Elsa and Gabrielle is intimate and unique to them. The voice-over that accompanies this scene emphasises the importance of good positioning and attachment of the mother and the baby during a breastfeed.

After showing the scene we suggest that you reinforce the information given and distribute the handout provided in Module 9. When possible dolls should be provided for participants to practise positioning and attachment of a baby. Using visual aids, such as those provided in Module 3, would enhance your presentation.

Predicted outcome

Due to the depth of the issues raised, the video should stimulate a range of comments and questions from participants. Use them to trigger discussions. Be creative and think of ways to address:

- the feelings, attitudes, beliefs and expectations surrounding breastfeeding and how these have formed;
- how participants feel about breastfeeding in public;
- concerns women and men have about breastfeeding;
- how these concerns can be reduced;
- the support, resources and information available to the breastfeeding family;
- the individual nature of the breastfeeding experience;
- the role good positioning and attachment of mother and baby play in preventing problems.

4. CONCLUSION

Congratulations, you have now completed Module 7 – *Breastfeeding and you: preparing the way*. In this module we have explored:

- the issues raised in each scene of the video;
- how you would use the video in an antenatal session;
- the impact the video and subsequent discussions will have on your participants.

This video should stimulate much discussion in your groups, so please use it as appropriate in your sessions.

Breastfeeding-related learning strategies

CONTENTS

1.	Introduction	86
2.	How to use the activities	86
3.	Preparing to breastfeed	88
4.	Learning to breastfeed	99
5.	The reality of breastfeeding	103
6.	Becoming a parent	107
7.	Conclusion	110

1. INTRODUCTION

Becoming a parent is one of the most significant life events an individual will encounter and yet in contemporary society many are ill-prepared. Modern lifestyle and a reduction in traditional family networks have meant that expectant parents do not receive the experiential learning and parental role modeling of yesteryear. You, as an educator, are in a unique position to be able to provide this for them.

The activities in this module may focus on breastfeeding, but many can be broadened or adapted to address a range of parenting issues. Be flexible and creative in their use.

1.1 Learning outcomes

Upon completion of this module you should be able to:

- identify activities that you could incorporate in your programs/sessions;
- describe how the activities could be implemented;
- state the likely outcome of the activities.

2. HOW TO USE THE ACTIVITIES

The activities in this module:

- have been **designed to stand alone**. Each activity has a set of instructions and the activities can be used independently or in combination with others in the handbook.
- **cover a range of breastfeeding issues** and for convenience they have been placed into four categories. Selecting one activity from each category would cover a range of breastfeeding issues in your program/session. Remember, however, that you should base your selection on the needs of the participants and the time available in the program/session. Handouts for participants have been included in Module 9.
- **should be of interest to male and female participants**. Men may not spontaneously ask as many breastfeeding questions as women in the antenatal period, but this is no indication of their level of interest or their knowledge base. To foster peer support and sharing of ideas, concerns and interests we have suggested single gender, small groups for several of the activities. The composition of the small groups can, however, be changed as required.
- **can be used at any stage of the pregnancy**. Monitor the

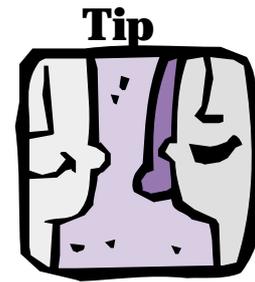
needs of your group and integrate the activities as appropriate.

- **may be appropriate or they can be adapted for special needs groups.** The language used in the activities should allow them to be used in age or culture-specific groups.
- **have been designed for a group of 20 people** as this is the average size of antenatal education groups in Australia. If your groups differ in size, adjust the activities so you have 4-6 participants in a small group.
- **have been used by the principal author and other antenatal educators in their professional practice.**
- **have an aim, the materials required are listed, time allocation is given, the method of facilitation is stated and a predicted outcome is given.** The time allocated to each activity is provided as a guide. As you become more familiar with the activities and the needs of the participants, you should vary the time according to your needs and theirs.

As you read through the module you will notice that for several of the activities we have given you two methods by which the activity can be presented to the group. In selecting the method you will use, think about:

- the learning needs of the group;
- the unique characteristics of the participants, such as their age, culture and socioeconomic background;
- your familiarity with the learning strategy;
- your understanding of the issues the activity will raise;
- how it will complement the other activities being used in the session and your program.

The outcomes of the activities have been described as 'predicted' because they are based on the outcomes that members of the project team have experienced. Adult learners are fun to work with, but they can be unpredictable so you may find the outcomes from your groups are quite different.



When planning the structure of a program/session you should aim to:

- open with an activity or an ice-breaker that will create a comfortable learning environment;
- move from basic to complex ideas;
- move from known facts to new ones;
- move from the beginning of a process to its conclusion;
- move from concrete content to abstract levels of understanding, reasoning and problem solving;
- place content of a similar nature together.

3. PREPARING TO BREASTFEED

Activity 3.1: A family 'feeding' tree

Background

The infant feeding experience of family members can have a significant, yet seldomly recognised, influence on the experience of new parents. For this reason it is useful for women and men to explore their family 'feeding' tree.

Aim of the activity

To give participants an understanding of how the infant feeding experiences of family members can influence their beliefs and their experience.

Note: Two methods of presentation have been given for this activity. Method one focuses on the participant's own family tree, while method two explores the experience of others. Assess your group and select the most appropriate method.

Method one

Materials Required

- Paper and pen for each participant

Time allocation

Drawing the tree = 5 minutes

Small group discussion = 10 minutes

Method

Each participant is to draw their family tree on a piece of paper and under the names on the tree they write how the person was fed as a baby.

Ask participants to commence the tree with their grandparents if they know how they were fed as a baby, but if they don't they can begin with their parents.

Give participants 5 minutes to complete their tree. Divide the large group into sub groups of 4–6 people. Ask participants to compare their trees and discuss the influence family members may have on their infant feeding experience.

Complete the activity with a comment about how family members can influence breastfeeding. Encourage further exploration/discussion of this issue before they have their baby, as it can help them identify the family members who will provide support in the early postnatal weeks.

Method two

Materials Required

- *Breastfeeding and you: preparing the way* – the video

Time allocation

Scene 1 = 5 minutes

Large group feedback and discussion = 5 minutes

Method

Give the group an overview of Scene 1 and ask them to note Elizabeth's comments regarding her infant feeding experience and that of Anna's mother.

At the end of Scene 1, turn off the video and ask for a description of how Elizabeth and Anna's mother fed their infants. Ask participants if they know how they were fed as a baby.

Complete the activity with a comment about how family members can influence breastfeeding. Encourage further exploration/discussion of this issue before they have their baby, as it can help them identify the family members who will provide support in the early postnatal weeks. Describe the family feeding tree and suggest that they prepare their own.

Predicted outcome

Some participants may not know how family members have fed their infants. Feeding methods may not have been discussed within the family, participants may have been separated from their family years ago, or they may have been adopted. As family experiences can influence their own experience and their beliefs, suggest that they may like to explore the issue further.

Activity 3.2: Practical wisdom

Background

Expectant and new parents are given so much advice and information it is little wonder that they begin to question what is fact, what is fiction and what is in between. Exposing and clarifying some of the stories and practical wisdom surrounding breastfeeding can assist women and men as they embark on their journey.

Aim of the activity

To expose and clarify some of the practical wisdom surrounding breastfeeding.

Materials required

- Paper and pen for each small group

Time allocation

Small group discussion = 10 minutes

Large group feedback and discussion = 10 minutes

Method

Divide the large group into four single gender groups. Give each group some paper and a pen. Ask them to discuss the following questions and write their answers on the paper. Allow 10 minutes for the discussion.

Questions:

- *What have you heard/ read about breastfeeding?*
- *From whom or where did you hear this?*

Close the discussions with a spokesperson from each group presenting the answers to the large group. Follow the presentations with a general discussion about the stories women and men may hear about breastfeeding and advice they may be given. Emphasise the importance of clarifying incomplete or inconsistent information/ advice they receive and, to complete the activity, give participants a list of resources they may like to access. A list is provided in Module 9.

Predicted outcome

The answers to this learner-centred activity should be enlightening as participants will probably mention not only the stories and advice they have heard, but also their fears, interests and concerns about breastfeeding. Through the use of single gender groups you should be able to identify and compare the interests and concerns of the women and the men in the group.

Activity 3.3: Myths and half-truths about breastfeeding

Background

As stated in Module 3, the family and community in which the mother lives can have a major influence on her breastfeeding experience. Breastfeeding practices and 'rules' frequently exist and if they contradict those accepted as common practice, new parents can become quite confused. Women and men should be aware of this problem, but they also need to realise that knowledge and practices are time limited and culturally specific so what is current today may be old tomorrow.

Aim of the activity

To acknowledge the existence of myths and half-truths in the community and to clarify some of those related to breastfeeding.

Materials required

- Small cards with one myth/half-truth written on each card. On the next page you will find a template that you can photocopy for your cards.
- One copy of the 'Response Sheet'.
- Paper and pen for each small group.

Time allocation

Small group discussion = 10 minutes

Large group feedback and discussion = 10 minutes

Method

Divide the large group into sub groups of 4–6 people. Give each group two or three of the 'myth' cards, some paper and a pen. Ask them to discuss each card and summarise their comments on the paper. Allow 10 minutes for the discussion.

Close the discussions with a spokesperson from each group presenting the comments to the large group. Follow the presentations with a general discussion about the myths and half-truths women and men may hear about breastfeeding and explain how each community and culture can have their own. Emphasise the importance of clarifying incomplete or inconsistent information/advice they receive and, to complete the activity, give participants a list of resources they may like to access.

A list is provided in Module 9.

Note: A 'Response Sheet' has been provided for the myths in this activity. You may like to share the information with the group to clarify any of the issues/concerns raised in the small group discussions. Remember that the myths and half-truths of one community/culture may be the common practice in another.

Predicted outcome

In addition to discussing the myths provided in this teacher-centred activity, you may find that each group will share a range of stories they have heard. These stories can be enlightening as they will probably include not only myths and half-truths, but issues that are of concern. As the educator you do not need to address all concerns, but rather you should refer them to resources they can access themselves. For example, breastfeeding books, brochures, a lactation consultant or a Nursing Mothers' Association of Australia counsellor.

Myths and half truths about breastfeeding

1. Breast size affects milk production

6. There is no milk in the first few days

2. Breastfeeding causes sagging breasts

7. Women with inverted or flat nipples cannot breastfeed

3. Nipple creams prevent sore nipples

8. Drinking milk makes milk

4. Fair skin women are more likely to have nipple problems

9. I can't express any milk by hand, so I must not have any

5. My mother didn't make enough milk so I won't

10. If I eat cabbage or green leafy vegetables my baby will have wind

Myths response sheet

1. The size of the breast does not effect milk production in the majority of women as the breast is mainly composed of fatty and connective tissue, rather than milk-producing glands. Between 1 and 5% of women do not develop sufficient milk-making tissue for adequate milk production. Milk quantity is, however, related to the strength, quality and duration of infant sucking.
 - NMAA. Breast and nipple care. Victoria: NMAA, 1998.
 - Neifert MR, Seacat JM, Jobe WE. Lactation failure due to insufficient glandular development of the breast. *Paediatrics* 1986;76:823-828.
2. Research indicates that breast shape is affected by heredity, age and pregnancy in that order and minimally by breastfeeding.
 - Lawrence R. Breastfeeding: a guide for the medical profession, 5th Edition. Mosby 1999:244.
3. Nipple creams tend to make the skin soft and can lead to allergic reactions. Recent research shows that the most effective management of sore/tender nipples is fresh air and breastmilk. Nipple damage is prevented by the baby being correctly positioned at the breast.
 - Lavergne NA. Does application of tea bags to sore nipples while breastfeeding provide effective relief? *JOGNN* 1997;26:53-58.
 - Buchko BL, et al. Comfort measures in breastfeeding primiparous women. *JOGNN* 1993;23:46-52.
 - L'Esperance CM. Pain or pleasure: the dilemma of early breastfeeding. *Birth and the Family* 1980;7(1): 21-26.
 - NMAA. Breast and nipple care. Victoria: NMAA, 1998.
4. Researchers have investigated this belief and have found no link between red hair or fair skin women and sore nipples.
 - Zeimer MM, et al. Methods to prevent and manage nipple pain in breastfeeding women. *Western Journal of Nursing Research* 1990;12:732-744.
 - Brockway L. Hair colour and problems in breastfeeding. *Midwives Chronicle and Nursing Notes*, March 1986:66-67.
5. Breastfeeding was not fully supported by hospital practices in the past as mothers and babies were separated and complementary feeds were common. This interfered with the supply = demand mechanism.
 - Humenick SS, Hill PD, Wilhelm S. Postnatal factors encouraging sustained breastfeeding among primiparous and multiparas. *Journal of Perinatal Education* 1997;6(3):33-45.
 - Yamauchi Y, Yamanouchi I. Breastfeeding frequency during the first 24-hours after birth in full-term neonates. *Paediatrics* 1990;86:171-175.
 - Slaven S, Harvey D. Unlimited suckling time improves breastfeeding. *Lancet* 1981;1:392-393.
 - Salaria EM, Easton PM, Carter JI. Duration of breastfeeding after early initiation and frequent feeding. *Lancet* 1978;2:1141-1143.
6. Breastmilk (colostrum) is made and stored in the breast from 16-weeks gestation. The quantity is designed to meet the nutritional needs of the new baby. It is rich in protein, calories, antibodies and is a laxative that stimulates the new baby's gut. Milk volume gradually increases as the baby's requirements change over the first few days.
 - Humenick SS, et al. The maturation index of colostrum and milk (MICAM): a measurement of breast maturation. *Journal of Nursing Measurement* 1994;2:169-186.

- Hartmann PE. Lactation and reproduction in Western Australian women. *Journal of Reproductive Medicine* 1987;32:543-547.
 - Hartmann PE, Prosser CG. Physiological basis of longitudinal changes in human milk yield and composition. *Fed Proc* 1984;43:2448-2453.
 - NMAA. An introduction to breastfeeding. Victoria: NMAA, 1999.
7. Approximately 10% of women have non-protractile or inverted nipples. Breastfeeding with inverted nipples can be a challenge for mothers and midwives in the early days, but many women are able to breastfeed successfully.
- Alexander J, Grant A, Campbell M. Randomised controlled trial of breast shells and Hoffman's exercises for inverted and non-protractile nipples. *British Medical Journal* 1992;304:1030-1032.
 - Alexander J. Antenatal preparation of the breast for breastfeeding. *Antenatal care: a researched-based approach*. London: McMillan, 1990.
 - NMAA. Breast and nipple care. Victoria: NMAA, 1998.
8. It is not necessary to drink extra milk. Breastfeeding mothers should eat a variety of nutritional foods in moderation. They should drink to satisfy thirst and eat to satisfy hunger.
- Illingworth RS, Kilpatrick B. Lactation and fluid intake. *Lancet* 1953;ii:1175-1177.
 - Dearlove JC, Dearlove BM. Prolactin, fluid balance and lactation. *British Medical Journal of Obstetrics and Gynaecology* 1981;123:845-846.
 - NMAA. An introduction to breastfeeding. Victoria: NMAA, 1999.
9. Hand expression is a learnt skill. Some women are unable to get milk from the breast by expressing due to poor technique. Women who are using breast pumps for long term expressing may experience some delay with their let-down reflex.
- NHMRC. Infant feeding guidelines for health workers: expressing and storing breastmilk. Australia: AGPS, 1995:35.
10. There is no evidence to suggest that the foods a mother eats will effect a baby, if foods are eaten in moderation. Breastfeeding mothers should eat a variety of nutritional foods.
- Riordan J. The cultural context of breast-feeding: food restrictions, breastfeeding and human lactation, Riordan J and Auerbach K Jones and Bartlett. Massachusetts, 1999:42-43.

Activity 3.4: Infant feeding and the media

Background

In Modules 2 and 3 we identified how the media portrays the breast and breastfeeding, and how it can sensationalise related issues. This can have an impact on new parents, so it is worthwhile preparing them for it.

Aim of the activity

To recognise and clarify the role of the media in portraying infant feeding norms.

Materials required

- 3 or 4 articles from newspapers or magazines that sensationalise the breasts, breastfeeding, formula feeding, bottles, or dummies. You can contact the Lactation Resource Centre for articles if you have problems finding some.
- Paper and pen for each small group

Time allocation

Small group discussion = 10 minutes

Large group feedback and discussion = 10 minutes

Method

Divide the large group into sub groups of 4 – 6 people. Give each group one article, some paper and a pen. Ask them to discuss the article and summarise their comments on the paper. Allow 10 minutes for the discussion.

Close the discussions with a spokesperson from each group presenting the comments to the large group. Follow the presentations with a general discussion about the media and how it can sensationalise infant feeding. Emphasise the importance of clarifying incomplete or inconsistent information they receive and, to complete the activity, give participants a list of resources they may like to access. A list is provided in Module 9.

Predicted outcome

Through the process of discussing the articles the participants are likely to mention a range of articles they have encountered. This adds to their awareness of the impact the media can have and encourages them to seek clarification if they feel the information being presented is incorrect or incomplete.

Activity 3.5: Breastfeeding and you

Background

Breastfeeding education has tended to focus on the physical and biological aspects of breastfeeding. Although women and men do want to know 'how to do it', they should be encouraged to explore and discuss how they feel about breastfeeding and the impact they perceive it will have on their lives before they begin. The decision to breastfeed is frequently made prior to conception without a true understanding of the individual nature of the process.

Aim of the activity

To stimulate, during pregnancy, an interest in, and a consideration of, the social and emotional aspects of breastfeeding.

Note: There are many questions that can be used to trigger psychosocial discussions and several ways to present them to a group. For example, you can present them as trigger questions during the course of an antenatal program in small or large, mixed or single gender group discussions, they can be presented on graffiti sheets, as homework exercises, or by caregivers during the antenatal period. You can even integrate a number of them through a program, presenting them in different ways to provide variety.

If the program you facilitate has another facilitator/presenter or a guest speaker, ask whether they use discussion triggers in their session and if so, which they use. You may want to sit in on their session to confirm their approach. Replication of activities can be useful if you want to see whether there has been a progression of ideas within the group, but it can also be a waste of time.

Method one

Materials required

- Small cards with one trigger question written on each card
- Paper and pen for each small group

Time allocation

Small group discussion = 15 minutes

Large group feedback and discussion = 15 minutes

Method

Divide the large group into four single gender groups. Give each group 2 or 3 trigger questions, such as the ones listed below, some paper and a pen. Ask them to discuss the question/s and summarise their comments on the paper. Allow 15 minutes for the discussion.

Close the discussions with a spokesperson from each group presenting the comments to the large group. Follow the presentations with a general discussion about what breastfeeding means to them, their partner and their family. Complete the activity with a summary of the issues discussed and encourage further exploration/discussion of this issue before they have their baby, as it can help them identify who will provide support in the early postnatal weeks.

Sample trigger questions – select appropriate questions from this list or create your own

- What does breastfeeding mean to you? What has influenced your thoughts/feelings?
- What does breastfeeding mean to your partner?
- Who owns a woman's breasts – the mother, the partner, the baby, society?
- What effect will breastfeeding have on the relationship with your partner?
- What does your mother think about breastfeeding?
- What does your family think about breastfeeding?
- Were you breastfed?
- How do you feel when you see a woman breastfeeding in public?
- What do you think the baby feels when it is breastfeeding?

Method Two

Note: Discussion triggers can be presented to a group through the use of graffiti sheets, as described in Module 5. For presentation on a graffiti sheet remember that the trigger should be written as an incomplete statement. For example: 'Breastfeeding means...' and 'Breastfeeding makes me feel...'

Materials required

- Graffiti sheets with one trigger statement written on each sheet, and pens.

Time Allocation

Graffiti sheets = 10 minutes

Large group feedback and discussion = 15 minutes

Method

Place the graffiti sheets and pens around the room/corridor on tables, chairs or pinned to the wall. Explain the purpose of the activity and ask participants to move around the room writing their response to the trigger statements on each graffiti sheet.

At the end of the exercise ask participants to collect the graffiti sheets and return to the large group for feedback and discussion. Complete the activity with a general discussion about what breastfeeding means to them, their partner and their family. Encourage further exploration/discussion of this issue before they have their baby, as it can help them identify who will provide support in the early postnatal weeks.

Predicted outcome

The amount of discussion that occurs will vary and is influenced by the level of trust and comfort within the group. If your group know each other and the level of trust is high, you may find it useful to increase the amount of time allocated to this activity.

Activity 3.6: Preparing for breastfeeding in early pregnancy

Background

As we identified in Module 2, breast changes occur early in pregnancy, so women tend to have many questions regarding the care of their breasts at this time. If your facility offers an early pregnancy session, you should include information on breast changes in pregnancy, breast care and how to prepare for breastfeeding.

Aim of the activity

To give participants an understanding of how to care for their breasts during pregnancy and how they can prepare for breastfeeding.

Materials required

- Paper and pen for each small group
- Breast model and visual aids

Time allocation

Small group discussion = 10 minutes

Large group feedback and discussion = 15 minutes

Method

Divide the large group into four single gender groups.

- Two of the groups, one male and one female, are to brainstorm and list on paper the changes they have noted in the breasts since the beginning of the pregnancy, what the changes mean and how they are perceived by women and men. In addition they are to discuss how they can prepare for breastfeeding.
- Two groups are to reflect on their own family's breastfeeding experience and discuss how it could influence their own experience.

Allow 10 minutes for the discussion.

Note: Dividing the groups and allocating topics in this way increases the number of issues discussed. If the group has already explored their family 'feeding' tree, you will need to change the discussion topic for two of the groups.

Close the discussions with a spokesperson from each group presenting the responses to the large group. Complete the activity with a description of:

- breast changes in pregnancy, what they mean and how they are perceived by women and men;
- shapes and types of breasts, areola and nipples;
- breast care and breast self examination;
- breast creams and ointments;
- types of bras and their use;
- how the experience of family members can influence their own experience and their beliefs.

You may like to use visual aids, such as the graphics in Module 3, to enhance your presentation.

Predicted outcome

Many groups will be able to describe the breast changes that occur early in the pregnancy but they may not know current breast care practices. For example, they may think they have to apply creams or ointments to the nipple.

Some participants may not know how family members have fed their infants. Feeding methods may not have been discussed within the family, participants may have been separated from their family years ago, or they may have been adopted. As family experiences can influence their own experience and their beliefs, suggest that they may like to explore the issue further.

Activity 3.7: Preparing for breastfeeding in late pregnancy

Background

There is a tendency for educators to think that as the birth becomes imminent most women are only interested in labour and the types of pain relief they may require. As we highlighted in Module 2, this is not necessarily the case. Anticipatory guidance at this time is important as it helps the expectant parents realise the impact breastfeeding may have on their life and their relationship.

Aim of the activity

To give participants an understanding of how they can prepare for breastfeeding as they approach the birth.

Method one

Materials Required

- *Breastfeeding and you: preparing the way* – the video
- Discussion Triggers for Scenes 3 and 4, which are in Module 7
- Paper and pen for each small group

Time allocation

Scenes 3 and 4 of the video = 15 minutes

Small group discussion = 10 minutes

Large group feedback and discussion = 10 minutes

Method

Give the group an overview of Scenes 3 and 4 and ask them to note how Anna and Adam are preparing for breastfeeding.

At the end of Scene 4, turn off the video and divide the large group into four, single gender groups. Give two groups the discussion triggers for Scene 3, two groups the discussion triggers for Scene 4, some paper and a pen. Ask them to discuss the discussion triggers and write their responses on the paper. Allow 10 minutes for the discussion.

Close the discussions with a spokesperson from each group presenting the responses to the large group. Follow the presentations with a large group discussion. Complete the activity with a summary of how women and men can prepare themselves for breastfeeding and explain how every breastfeeding experience is different.

Method two

Materials Required

- Paper and pen for each small group

Time Allocation

Small group discussion = 10 minutes

Large group feedback and discussion = 10 minutes

Method

Divide the large group into four single-gender groups.

- Two of the groups, one male and one female, are to brainstorm and list on paper, what they can do to prepare for breastfeeding.
- Two groups are to discuss and list on paper what their role as a breastfeeding mother/father involves. In addition they are to identify the role of the breastfeeding baby.

Allow 10 minutes for the discussion.

Close the discussions with a spokesperson from each group presenting the responses to the large group. Complete the activity with a summary of how women and men can prepare themselves for breastfeeding and outline the roles of the mother, the partner and the baby in breastfeeding. Emphasise the diversity of the breastfeeding experience and give participants a list of resources they may like to access. A list is provided in Module 9.

Predicted outcome

The outcome of this activity will vary according to the amount of personal experience the participants have with breastfeeding. You will generally find that if a number of participants have family or friends with babies or infants, they will have a clearer idea of what they can do to prepare themselves for breastfeeding.

4. LEARNING TO BREASTFEED

Background

There are many practical activities that can be used to demonstrate breastfeeding techniques and skills. They may sound enticing and will certainly stimulate discussion and participation, but be careful when you are planning your programs/sessions. The quality of the information is more important than quantity. You can always try the others at another time.

Activity 4.1: Oranges and breasts

Aim of the activity

To make participants aware of the ways milk can be obtained from the breast and how effective they are.

Materials required

- The week **before** the activity ask participants to bring to the next session one orange cut into six wedges.

You provide:

- One straw and one cup for each participant
- Dolls, a breast model and visual aids
- *Breastfeeding and you: preparing the way* – the video

Time allocation

15 – 20 minutes

Method

Ask each participant to take one wedge of orange and a straw. They are to suck as much juice from the wedge as possible through the straw. Ask them to rate, on a scale of 1 to 10, the efficiency of removing juice from the orange by this method. 1 = inefficient, 10 = efficient. This method is usually given 0-1 out of 10.

Ask each participant to take another wedge of orange and a cup. They are to squeeze as much juice from the wedge as possible into the cup. Ask them to rate the efficiency of this method on a scale of 1 to 10. This method is usually given 5-7 out of 10.

Finally they take their last wedge and are asked to suck as much juice from the piece as possible, using their lips, tongues and gums, but not their teeth, as they will damage the flesh of the orange. They are to give an efficiency rating of the method. This method usually is given 9-10 out of 10.

At the end of the exercise explain the reason for doing it and give the following description.

The orange and the straw represent the amount of milk a baby receives when it sucks on the nipple only. The orange and the cup represent the amount the baby would receive from expressing milk and giving it via a bottle or cup. The last method represents the amount received by the baby when it is feeding correctly on the mother's breast. It imitates the ability of a baby, with a deep mouthful of breast, to extract milk from the breast through the massaging action of their lips, tongue and gums, along with the suction as they swallow.

Complete the activity with an explanation of the different ways milk can be obtained from the breast and describe when each one would be used. Explain the baby's role in breastfeeding and show how the baby's whole body needs to be in alignment and facing the breast, so the baby can use its jaw effectively.

You may like to enhance your presentation by using visual aids, such as the graphics in Module 3, a breast model, dolls and by showing the final scene of the video *Breastfeeding and you: preparing the way*. Whenever possible dolls should be passed around the group so participants can practise the technique. Handouts for participants are provided in Module 9.

Predicted outcome

The participants will be amazed by the difference in the amount of juice they obtain from the three methods. It reinforces the importance of good positioning and attachment of the baby and will encourage them to practice their positioning techniques with the dolls. If the women attending the session are at an advanced stage of their pregnancy, they may find it difficult to position the baby. It is interesting, however, to watch the way the dolls are handled. Participants will watch you, so make sure you handle the doll as if it were a baby.

Activity 4.2: Breasts, nipples and sucking

Aim of the activity

To make participants aware of the different types of sucking and how the breast can be shaped to facilitate successful attachment.

Materials required

- Dolls and a breast model
- The other materials vary according to the method used

Time allocation

Will depend on the number of methods used.

Method one:

Sandwiches and breasts

Begin by asking the participants 'What shape is a baby's mouth?' The answer is 'A baby's mouth is a longitudinal oval shape, rather than a circle'. Once they understand the shape of the mouth, you should explain that the woman's breast needs to be shaped to meet that of the baby's mouth.

To demonstrate this place the breast model in front of you so as to mimic your own breast. Cup the breast model with your left hand on the outer quadrant, thumb on the top and the fingers underneath. Your thumb and fingers should be at least 3cm away from the nipple, on the breast. As you gently squeeze the breast, the breast tissue narrows longitudinally and elongates horizontally.

Maintain this hold for a few minutes while you explain that if the baby is in the cradle or underarm position, its mouth will be longer longitudinally and narrower horizontally. Exactly the opposite to the current breast shape.

To shape the breast to fit the baby's mouth better, slide your hand so it cups under the breast. Gently squeeze it once more. The breast is now shaped in the same direction as the baby's mouth.

You can use a sandwich to demonstrate this shaping exercise. The sandwich is shaped so that the best bite is achieved if the sandwich is placed horizontally or parallel to the mouth.

Method Two:

Fingers and arms/nipples and breasts

To compare the difference in breastfeeding when a baby is attached to the nipple versus the breast, this simple exercise can be demonstrated. The baby needs to have a wide-open mouth to get as much breast tissue into its mouth as possible.

Ask participants to suck on the end of one of their fingers, as if they were sucking just on a nipple. Whilst they are sucking ask them to think about the shape of their mouth, their cheeks and the jaw and how they feel.

Now get them to open their mouth wide and suck on their arm. Once again they are to notice the shape of their mouth, their cheeks and the jaw.

At the end of the exercise, ask participants:

- to describe the difference between the two types of sucking;
- what they think would happen when a baby is nipple sucking, as opposed to breast sucking?
- what would happen to the nipple?
- would the baby get much milk through nipple sucking?

Method three:

Balloons, condoms and engorgement

Using a balloon, or when appropriate, a condom as it has a nipple, you can give a number of examples of what can happen to the breast under different circumstances.

Give each participant a balloon or condom and ask them to blow them up to various levels. Some should make them big, some small and some medium. When they are inflated they should observe what happens to the nipple. For example they should notice that when a condom is over-distended, the nipple flattens out. This demonstration simulates the breast when it becomes venous or milk-engorged. The nipple appears to flatten out as the breast enlarges, which can make it difficult for a baby to attach.

Complete the activity with an explanation of the different types of sucking and how the breast can be shaped to facilitate successful attachment. Explain the baby's role in breastfeeding and show how the baby's whole body needs to be in alignment and facing the breast, so the baby can use its jaw effectively.

You may like to enhance your presentation by using visual aids, such as the graphics in Module 3, a breast model, dolls and by showing the final scene of the video *Breastfeeding and you: preparing the way*. Whenever possible dolls should be passed around the group so participants can practise the technique. If the women attending the session are at an advanced stage of their pregnancy they may find it difficult to position the baby. It is interesting, however, to watch the way the dolls are handled. Participants will watch you, so make sure you handle the doll as if it were a baby. Handouts for participants are provided in Module 9.

Predicted outcome

Practical activities, such as those described above, stimulate interest so incorporate them into your session whenever you can. For example you could finish a birth session with the oranges and breasts activity. Explain the relevance of the activity to the session and emphasise the close connection between the end of labour and the first breastfeed.

Activity 4.3: How breastfeeding begins

Aim of the activity

To give participants an understanding of how breastfeeding is initiated.

Materials required

- Breast model and visual aids
- *Breastfeeding and you: preparing the way* – the video

Time allocation

15–20 minutes

Method

Briefly describe, using visual aids, the following:

- the breast – its role and function as the birth approaches;
- the hormonal changes that occur once baby is born and placental separation has occurred;
- the natural instincts of the baby;
- how the mother feels immediately after the birth;
- the benefits of early initiation of breastfeeding;
- why initiation may be delayed, the effect this has on breastfeeding outcome and how this situation can be managed;
- the differences between colostrum, transition milk and mature milk – their amounts, their colour, etc.
- the breast changes in the early postnatal days.

You may like to use the information and the flow chart in Module 3 to enhance your description. In addition the final scene of the *Breastfeeding and you: preparing the way* can be used to supplement your input. Complete the activity with a discussion of the role of the mother, the baby, the staff and partner in breastfeeding. Emphasise the importance of physical and emotional support in the postnatal period and give participants a list of resources they may like to access. A list is provided in Module 9.

Predicted outcome

Although this is a more didactic approach to those described previously it should promote questions and discussion. To complement your description and maintain interest in the topic you could use visual aids or the video.

Activity 4.4: Breastfeeding according to need

Aim of the activity

To give the participants an understanding of the meaning and benefits of breastfeeding according to need.

Time allocation

15 minutes

Method

Briefly explain:

- the feeding patterns of a newborn baby compared with those of a baby at one week and how the pattern changes as the baby grows;
- the meaning of 'rooming in' and the benefits of feeding according to need;
- the breast changes in the early postnatal weeks. For example on day 3 they are full and by week 3 they are settling and softer.

Complete the activity with a discussion of the role of the mother, the baby, the partner and the postnatal support services in the early postnatal period. Emphasise the importance of physical and emotional support in the postnatal period and give participants a list of resources they may like to access. A list is provided in Module 9.

Predicted outcome

Your participants may be concerned as to whether they will be able to breastfeed so it is helpful to learn what will happen to their breasts and the baby's feeding in the early postnatal weeks.

5. THE REALITY OF BREASTFEEDING

Activity 5.1: The reality of breastfeeding

Aim of the activity

To give the participants an understanding of what it is like to breastfeed a baby in the early postnatal weeks.

Materials required

- Two sets of new parents who are willing to discuss their postnatal experience

Time allocation

45-60 minutes

Method one

Invite one or two sets of new parents to the antenatal session to discuss their postnatal experience. The simplest way to acquire the parents is to recruit them from a previous antenatal program and confirm their availability and interest through a telephone call 3-4 days prior to the session.

Note: The time spent on this activity will depend upon the focus that you place upon it. Adults can learn a great deal from their peers so if you want the parents to discuss their birth and postnatal experiences, allow at least half an hour for the birth and $\frac{1}{2}$ – $\frac{3}{4}$ hour for the postnatal experience.

Your role as facilitator will vary depending upon the spontaneity of the participants. You may need to guide the discussion through the use of questions that trigger responses, such as those below, or you may need to refocus an active discussion to keep it relevant. As one of your aims is to give participants an understanding of the reality of breastfeeding, make sure that some time is spent discussing their experience. Complete the activity with a summary of the issues discussed.

Trigger questions

- How would you describe the first six weeks as a mother/father?
- What did you enjoy?
- What have you found hard?
- Has the experience been anything like you expected?
- How would you describe your breastfeeding experience at the beginning? How would you describe it now?
- What has helped you with breastfeeding? What have you found hard?
- What handouts, books, person/people or resources, if any, have you found particularly helpful?

Method two

Begin the activity as described above and after one hour have a break. Divide the large group into single gender groups with the mothers and fathers, or female and male educators, facilitating the small group discussions. This can allow a more intimate discussion to occur. Complete the activity with a summary of the issues discussed.

Predicted outcome

This activity should stimulate an active question and answer session as it brings a sense of reality to the expectant parents. You may need to trigger the initial discussion, but once the level of trust within the group increases, you should find that the questioning becomes spontaneous.

Activity 5.2: 'What if' cards

Aim of the activity

To show participants they have the problem solving skills required by a new parent.

Materials required

- Small cards with one scenario written on each card. On the next page you will find a template that you can photocopy for your cards.
- One copy of the 'Key Issues' fact sheet
- Paper and pen for each small group

Time allocation

30–45 minutes depending on the number of scenarios used.

Method

Divide the large group into sub groups of 4–6 people. Give each group a scenario card, some paper and a pen. Ask them to discuss the scenario and summarise their answers to the problem on the paper. Allow 10–15 minutes for the discussion.

Close the discussions with a spokesperson from each group presenting the answers to the large group. Follow each presentation with a discussion about the key issues in the scenario. We have provided the key issues that need to be addressed on a fact sheet for your reference. Emphasise the importance of clarifying incomplete or inconsistent information/advice they receive and, to complete the activity, give participants a list of resources they may like to access. A list is provided in Module 9.

Notes: The total time allocated to this activity will depend upon the number of scenarios to be discussed. As a guide allow one hour for the activity if you use 4 or 5 scenarios. Scenarios are an excellent way to begin a session if your program is ongoing. You can distribute the cards to those that are present at the beginning of the session and latecomers can join a group as they arrive. After 15 minutes of discussion they form into the large group and you can cover a multitude of information in the discussion that ensues.

The scenarios provided below cover a range of breastfeeding issues. Adapt them or create your own to meet the specific needs of your group. The experiences women and men describe at an antenatal program reunion can be modified for use and are generally more effective because they are reality-based situations. You need, however, to give fictitious names to prevent identification of the people involved.

Predicted outcome

The degree to which the participants will be able to solve the problems will vary, but you will find that this activity will stimulate many questions. It is a reality-based activity that should help them prepare for their own experience.

Activity 5.2 (cont.): Breastfeeding scenarios

1. Cassie and baby Ben have been dozing and sleeping for the first day and now Ben has woken and seemingly wants to breastfeed continuously. Cassie is in tears and doesn't know what to do. What do you think is happening to Ben and how could Cassie deal with this situation?
2. Mary Louise complains to her midwife that her nipples are tender and they have blisters on them. Why do you think they are tender and blistered and how could Mary Louise deal with this situation?
3. Towards the end of the day Rula feels a bit achy and generally unwell. She has a temperature and one of her breasts has a red area that is tender and hot to touch. What do you think is happening here and what should Rula do?
4. Judith and Thomas are sailing along with breastfeeding. At five weeks Thomas becomes very unsettled and wants to feed frequently for a few days. Someone tells Judith to give Thomas a bottle, as he 'must still be hungry'. What do you think is happening and what should Judith do?
5. Elizabeth has a three-week-old baby who is breastfeeding and sleeping well. Elizabeth, however, feels tired, run down and is skipping meals. What should Elizabeth do?
6. Baby Louise is now ready for her first breastfeed. Angela, her mother, feels overwhelmed as her caesarean section was not planned and she is tired, sore and unsure of how to manage Louise and this breastfeed. What do you think Angela and Louise should do?
7. Prudence has premature twins, babies Josh and Sara. They are in the Special Care Nursery and are both being fed by a 'drip'. Prudence wants to breastfeed. What should she do?
8. Skye is breastfeeding three-week-old Cameron. Cameron is settled after taking just one breast each feed. Skye has been told that she should be offering Cameron 20 minutes from both breasts at each feed. How do you think Skye feels and what should she do?
9. Yvonne is 36 weeks pregnant and her family lives overseas. She wants to breastfeed but is wondering how she will cope alone. What should she do?
10. Tehera is a university student from Bengal who has just had her first baby. While all her friends at home breastfeed, she is unsure of how she will manage to breastfeed her new baby with her university commitments and without the support of her family.

Activity 5.2 (cont.): Key issues fact sheet

Scenario One:

This is normal behaviour for a newborn – see Module 3. Telling parents that this is a normal 'time limited' behaviour prevents tears, distress and unnecessary concern regarding milk supply. Women should plan for this by sleeping when their baby sleeps and controlling visitors.

Scenario Two:

Encourage mothers to tune into and interpret the sensations of the baby feeding. Checking nipple shape at end of a feed will help them to work out if the baby was correctly attached. Nipple tenderness peaks around day 5-6 and then diminishes. This is normal stretching of the muscle fibres and skin. Damage to the skin of the nipple is caused by incorrect attachment. Learning to breastfeed is a skill and sometimes during the learning process small blisters and grazes occur but they heal quickly. This can be managed with support, reassurance, fresh air, applying breastmilk to the nipple and wearing non-restrictive clothing.

Scenario Three:

Mastitis can be quickly resolved by applying warmth to the area before a breastfeed, feeding with the baby's chin facing the affected area, and applying cold compresses or cabbage leaves after the feed. Antibiotics should be used if there is no improvement after 24 hours. Plenty of rest and fluids are required. This situation can be prevented by encouraging new mothers to check their breasts after feeds. Regular breast self-examination lays the foundation for good breast health.

Scenario Four:

Thomas is probably having a frequency day or growth spurt. These usually occur at 10-14 days, 4-6 weeks and 3-4 months. Introducing a bottle at this stage will commence the weaning process and undermine the mother's trust in the ability of her breast to produce the milk required to nurture her baby. Bottle feeding is more work for the mother.

Scenario Five:

Breastfeeding mothers need to be aware of their own needs. They should eat when hungry and drink when thirsty. Plan quick meals, healthy snacks and blender drinks. Enlist help from family and friends with cooking. There is no need for fancy supplements. Support for the mother is required, not 'help with the feeding'.

Scenario Six:

The baby's feeding cues must be identified and confirmed. Angela could be assisted into a comfortable position either upright, lying down or supported on her side. Pain relief should be provided. Reassurance should be given because Angela may lack a sense of trust in her body due to the Caesarean section. The shape of the nipple should be checked at the end of the feed, as Angela will be unable to 'feel' the feed due to the pain relief.

Scenario Seven:

Regular breast massage and expression of the breastmilk, by hand or an electric pump, is required. The frequency should gradually increase to 6-8 times in 24 hours. Visiting the nursery regularly, establishing a relationship with the staff and caring for the babies will aid the attachment process. Skin contact and kangaroo care are important. Separate diaries could be kept for the babies to keep track of their progress. Support can be obtained from the Australian Multiple Birth Association and the Nursing Mothers' Association of Australia.

Scenario Eight:

'Telling' mothers what to do undermines their self-confidence. Timing feeds disempowers mothers as it focuses their attention away from the baby's cues to a fixed, clock-driven time frame. Women's breasts are individual. Some mothers may need to offer both breasts, some may not. Mothers and babies need to work it out for themselves. The indicators of 'enough milk' are 6-8 wet nappies per day, an alert baby and weight increase.

Scenario Nine:

Women often unconsciously seek the direct support of their mothers at this time. Acknowledging the presence or absence of the mother as role model can be a useful discussion point for parents. Identify community resources such as the Nursing Mothers' Association of Australia, playgroups etc. Initiate a discussion regarding realistic support from friends.

Scenario Ten:

Breastfeeding in public in Australia is not very common, so newcomers or visitors may presume that Australian women do not breastfeed and thus they do not wish to challenge the host society's norms. Working or studying and breastfeeding is possible, and becoming more common – see the Nursing Mothers' Association of Australia booklet. Identify local, culturally specific, community support groups – both lay and professional.

Activity 6.1: The 24 hour clock

Aim of the activity

To make expectant parents aware of the demands that a baby places on their time and how their lifestyle will change when they become a mother/father.

Materials required

- One copy of the 24-hour clock activity for each participant, and pens

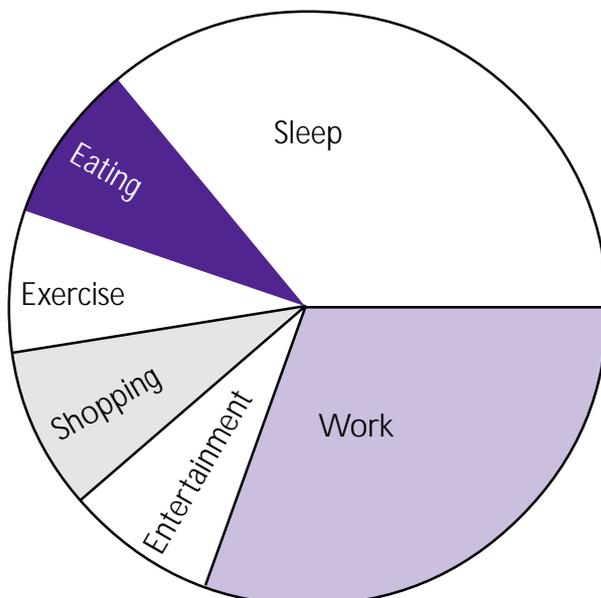
Time allocation

15 minutes

Method one

Give each participant a sheet of paper with two circles drawn on it – each circle represents a 24-hour clock.

Ask them to allocate portions of the first 'clock' to the activities that occupy their typical 24-hour weekday as it is at present. Ask them to categorise the activities e.g. paid work, sleep, domestic chores, leisure time activities etc.



When they have completed the first clock, ask them to divide the second 'clock' into how they believe their time will be allocated when they have their baby at home.

Complete the activity with participants comparing their clocks. Discuss how and why the 'clocks' are different and identify any major differences between those of the women and those of the men. Give an example of a clock you have prepared yourself and emphasise the unique nature of every parenting experience. Reinforce the need for support in the postnatal period and give participants a list of resources they may like to access. A list is provided in Module 9.

Method two

This activity can be presented as a homework activity.

Predicted outcome

The time allocated to daily activities will vary within the group, particularly between the women and the men. Use this activity to stimulate a discussion about the roles of the individuals involved and emphasise the need for support in the postnatal period.

Activity 6.2: 'My needs are'

Aim of the Activity

To give the participants an understanding of the physical and emotional needs of the mother, the father and the baby in the early postnatal weeks.

Materials required

- Paper and pen for each small group

Time Allocation

Small group discussion = 10 minutes

Large group feedback and discussion = 10 minutes

Method

Divide the large group into 3 groups – group 1 is the mother, group 2 is the father and group 3 is the baby. Give each group some paper and a pen. Ask them to list on the paper the physical and emotional changes that they will experience in the early postnatal weeks and the needs they will have as the mother, father and the baby. Allow 10 minutes for the discussion.

Close the discussions with a spokesperson from each group presenting the responses to the large group. Follow the presentations with a general discussion about the changes and needs of the mother, father and the baby in the early postnatal weeks. Emphasise the importance of support in the postnatal period and, to complete the activity, give participants a list of resources they may like to access. A list is provided in Module 9.

Predicted outcome

Incorporating the baby in this activity will provide interest and it will bring a sense of reality to the expectant parents.

Activity 6.3: Community resources

Aim of the activity

To increase the participants' awareness of community resources available to new parents.

Materials required

- Paper and pens

Time allocation

This is a homework exercise. Allow 5 minutes to describe the exercise in one session and 10 minutes for feedback in a subsequent session.

Method

At the end of a session tell participants they have a homework activity to do prior to the next session. Each pair is given the name of one community resource that is available to new parents. Ask them to investigate the resource and answer the questions listed below. They are to present the answers to the group during a subsequent session.

The questions

- Where in your local area is the resource located?
- What services does the resource provide?
- Who operates the resource?
- How do you access it?
- Do you have to pay for the service?
- Does it provide other services?

Note: Due to regional and state variation in community resources available to new parents, the list provided below is to be used only as a guide. Please adapt the list to suit the needs of your participants and your local area.

Community resources the participants could investigate are:

- Early Childhood/Maternal and Child Health Centres
- Family Care Cottages
- Mothercraft Facilities
- Poisons Information Line
- The Nursing Mothers' Association of Australia
- The Australian Multiple Birth Association
- The Family Planning Association
- Their General Practitioner
- Women's Health Clinics/Centres
- Parent Help Line.

Predicted outcome

Many participants will not be familiar with the resources available in their local area. This activity will stimulate their interest.

7. CONCLUSION

Congratulations, you have now completed Module 8 – Breastfeeding-related learning strategies. In this module we have explored:

- activities that you could incorporate in your programs/sessions;
- how the activities could be implemented;
- the likely outcome of the activities.

As we mentioned in Module 4, adults enjoy variety but quality is far more important than quantity. So be flexible, be realistic with the time allowed for each activity and take note and respond to the group's reaction to each one.

Handouts for participants

CONTENTS

1.	Introduction	112
2.	How to use reference material	112
3.	The handouts for participants	113
4.	Conclusion	114

1. INTRODUCTION

Participants in a group see what they want to see, hear what they want to hear and pay attention to whatever is relevant, interesting and meets their specific learning needs. In this handbook we have suggested many strategies by which you can enhance learning in your groups. One strategy which is frequently wasted, or inappropriately used, is the distribution of printed material.

As mentioned in Module 3, the amount of information available to expectant and new parents is extensive and can be overwhelming. As an educator you should not perpetuate the problem but rather assist women and men through the information gathering process.

1.1 Learning outcomes

Upon completion of this module you should be able to:

- identify the material that would be of interest to your target population;
- describe how the material could be distributed.

2. HOW TO USE REFERENCE MATERIAL

Reference material, such as handouts and brochures, can be used to reinforce and increase the retention of important information, as well as address issues you have been unable to cover during a program/session. To maximise its impact, reference material should be distributed at a relevant time in the session and the important points should be explained or summarised. If the material is complex or it covers an issue that has not been dealt with in the session, then a more detailed description may need to be given.

Reference material can be expensive to reproduce and it may have a limited life span, so prior to distribution make sure that it is accurate, concise, up-to-date, relevant to the issues being addressed and does not contain unacceptable advertisements.

3. THE HANDOUTS FOR PARTICIPANTS

At the end of this module we have provided handouts which you may like to distribute to participants in your programs/sessions. Three of them complement the video and the activities in Modules 7 and 8 and will give participants the information they require before they have their baby. Please copy and distribute them as required.

In addition we have included *7 helpful hints for learning to breastfeed* and *7 helpful hints for solving breastfeeding problems*. These brochures were produced by the Nursing Mothers' Association of Australia as one part of the National Breastfeeding Strategy. They are in 6 languages including English.

For participants who speak Chinese, Arabic, Vietnamese or Korean we have included *Successful breastfeeding*. Additional resources are listed in Module 6.

3.1 *Learning to breastfeed: positioning and attaching the baby*

This handout has been designed to accompany the video, *Breastfeeding and you: preparing the way*. It can, however, be used independently as it emphasises the importance of good positioning and attachment of mother and baby during a breastfeed. This underpins a positive breastfeeding experience for mother and baby.

3.2 *Breastfeeding resources for parents*

This handout identifies useful resources for parents. Among the many resources available today, these are the most current and are recommended by the project team. If participants have special needs which have not been addressed in this list, you may like to refer to the additional resources listed in Module 6.

3.3 *Breastfeeding and you: preparing the way*

This handout has been designed to accompany the video of the same name. It summarises the issues raised and provides trigger questions for women, partners and their families.

3.4 *7 helpful hints for learning to breastfeed*

Produced by the Nursing Mothers' Association of Australia this handout is in English, Arabic, Chinese, Vietnamese, Turkish and Spanish.

3.5 7 helpful hints for solving breastfeeding problems

Produced by the Nursing Mothers' Association of Australia this handout is in English, Arabic, Chinese, Vietnamese, Turkish and Spanish.

3.6 7 helpful hints for learning to breastfeed – Korean

Due to a lack of resources available in Korean, the Nursing Mothers' Association of Australia handout described above has been translated.

3.7 7 helpful hints for solving breastfeeding problems – Korean

Due to a lack of resources available in Korean, the Nursing Mothers' Association of Australia handout described above has been translated.

3.8 Successful breastfeeding

Produced by the NSW Multicultural Health Communication Service, this hand-out is in Chinese, Arabic, Vietnamese and Korean.

4. CONCLUSION

Congratulations, you have now completed Module 9 – Handouts for participants. In this module we have explored:

- the material that would be of interest to your target population;
- how the material could be distributed.

The amount of information available to women and men is extensive and can be overwhelming. To assist participants in their information gathering process think about the handouts you distribute and ensure that they are concise, up-to-date, relevant to their learning needs and do not contain unacceptable advertising.

Learning to breastfeed: positioning and attaching the baby

Human milk provides an unequalled food for the healthy growth and development of infants. Breastfeeding, with its unique biological and emotional influences, confers many long-term benefits to both mother and child.

Learning to breastfeed can take time, patience and practice. Before you have your baby, a skill you can begin to learn is good positioning and attachment of the baby during a breastfeed. To help you here are some basic guidelines.

1. You should be comfortable and well supported, either sitting upright or lying down with your breast falling gently towards the baby.
2. Turn the baby on its side so that its whole body and legs are in a straight line facing your breast and nipple. Tuck the baby's legs around your body.
3. Support the baby across the shoulders with your arm and hand underneath the baby, so the baby's whole body can be moved to the breast, not just the head.
4. Make sure the baby's mouth is facing your nipple, with the nipple closer to the baby's nose than their bottom jaw.
5. Make sure the baby's neck is straight and the chin is not tucked onto its chest. The baby is then able to scoop a mouthful of breast with his lower jaw.
6. You may need to shape your breast gently to match the baby's mouth, but there is no need to squash or pinch your breast.
7. You may need to tease the baby's mouth open. Wait for the baby to open its mouth very wide. Wait until this happens before attaching.
8. Bring the baby to your breast – not the breast to the baby.
9. The baby may look 'off centre' on the areola, with more areola covered by the lower jaw and some areola visible under the baby's nose. The baby's chin is tucked into your breast with its nose free of the breast.
10. The first few suckles may be uncomfortable, but this will fade as the milk releases. Watch as the baby's sucking becomes slow and

rhythmical and the baby begins to swallow regularly. If it continues to be uncomfortable take the baby off and try again.

11. Learn to **feel** the feed so you become familiar with the sensation of feeding.
12. Look at your nipple shape when the baby comes off the breast. It should be lengthened but **not** squashed or pinched.

Things to remember

- The baby's **feeding pattern will vary** over the first few weeks. Babies will want to feed more or less often as their needs change. Sometimes they will have a frequency day (growth spurt) around day 10, six weeks and three – four months of age.
- **Length of feeding time will vary** with each feed. Allow the baby to milk the first breast before offering the second side. You will learn to judge this, once your milk comes in, by the softening of your breasts after feeds.
- In the early days, when your breasts are learning about the baby, it helps if you **allow the baby to stay on the first breast** while sucking effectively and the feed is comfortable for you. When the baby comes off consider offering either the first breast again, or the second breast, depending on the fullness of the breast.
- **Good positioning and attachment** of the baby during a breastfeed **prevents** nipple damage and breast infection as the baby is able to milk your breast more effectively.
- **Checking your breast** after each feed, or at least once a day, for any firm or tender areas is **good breast health**.

It is normal to take some weeks for you and your baby to establish a breastfeeding relationship. For some mothers this means that it takes time to develop confidence in understanding their baby's needs.

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January 2000

Breastfeeding resources for parents

Books and pamphlets

'Breastfeeding I Can Do That' by Sue Cox. TasLac, Tasmania. 1997.

'Breastfeeding... Naturally' by NMAA. Nursing Mothers' Association of Australia, Melbourne. 1996.

'Bestfeeding: Getting Breastfeeding Right for You' by Mary Renfrew, Chloe Fisher and Suzanne Arms. Celestial Arts, USA. 1990.

Nursing Mothers' Association of Australia
Booklets

- An Introduction to Breastfeeding
- And So to Family Foods
- Breast and Nipple Care
- Breastfeeding After A Caesarean Birth
- Breastfeeding and Hospitalisation
- Breastfeeding Babies with Clefts of Lip and/or Palate
- Breastfeeding Twins
- Breastfeeding Through Pregnancy and Beyond
- Breastfeeding Your Premature Baby
- Breastfeeding Your Baby with Down Syndrome
- Breastfeeding, Women and Work
- Coping with Breast Refusal
- Especially For Grandparents
- Expressing and Storing Breastmilk
- Increasing Your Supply
- Keeping Baby Cool
- Looking After Yourself
- Relactation and Adoptive Breastfeeding
- Sex and the Breastfeeding Woman
- Survival Plan
- Too Much
- Understanding Wakeful Babies
- Weaning
- Why Is My Baby Crying?
- Your Toddler and the New Baby.

The booklets can be obtained from
Merrily, Merrily Enterprises Pty Ltd
Phone 1800 032 926 or (03) 9886 9399
or your local NMAA group.

Audio tapes

Nursing Mothers' Association of Australia

- Breastfeeding ... Right from the Start
- Softly Softly

Organisations

Nursing Mothers' Association of Australia
www.vicnet.net.au/~nmaa
Australian Multiple Birth Association
www.amba.org.au

Check your telephone directory for the number
of your local group.

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Breastfeeding and you: Preparing the way

You may be aware of the nutritional and health benefits of breastfeeding for your baby but a decision to breastfeed has to take into account your needs as well. You may wonder how you will manage feeding your baby. Whether this is your first or subsequent pregnancy, having a baby certainly changes things. Welcome or not, change requires adjustment.

Many women and men assume that breastfeeding comes naturally. It is more realistic to view breastfeeding as a skill, which is learnt over time. It is a journey of discovery, which begins in pregnancy as you think and prepare for feeding your baby. It then continues over the days, weeks and months after the birth.

To help you prepare for this experience we have put together a series of questions you might like to think about during your pregnancy. They are designed to help you explore how you feel about breastfeeding. They will also assist you to seek the support you will need as you and your new baby learn about breastfeeding together.

Questions for me to think about

- How do I feel about breastfeeding?
- How have my feelings been affected by my family, my friends, my partner, and information I have read?
- How was I fed as a baby?
- What anxieties and fears do I have about breastfeeding?
- If I have breastfed before what was it like?

Questions for me to act upon

- Who can I talk to to get a clearer perspective?
- Who can I approach to give me support?
- What can I ask them to do to support me? Make a list of things they can do.
- If I have had difficulties breastfeeding before, what help will I need to make this experience more enjoyable?

Remember, breastfeeding is much easier with help

Questions for my midwife, doctor or antenatal educator

- What breastfeeding support can I expect in hospital and at home from health staff?
- Where can I get up-to-date written information on breastfeeding?
- What antenatal class can I attend with my support person to discuss issues of interest to me?
- What local support groups can I join now or after my baby is born?
- Who in my local area has a special interest in breastfeeding?
- If I encountered difficulties before with my milk supply, my baby, or experienced other problems or discomforts – how can I reduce the risk of this occurring again?

In making your decision about breastfeeding it is important to work out how you feel about breastfeeding. It is just as important to identify the practical and emotional support available to help you should you need it.

If you have additional concerns, or previous breastfeeding problems, contact a NMAA counsellor, lactation consultant or health professional with a special interest in breastfeeding *before* you have your baby.

Nursing Mothers' Association of Australia
www.vicnet.net.au/~nmaa

Check your local telephone directory for the number of your local NMAA Group.

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7 Helpful hints for learning to breastfeed

Most women can breastfeed. Confidence, support and knowledge all help. These hints will set you on the right track.

1. Sit or lie comfortably - with your own and your baby's clothing out of the way.

2. Turn your baby's body towards you - support him behind his neck and shoulders (not his head) and hold him at the level of your breast. His lower arm can be wrapped around your waist, or tucked along his body which is curved around yours. Hold him in close with his chest against yours, his head tilted back a little

3. Gently touch your baby's mouth with your breast - to encourage her to open her mouth wide to search for your nipple, or wait until her mouth is wide open. Her tongue needs to be forward and well down.

4. Bring your baby to your breast - not your breast to your baby, making sure he takes a good mouthful of breast and areola (the darker area around the nipple). His lips need to be spread, creating a seal and do not appear rolled in.

5. Check her chin is well in against your breast - and her nose is clear to breathe freely without your fingers helping. Check that your breast does not look or feel pulled out of shape.

6. When your baby is feeding well - her jaws and possibly her face muscles and the tips of her ears will all move. You may hear her swallowing.

7. If it doesn't feel right - it probably isn't. Start again, because letting your baby suck in the wrong way can cause problems. It is OK to ask for help. Breastfeeding with good positioning and attachment should not be painful. It should feel good when your baby is feeding the right way

Mother's milk. Perfect.

For help and information about breastfeeding your baby or membership enquiries call the Nursing Mothers' Association on 1300 302 201.



*nursing
mothers*

Korean
July 1998

모유 먹이는 법을 배우는 데 유용한 7가지 도움말 7 Helpful hints for learning to breastfeed

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1. 편안한 자세로 앉거나 누우십시오 - 엄마의 옷과 아기의 옷이 걸려서 방해가 되지 않는 상태로.
2. 아기의 몸을 돌려 엄마와 마주 보게 하십시오 - 아기를 복과 어깨를 (머리가 아니라) 받치고 엄마의 가슴 높이로 안으십시오. 아기의 팔 아래쪽은 엄마의 허리쪽으로 돌려 감게 해도 되고, 아니면 아기의 몸과 나란히 곡선을 이룬 상태로 엄마의 몸에 붙여도 됩니다. 아기의 가슴을 엄마의 가슴에 가까이 대고, 아기의 머리가 약간 뒤로 젖혀진 상태로 안으십시오.
3. 아기의 입을 젖으로 가볍게 건드리십시오 - 아기가 입을 크게 벌리고 엄마의 젖꼭지를 찾게 하든가, 아니면 아기가 입을 크게 벌릴 때까지 기다리십시오. 그리고 아기의 혀는 입 밖을 향하여 아래로 잘 내려가 있어야 합니다.
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6. 아기가 젖을 잘 먹고 있는 경우에는 - 턱과 귀가 다 움직이고, 얼굴의 근육까지도 움직일 수 있습니다. 그리고 삼키는 소리가 들리는 경우도 있습니다.
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엄마의 젖. 완벽합니다.

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ASSOCIATION OF AUSTRALIA

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7 Helpful hints for solving breastfeeding problems

1. Breastfeeding has to be learned - Breastfeeding doesn't necessarily come naturally. For most mothers, it has to be learned. Some babies and their mothers learn quickly, others take a little longer. So if you're having difficulties with breastfeeding - ask for help from the Nursing Mothers' Association or your child health centre. Lots of mothers have the same problems. With a bit of help, you and your baby will enjoy breastfeeding.

2. Getting baby attached properly and in the right position - Getting baby in just the right position and attached properly is important for successful breast-feeding. If feeding hurts, your baby is almost certainly not "on the breast" or "attached" properly. The tip card "7 helpful hints for learning to breastfeed" tells you more about attachment and positioning.

3. How often does my baby need to feed? - It's best to feed whenever your baby seems hungry. When your baby is new, feed at least 8 times in 24 hours including during the night. As he grows, your supply and his needs will change and you may find that he doesn't need to be fed as often.

4. Do I have enough milk? - Sometimes mothers feel that they don't have enough milk or that their milk is not good enough. Be reassured - your milk is the perfect food for your baby if you feel that your baby wants more, let her feed as long or as often as she likes. The more your baby sucks, the more milk you will make. After a few days, your milk supply will build up to meet your baby's needs. A totally breastfed baby is getting enough milk if he or she has six to eight wet (cloth) nappies every 24 hours, is gaining some weight and seems alert and reasonably content.

5. Sore breasts and blocked milk ducts - When you first start making milk, your breasts may feel very full and uncomfortable. If a milk duct becomes blocked, your breasts may become **sore**. The milk banks up, and part of your breast may become tender, hardened and reddish. It can be caused by your baby not sucking properly or not being well positioned at the breast, a tight bra or clothing, or engorgement of the breast. Try feeding your baby more frequently or feeding in slightly different positions. Gently massage the sore part from behind and towards the nipple during the feed and if you need to, use a cold pack afterwards. If you feel unwell or if the problem persists for more than 24 hours, you need to see your doctor.

6. Sore nipples - It's normal for your nipples to be sensitive in the first few days of breastfeeding - but they will get better. Wash them only with water - soaps or shampoo will dry them out. A little breastmilk on the nipple allowed to air can help sore or dry nipples. If your nipples become very sore or cracked your baby may not be attaching properly when feeding.

7. Where to get help ~ Nursing Mothers' Counsellors can help you solve breastfeeding problems. Just like riding a bike or driving a car, it takes practice and support to learn to breastfeed. Remember if it hurts, something is not right and you may need help

Mother's milk. Perfect.

For help and information about breastfeeding your baby or membership enquiries call the Nursing Mothers' Association on 1300 302 201.



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mothers*

모유 먹이기에 따르는 문제점들을 해결하는 데 유용한 7가지 도움말 7 Helpful hints for solving breastfeeding problems

1. 모유를 먹이는 방법은 배워야 하는 것입니다 - 모유먹이기는 누구나 서질로 잘 하게 되는 것이 아닙니다. 대부분의 아기 엄마들은 배워서 익혀야 합니다. 빨리 배우는 아기들과 엄마들이 있는가 하면, 시간이 좀 걸리는 경우도 있습니다. 그러므로 모유 먹이기에 어려움이 따르면, 육아협회[Nursing Mothers' Association]나 유아보건센터에 도움을 청하도록 하십시오. 같은 어려움을 겪는 엄마들이 많습니다. 약간의 도움으로도, 아기와 함께 모유먹이기를 즐길 수 있게 될 것입니다.

2. 젖의 바른 위치를 정확하게 물리기 - 모유를 제대로 먹이기 위해서는 아기에게 젖의 바른 위치를 정확하게 물리는 것이 중요합니다. 아기에게 젖을 먹일 때 아프면, 젖을 "물린 위치"가 틀렸거나, 아니면 젖을 "물린 방법"이 잘못 된 것임에 거의 틀림 없습니다. 젖을 물리는 방법과 위치에 관해서는 "모유 먹이는 법을 배우는 데 유용한 7가지 도움말"이라는 제목의 안내서에 더욱 자세히 설명되어 있습니다.

3. 젖은 얼마나 자주 먹여야 하나? - 아기가 배고파 보일 때마다 먹이는 것이 가장 좋습니다. 신생아의 경우는 밤낮을 합해서 24시간 동안에 최소한 8번을 먹이십시오. 아기가 필요로 하는 수유의 횟수와 엄마 젖의 생산량은 아기가 자라면서 변하게 되므로, 나중에는 신생아 때만큼 자주 먹일 필요가 없게 될 것입니다.

4. 젖이 과연 충분한가? - 자신의 젖이 아기에게 양적으로나 질적으로 충분치 않다고 생각하는 엄마들이 간혹 있습니다. 안심하십시오 - 엄마의 젖은 아기에게 완벽한 음식입니다. 아기가 젖을 더 먹고 싶어 하는 것같이 생각되면, 아기가 원하는 만큼 오래 먹이고 자주 먹이십시오. 젖은 아기가 많이 빨수록 그만큼 더 많이 만들어 집니다. 며칠 지나면, 젖의 생산량이 아기에게 필요한 만큼 늘어날 것입니다. 모유만 먹는 아기의 경우에는 오줌 기저귀(형질)가 24시간마다 여섯 개 내지 여덟 개 나오고, 체중이 늘며, 푹푹하고 만족해 보이는 편이면, 젖을 충분히 먹고 있는 것입니다.

5. 아픈 유방과 막힌 유선 - 젖이 처음 돌기 시작할 때는, 유방이 크게 부풀고 불편하게 느껴지는 경우가 있습니다. 유선이 막히게 되면, 유방이 아프게 될 수도 있습니다. 젖이 가득 차오르고 유방이 부분적으로 아파지면서 단단해지고 뻣그스름해 집니다. 이런 현상은 아기가 정확하게 빨지 않거나 젖을 잘못 물림으로서 생길 수 있으며, 꼭 끼는 브라나 옷 때문일 수도 있고, 또는 유방이 충혈되었기 때문일 수도 있습니다. 그럴 때는 젖을 좀 더 자주 먹이거나, 또는 위치를 약간 바꾸어 먹여 보십시오. 젖을 먹이는 동안 아픈 부위를 가볍게 유두 쪽으로 내리듯이 마사지 하십시오. 그리고나서 필요하다면 냉찜질을 하십시오. 몸이 안 좋게 느껴지거나 문제가 24시간 이상 지속되는 경우에는, 의사에게 가 봐야 합니다.

6. 아픈 유두 - 모유를 먹이기 시작하여 처음 며칠 동안은 유두가 민감해지는 것이 보통입니다 - 하지만 시간이 가면서 나아지게 됩니다. 유두를 씻을 때는 물만 사용하십시오 - 비누나 샴푸를 쓰면 유두가 건조해 집니다. 유두에 젖을 조금 발라서 공기에 쏘이면 아프고 건조한 유두가 좀 나아질 수 있습니다. 유두가 많이 아파지거나 갈라지면, 아기가 젖을 먹을 때 정확하게 물지 않기 때문일 수도 있습니다.

7. 도움을 받을 수 있는 곳 - 육아전문 카운셀러[Nursing Mothers' Counsellor]들은 모유 먹이기에 따르는 문제점들을 해결할 수 있도록 도와 드립니다. 자전거 타거나 차 운전할 때와 마찬가지로, 모유 먹이는 방법을 배우는 데는 연습과 도움이 필요합니다. 젖을 먹일 때 아프면, 뭔가 잘못 된 것이며 도움이 필요할 수도 있다는 점을 염두에 두십시오.

엄마의 젖. 완벽합니다.

아기에게 모유를 먹이는 것에 관하여 도움과 정보가 필요하거나 본 협회 회원자격에 관하여 문의하려면 육아협회에 전화하십시오. 전화번호는 1300 302 201입니다.

Successful Breastfeeding

Why breastfeed?

Breast milk gives babies an ideal, balanced food which is easily digested, and contains antibodies to protect them from some illnesses. As a baby grows, breast milk adjusts to suit his changing needs. This means he gets the right food for each stage of his development. The World Health Organisation recommends that women should breastfeed for at least six months.

How soon should you breastfeed?

As soon as possible after childbirth. At first the breasts produce an early milk (colostrum) which is either clear or a creamy yellow colour. It may not look like milk and the amount may be small, but it's rich in nutrients your baby needs. By about the third or fourth day the milk becomes thinner and whiter. If the baby seems unsettled and "fusses" at the breast at this stage, don't worry - he's just adjusting to the different amount of milk. Extra milk from a bottle isn't necessary and may disrupt breastfeeding.

Getting started

Breastfeed in a comfortable position (eg. lying on your side or sitting up with pillows to support your back and arms.) Make sure the baby's mouth is correctly attached to the nipple by:

- Making sure the baby's mouth is wide open with his tongue down. Brush your nipple against the baby's lips until he opens wide.
- Bringing the baby to your breast instead of moving your whole body and breast towards the baby.
- Making sure the whole nipple and as much of the areola (the coloured area around the nipple) as possible is in the baby's mouth.

The baby should suck steadily with no clicking noise. Let him suck for as long as he wants on one breast, then offer the other side. To remove the baby from the breast gently slip a finger into the corner of his mouth to break the suction. Always offer the second side first at the next feed.

To help a baby bring up wind during or after a feed, hold him sitting upright (not slumping) on your knee or against your chest without pressure on his tummy. Gently pat his back. Take time. Walk around. Not all babies bring up wind, however.

How often should you feed the baby?

As often as he wants. Frequent feeds won't make you run out of milk - the more the baby sucks, the more milk you'll make.

Is the baby getting enough milk?

Your baby is getting enough if he gains weight satisfactorily and has 6-8 wet nappies in 24 hours. Don't worry if he loses a little weight in the first few days - most babies do. Breastfed babies rarely need extra food or water from a bottle. If you're worried about our baby's weight, talk to an Early Childhood Centre Sister or doctor before giving any extra food from a bottle or spoon.

How can I increase my milk supply?

Try to relax and breastfeed your baby more often - the more the baby sucks, the more milk you produce. Poor diet, fatigue and stress can affect milk supply, so get enough rest, healthy food and plenty of fluids. Ask your partner or other family members if they can help with cooking or housework, and caring for the whole family.

Breast Problems

Painful lumpy breasts

When you first start making milk, or when the baby starts sleeping through the night, breasts can become engorged with milk, making it hard for the baby to feed. Soften breasts by expressing some milk (gently squeezing milk from the areola by hand) before a feed. Applying warm towels and massage helps.

Sore Nipples

If there's tenderness lasting longer than 15 to 20 seconds after the beginning of a feed get expert advice. Dampness also makes nipples sore. Loose cotton clothes and dry pads (not waterproof) inside your bra help. A sharp pain in the nipple lasting through a feed may mean a cracked nipple. Rub a drop of milk onto the nipple after feeding and let it dry. If the baby's sucking hurts a lot, before you put your baby on the breast start the milk flow by expressing a little by hand. If pain continues see your Early Childhood Centre Sister or doctor - a cracked nipple can lead to a breast infection.

Breast Infection

If when you and your baby have settled into a breastfeeding routine, and have flu-like symptoms (feeling sick and feverish), and your breast is hard, painful and red, see your doctor immediately. Early help to cure the infection will mean you can continue to breastfeed uninterrupted.

Where to go for help

The local Early Childhood Centre, the midwives at the maternity unit at your hospital or your family doctor. A maternity unit can also put you in touch with a lactation consultant or an ethnic obstetric liaison officer - this is a bilingual midwife who helps women from non-English speaking backgrounds. Ask the Early Childhood Centre if there is a trained interpreter available. This service is free and confidential.

Nuôi con bằng sữa mẹ đúng cách Successful Breastfeeding

Tại sao phải nuôi con bằng sữa mẹ?

Why breastfeed?

Sữa mẹ là thức ăn hoàn hảo, dễ tiêu cho em bé và có chứa nhiều kháng thể bảo vệ em bé chống lại một số bệnh. Khi bé tăng trưởng, sữa mẹ cũng thay đổi để phù hợp với sự phát triển cơ thể của bé. Tổ Chức Y Tế Thế Giới (The World Health Organisation) khuyến khích phụ nữ nên cho con bú sữa mẹ ít nhất trong sáu tháng.

Nên cho bé bú lúc nào sau khi sinh?

How soon should you breastfeed?

Nên cho bú liền sau khi bé chào đời. Thoạt đầu, vú tiết ra sữa non (colostrum) có màu trắng trong hoặc vàng kem. Sữa non trông có vẻ không giống như sữa thật và số lượng tuy ít nhưng chứa nhiều chất dinh dưỡng em bé cần. Vào khoảng ngày thứ ba hoặc thứ tư, sữa mẹ trở nên lỏng và trắng hơn. Nếu trong khoảng thời gian này bé thường hay khóc và không chịu bú, đừng nên quá lo lắng vì bé đang tự điều chỉnh cho phù hợp với số lượng và chất sữa mới. Không cần cho bé bú dặm thêm sữa bình vì như thế có thể làm gián đoạn việc bú sữa mẹ của bé.

Khởi đầu

Getting started

Nên chọn một tư thế thoải mái khi cho con bú (thí dụ nằm nghiêng một bên hay kê gối đỡ lưng và cánh tay). Hãy cẩn thận cho miệng bé ngậm núm vú đúng thế bằng cách:

- Làm cho miệng bé mở rộng và điều quan trọng là lưỡi nằm dưới đầu vú. Dùng đầu núm vú khều môi bé cho đến khi bé mở miệng ra.
- Đưa bé đến gần vú thay vì di chuyển cá thân người mẹ và vú đến gần bé.
- Để ý miệng bé ngậm cá núm vú và quầng vú (the areola) càng nhiều, càng tốt.

Bé nên nút đều đặn và không gây tiếng động. Cho bé bú một bên vú cho đến khi chán rồi mới đổi sang vú bên kia. Muốn tách rời bé ra khỏi vú, đưa một ngón tay một cách nhẹ nhàng vào góc miệng của bé để làm cho bé ngưng nút. Khi cho bé bú lần kế tiếp, luôn luôn cho bé bú bên vú mình vừa cho bú giờ lần trước.

Để giúp cho bé ợ hơi trong lúc bé đang bú hay sau khi bé bú xong, giữ bé ngồi thẳng (không nghiêng) trên đầu gối hay áp sát vào trước ngực bạn, nên tránh ép vào bụng của bé. Vỗ nhẹ vào lưng của bé. Đi tới lui chậm chậm. Tuy nhiên, không phải em bé nào cũng ợ hơi cả cho nên bà mẹ cũng đừng quá lo lắng nếu bé không ợ hơi được.

Nên cho bé bú bao nhiêu lần?

How often should you feed the baby?

Tùy theo nhu cầu đòi hỏi của bé. Cho con bú thường xuyên, bà mẹ đừng lo bị cạn sữa - bé càng bú nhiều chừng nào thì sữa sẽ tạo ra nhiều chừng ấy.

Em bé có được bú đầy đủ chưa?

How often should you feed the baby?

Bé bú đủ lượng sữa nếu bé lên cân đều đặn đúng tiêu chuẩn và đi tiêu, tiểu làm ướt 6-8 tã lót trong 24 giờ. Đừng lo nếu thấy bé sụt cân một ít trong mấy ngày đầu - hầu hết các trẻ sơ sinh đều như vậy. Bé bú sữa mẹ ít khi cần bú dặm thêm thực phẩm khác hoặc nước. Nếu bà mẹ

có gì lo lắng về trọng lượng của bé, nên hỏi y tá ở Dưỡng Đường Ấu Nhi (Early Childhood Clinic Sister) hoặc bác sĩ trước khi cho bé bú hoặc ăn dặm thêm.

Làm sao có thể tăng số lượng sữa?

How can I increase my milk supply?

Cố gắng nghỉ ngơi và quan trọng là cho bé bú thường xuyên hơn - bé bú càng nhiều sữa sẽ chảy ra càng nhiều. Ăn uống khăm khổ, mệt mỏi và căng thẳng có thể ảnh hưởng đến lượng sữa cung cấp, cho nên cần nghỉ ngơi đầy đủ, ăn thực phẩm bổ dưỡng và uống nhiều nước. Hãy yêu cầu người chồng hay người thân khác trong gia đình xem họ có thể giúp đỡ bạn việc nấu nướng hay công việc nội trợ và chăm sóc cho cả gia đình không.

Những chứng bệnh của vú?

Breast Problems

Vú bị căng cứng và đau

Painful lumpy breasts

Khi bà mẹ khởi sự cho con bú, nhất là sau khi em bé ngủ suốt đêm, vú có thể bị căng cứng sữa, làm cho em bé gặp khó khăn khi bú. Làm vú bớt căng cứng trước khi cho con bú bằng cách nặn bỏ một ít sữa (dùng tay nặn nhẹ một ít sữa ra khỏi đầu núm vú). Dùng khăn thấm nước ấm và xoa bóp cũng có hiệu quả.

Đau đầu vú?

Sore nipples

Từ lúc bắt đầu cho con bú, nếu sau 15 đến 20 giây mà đầu vú vẫn còn cảm giác đau đớn thì cần đi khám bác sĩ. Ngay cả sự ẩm ướt cũng là nguyên nhân làm đau đầu vú. Mặc quần áo rộng bằng vải sợi và dùng miếng lót đầu vú loại dễ hút nước đặt bên trong áo lót cũng có hiệu quả. Cảm giác đau nơi đầu vú trong suốt thời gian con bú có thể dẫn đến chứng nứt đầu vú. Sau mỗi lần cho con bú xong, thử nặn sữa thoa nơi đầu vú và chờ cho khô. Nếu việc bé nút sữa làm bà mẹ đau, trước khi cho con bú hãy khơi dòng sữa bằng cách dùng tay nặn nhẹ nơi đầu vú. Nếu vẫn còn thấy đau khi cho bé bú, hãy đến gặp nhân viên y tá tại Dưỡng Đường Ấu Nhi hoặc bác sĩ để xin khám vì đầu vú bị nứt có thể dẫn đến việc nhiễm trùng vú.

Sự nhiễm trùng vú?

Breast infection

Nếu sau khi việc cho con bú đã trở nên quen thuộc và người mẹ có triệu chứng như bị cúm (cảm thấy không khỏe và sốt), vú cương cứng, đau đớn và có màu đỏ, hãy đi khám bác sĩ ngay. Nếu được chữa trị sớm chứng nhiễm trùng vú thì việc cho con bú sẽ không bị gián đoạn và đỡ đau.

Nơi nào có thể giúp khi cần

Where to go for help

Trung Tâm Ấu Nhi địa phương (Early Childhood Centre) hoặc nhân viên hộ sinh trong khu hộ sản của bệnh viện. Ở khu hộ sản bà mẹ cũng có thể được sự hướng dẫn và giúp đỡ của nhân viên cố vấn về việc sanh sữa hoặc nhân viên liên lạc sản khoa người Việt. Hãy hỏi Trung Tâm Ấu Nhi xem họ có thể cung cấp một thông dịch viên có huấn luyện hay không. Dịch vụ này miễn phí và được giữ kín.

성공적인 모유 수유법 Successful Breastfeeding

모유를 먹이는 이유는?

모유는 영양분이 골고루 균형있게 들어있고 소화시키기 쉬운, 아기들에게 이상적인 음식입니다. 그리고 모유에는 아기들을 질병으로부터 보호해 주는 항체들이 들어있습니다. 모유의 성분은 아기의 발육에 따라 달라지는 신체요구조건에 맞추어 조절됩니다. 이는 아기가 각 발육단계에 적합한 음식을 먹게 된다는 뜻입니다. 세계보건기구에서는 여성들에게 적어도 6개월 동안은 모유를 먹이라고 권장하고 있습니다.

모유는 언제부터 먹이기 시작해야 하나?

해산 후 되도록이면 빨리 먹이기 시작하십시오. 초기에 나오는 젖(초유)은 맑거나 크림같이 노르끼리한 색인데, 젖같이 안 보이고 양이 적더라도 아기에게 필요한 영양분은 풍부히 들어있습니다. 삼사 일째쯤 되면 젖이 묽어지고 색이 뽕애 집니다. 이 단계에서는 아기가 편치 않은듯이 보이고 "젖투정"을 하더라도 걱정할 것이 없습니다 - 젖의 양이 달라지는 것에 적응하느라고 그럴 뿐입니다. 젖병으로 분유를 따로 더 먹이는 것은 모유먹이기에 방해만 될 뿐이지 아기에게는 필요치 않습니다.

시작 단계

모유를 먹일 때는 우선 편안한 자세를 취해야 합니다 (예. 옆으로 눕던가 아니면 배개로 허리와 팔을 받치고 앉음). 그리고 다음과 같은 방법으로 아기의 입이 젖꼭지에 바르게 물리게끔 해야 합니다:

- 아기의 입이 크게 벌어져 있고 혀가 아래로 내려가 있는지 확인합니다. 아기가 입을 크게 벌릴 때까지 젖꼭지로 아기의 입술을 가볍게 건드립니다.
- 엄마의 몸을 움직여 젖을 아기에게 갖다낼 것이 아니라 아기의 몸을 움직여 젖에 갖다댁니다.
- 젖꼭지 전체가 아기에 입에 들어가고, 유륜(젖꼭지 가장자리의 착색부분)도 되도록 많이 아기의 입에 들어가야 합니다.

아기가 쫓쫓소리를 내지 않고 꾸준히 빨면 젖을 제대로 빨고있는 것입니다. 아기가 원하는 만큼 한쪽 젖을 충분히 오래 빨리고 난 후, 다른 쪽도 마저 물리십시오. 아기를 젖에서 떼 때는 손가락을 아기의 입 옆으로 살며시 밀어 넣어 흡착상태를 깬 후에 합니다. 젖을 먹일 때는 항상 앞에서 나중에 먹인 쪽부터 먹이십시오.

젖먹이는 중간이나 후에 아기를 트림시키려면, 무릎 위에 곧추세워 앉히거나 (구부정하지 않게), 아니면 배가 눌리지 않게끔 하면서 가슴에 안습니다. 그리고는 가볍게 등을 두드려 줍니다. 천천히 하십시오. 아기를 안고 왔다갔다해 보기도 하십시오. 그러나 어느 아기나 다 트림하는 것은 아닙니다.

젖은 얼마나 자주 먹여야 하나?

아기가 원하는 만큼 자주 먹이십시오. 자주 먹이는 것으로 인해 젖이 떨어지게 되는 것이 아닙니다 - 젖은 아기가 많이 빨수록 그만큼 더 많이 만들어집니다.

아기가 젖을 충분히 먹고 있는가?

아기의 체중이 양호하게 늘고, 24시간 동안에 오줌기저귀가 6-8개 나오면, 아기가 젖을 충분히 먹고 있는 것입니다. 생후 몇일 후에 몸무게가 약간 줄어도 걱정할 것이 없습니다 - 대부분의 아기들이 그렇습니다. 모유를 먹고 자라는 아기들에게는 젖병으로 다른 음식이나 물을 따로 더 먹일 필요가 거의 없습니다. 아기의 체중이 염려되는 경우에는 젖병이나 숟가락으로 음식을 따로 더 먹이기 전에 유아보건센터(Early Childhood Centre) 간호사나 의사와 먼저 상담하도록 하십시오.

젖이 더 많이 나게 하려면?

마음을 편히 갖고 아기에게 젖을 더 자주 물리도록 해 보십시오 - 젖은 아기가 많이 빨수록 많이 생깁니다. 건강치 않은 식생활, 피로, 스트레스로 젖이 잘 안 나게 될 수 있으니 휴식을 충분히 취하고, 건강식을 하며, 수분을 많이 섭취하십시오. 배우자나 다른 식구들에게 집안살림과 전가족 돌보는 일을 거들어 줄 수 있는지 물어 보십시오.

유방에 생기는 문제들

아프고 멍어리지는 유방

젖이 처음 돌기 시작할 때, 또는 아기가 밤새 깨지 않고 잠자기 시작할 때, 젖이 딱딱하게 붙어서 아기가 젖먹기 힘들게 되는 경우가 있습니다. 젖을 먹이기 전에 먼저 조금 짜 내어 (손으로 유륜을 살살 눌러서 젖을 짤) 부드러워지게 하십시오. 그리고 따뜻한 물수건을 대거나 마사지를 하면 도움이 됩니다.

아픈 젖꼭지

젖을 먹이기 시작하여 15초 내지 20초 이상 통증이 계속되면 전문가의 조언을 받아야 합니다. 젖꼭지가 축축해도 아프게 됩니다. 품이 넉넉한 면 옷을 입고 건조한 패드(방수되지 않는 것)를 브라 안에 대면 도움이 됩니다. 젖먹이는 동안 내내 젖꼭지가 쓰라리게 아프면 젖꼭지가 갈라졌다는 뜻일 수도 있습니다. 젖을 다 먹고 난 후에 젖을 한 방울 짜서 젖꼭지에 분질리 바른 후 그대로 말리십시오. 아기가 빠는 것이 많이 아프면, 젖을 물리기 전에 손으로 먼저 조금 짜서 젖이 잘 나오게 하십시오. 통증이 계속되는 경우에는 유아보건센터 간호사나 의사에게 가 보십시오 - 갈라진 젖꼭지로 인해 유염이 생기게 되는 수도 있습니다.

유염

모유먹이기가 자리잡히고 난 후에 감기같은 증세(몸이 아프고 열이 남)와 함께 젖이 딱딱하고 아프면서 빨강게 되면, 의사에게 즉시 가 보도록 하십시오. 감염을 조기에 완치할 수 있게 되면 중단하지 않고 계속 모유를 먹일 수 있습니다.

도움을 받을 수 있는 곳

각 지역 유아보건센터, 병원 산과의 조산사, 또는 가정의로부터 도움을 받을 수 있습니다. 산과에서는 또한 수유컨설턴트 (lactation consultant)나 소수민족 산과연락관 (ethnic obstetric liaison officer) (비영어권 여성들을 도와주는 조산사로서 영어와 한국어를 둘 다 구사함)과 연결시켜 줄 수도 있습니다. 유아보건센터에 보건전문 통역사가 있는지 물어 보십시오. 이 서비스는 무료이며 비밀이 보장됩니다.

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成功的母乳哺嬰 Successful Breastfeeding

爲何哺以母乳？ Why breastfeed？

母乳是嬰兒最理想的、營養均衡的食物，容易消化，並且含有抗體，能預防他們患上某些疾病。在嬰兒成長期間，母乳的成份會按照嬰兒的需要改變而轉變。這樣，嬰兒在每個成長期都能獲得正確的營養。世界衛生組織 (World Health Organization) 建議婦女們應該以母乳哺嬰不少於六個月。

妳應何時開始以母乳哺嬰呢？ How soon should you breastfeed？

嬰兒在出生後應該盡早哺以母乳。起初，乳房製造的初乳 (colostrum) 是沒有顏色的或是奶黃色的。它可能看來不像奶，而且份量可能少，但是它含有大量嬰兒所需的營養。到大約第三天或第四天，這種奶就變得稀一點和白一點。如果嬰兒在這個時期看來是不安寧，並且在哺乳時表現無謂的紛擾，不用擔心——他正在適應份量改變了的奶。不需要用奶瓶給他額外的奶，因為這樣做可能會干擾哺乳。

哺乳的步驟 Getting started

哺乳時姿勢要舒適(例如，妳可以側臥或坐起，以枕頭支撐著妳的背部和手臂)。要確保嬰兒的口是正確地與妳的乳頭相繫；

- 確保嬰兒的口是大大地張開，舌頭向下。用妳的乳頭掃嬰兒的唇，直至他把口大大地張開為止。
- 把嬰兒抱近妳的乳房，而不是把妳的整個身軀和乳房移向嬰兒。
- 確保妳的整個乳頭和乳暈(環繞乳頭有顏色的部位)的絕大部份都被含在嬰兒口中。

嬰兒應平穩地吮吸和沒有喀嚙聲。讓他在一個乳房隨意吮吸，不要限制時間，然後給他另一邊。若要把嬰兒從乳房移開，可以輕輕地把一只手指放入他的嘴角，以便阻止他繼續吮吸。在下次哺乳時，記住先給他上次授乳時最後吮吸的那邊乳房。

爲了幫助嬰兒在哺乳中途或哺乳後搓風(吐出吃奶時所吞進的空氣)，將嬰兒用手扶著，讓他坐正(不要讓他的身體屈曲)在妳的膝蓋上，或把他靠在妳的胸前，但不要壓著他的腹部。輕拍他的背部，不要着急，週圍行走。但是，不是所有嬰兒都搓風的。

妳應多久給嬰兒哺乳一次呢？ How often should you feed the baby ？

嬰兒什麼時候要奶，就給他哺乳吧。時常哺乳不會使妳缺奶——嬰兒吮吸的次數越多，妳所造的奶就越多。

嬰兒獲得足夠的奶嗎？ Is the baby getting enough milk？

如果妳的嬰兒體重增加的情況令人滿意，並且在二十四小時內有六至八塊濕尿布，他就獲得足夠的奶了。如果他在起初的數天內體重減輕了一點點，不要擔心——大多數嬰兒都會出現這種情形。母乳哺育的嬰兒很少需要用奶瓶給予額外的食物或水。如果妳擔心妳的嬰兒的體重，在未用奶瓶或匙羹給他額外的食物之前，請先請教幼兒保健中心 (Early Childhood Health Centre) 的護士或妳的醫生。

怎樣增加我的奶供應量？ How can I increase my milk supply ？

盡量放鬆及增加喂奶次數——嬰兒吮吸的次數越多，妳造的奶就越多。飲食不均衡、疲倦以及情緒壓力都會影響奶的供應量。因此，要有足夠的休息、吃健康的食物和喝大量的水份。請您的伴侶或其他家人幫忙烹煮或做家務及照顧全家吧。

乳房的問題 Breast Problems

乳房疼痛、出現硬塊 Painful lumpy breasts

在妳最初開始造奶時，或當嬰兒開始整晚熟睡而妳不用半夜起來哺乳時，妳的乳房可能會充乳，以致乳房變得很硬，使嬰兒難于吃奶。在未哺乳前，先擠出一些奶(用手輕輕地從乳暈擠出奶)，乳房就會軟一點而不會太脹了。在乳房上放暖毛巾及按摩會有幫助。

疼痛的乳頭 Sore Nipples

如果在開始哺乳之後，痛楚超過十五至二十秒鐘，妳應向專家請教。濕氣也會使乳頭疼痛。穿松身的棉布衣服和在胸圍內放上干的布墊(不是防水的那一種)會有幫助。如果在整次哺乳的過程中，乳頭出現刺痛的现象，這可能意味乳頭破裂了。在每次哺乳後，用少量奶塗在乳頭上揉一揉，等它干了為止。如果嬰兒吮吸時給妳很多痛楚，在未把嬰兒放到乳房上之前，用手先擠出少許奶，使奶開始流出。如果繼續出現痛楚，去見幼兒保健中心的護士或妳的醫生吧——裂開的乳頭可以導致乳房受到感染。

乳房的感染 Breast Infection

當妳和妳的嬰兒已形成某一種哺乳的習慣時，如果妳出現流行性感冒般的徵狀(感覺不適和發燒)，而且妳的乳房是硬的，疼痛和發紅，就應立即去見醫生。及早求醫可以使妳繼續以母乳哺嬰，而使哺乳不至中斷。

去哪里求助 Where to go for help

當地的幼兒保健中心或醫院產科的助產士都可以幫助妳。產科的職員也可以替妳與哺乳顧問 (Lactation consultant) 或民族產科聯絡員 (ethnic obstetric liaison officer) 聯絡——后者是雙語的助產士，幫助來自非英語背景的婦女。向幼兒保健中心查詢有沒有受過訓練的傳譯員吧，這項服務是免費和保密的。

الإرضاع الناجح من الثدي

لماذا الإرضاع من الثدي *Why breastfeed?*

يعطي حليب الأم الأطفال غذاءً مثالياً ومتوازناً يمكن هضمه بسهولة، وهو يحتوي على مضادات حيوية لحمايتهم من بعض الأمراض. وكلما كبر الطفل يتعدل حليب الأم ليتناسب مع حاجاته المتغيرة، وهذا يعني أنه يحصل على الغذاء المناسب في كل مرحلة من مراحل نموه. وتنصح «منظمة الصحة العالمية» (World Health Organisation) النساء بالإرضاع لمدة ستة أشهر على الأقل.

متى يجب أن تبدأي بالإرضاع؟ *How soon should you breastfeed?*

في أقرب فرصة بعد الوضع، أي في غرفة الولادة. وأول حليب يخرج من الثديين يدعى «اللباء» (colostrum) ويكون إما صافياً أو أصفر شاحب اللون. وقد لا يبدو كالحليب ويمكن أن يكون قليل الكمية، لكنه غني بالمغذيات التي يحتاجها طفلك، وفي حوالي اليوم الثالث أو الرابع يصبح الحليب أرق وأكثر بياضاً. وإذا كان طفلك يبدو غير مستقراً ولا يهدأ على صدرك في هذه المرحلة، لا تقلقي - فهو يتكيف مع الكمية المختلفة من الحليب فقط. إن إعطاء حليب إضافي من القنينة غير ضروري وقد يعيق الإرضاع.

كيف تبدأين؟ *Getting started*

مارسي الإرضاع وأنت في وضع مريح (مثلاً وأنت مستلقية إلى جانبك أو في وضع جلوس مُستيدة ظهرك ويديك بالمخدات). وتأكدي من أن فم الطفل ملتصق بشكل صحيح بحلمة الثدي وذلك باتباع ما يلي:

- التأكد من أن فم الطفل مفتوح على مداه ولسانه إلى أسفل. إفركي حلمتك على شفتي الطفل حتى يفتح فمه واسعاً.

- جلب الطفل إلى صدرك وعدم إحناء جسدك باتجاه الطفل.

- التأكد من أن الحلمة بكاملها وأكثر ما يمكن من الحلقة الملونة «اللعوة» (المساحة الموجودة حول الحلمة) داخل فم الطفل.

يُفترض بالطفل أن يرضع بشكل ثابت من دون إصدار صوت طقطقة. دعيه يرضع لما يشاء.

من الوقت على ثدي واحد ثم إعرضي عليه الجانب الآخر. ولكي تنزعي الطفل عن الثدي أدخلي أحد أصابعك بلطف في زاوية فمه كي توقفيه عن الإرضاع. إعرضي الجانب الثاني دائماً عند بداية الإرضاع التالية.

لمساعدة الطفل على التجشؤ أثناء أو بعد الإرضاع، إمسكيه بوضع الجلوس المستقيم (وليس المسترخي) على ركبتيك أو متكئاً على صدرك دون ضغط علي معدته. ربتي على ظهره بلطف. خذي وقتك إمش به. وتجدر الإشارة الى أن بعض الأطفال لا يتجشؤون.

كم مرة يجب أن تُرضعي الطفل؟
How often should you feed the baby?

متى يشاء، إنّ الإرضاع الكثير لا يسبب نشاف حليبك. فكلما رضع الطفل كلما ازداد إنتاجك للحليب.

هل يأخذ الطفل ما يكفي من الحليب؟
Is the baby getting enough milk?

إنّ طفلك يأخذ ما يكفي إذا كان يكسب الوزن بشكل مرضي وكان يتبول من ٦-٨ مرات كل ٢٤ ساعة. لا تقلقي إذا خسر قليلاً من وزنه في الأيام القليلة الأولى - فهذا يحصل لمعظم الأطفال. إنّ الأطفال الذين يرضعون من حليب الأم نادراً ما يحتاجون الى غذاء إضافي أو ماء من القنينة. إذا كنت قلقة على وزن طفلك، تحدثي الى «ممرضة عيادة الطفولة المبكرة»، (Early Childhood Clinic Sister) أو الى الطبيب قبل إعطائه أيّ غذاء إضافي من القنينة أو بالملعقة.

كيف أستطيع زيادة مخزون حليبي؟
How can I increase my milk supply?

حاولي الإسترخاء وارضعي طفلك أكثر - فكلما رضع الطفل كلما ازداد إنتاجك للحليب. إنّ النظام الغذائي الضعيف والتعب والإجهاد جميعها قد تؤثر على مخزون الحليب. إذن عليك بالإسترخاء بشكل كاف، وبنظام غذائي صحي وبشرب الكثير من السوائل. أطلبي من شريكك أو أحد أفراد أسرتك إذا كان بإمكانهم مساعدتك بتحضير الطعام وأعمال المنزل، وبرعاية جميع أفراد العائلة.

مشاكل الثدي Breast problems

ثديان متكتلان مؤلمان Painful or lumpy breasts

عندما تبدأين بإنتاج الحليب، أو عندما يبدأ طفلك بالنوم خلال الليل، يمكن أن يصبح الثديان محتقنان بالحليب، مما يشكل صعوبة على الطفل في الرضاعة. طري الثديين بالضغط على المنطقة المحاذية للحلمة لإنزال الحليب (أعصري الحليب بلطف من الحلمة بيدك) قبل الإرضاع. إنّ التدليك ووضع مناشف ساخنة يساعدك أيضاً.

حلمتان مؤلمتان Sore nipples

إذا شعرت بألم واستمر لأكثر من ١٥ أو ٢٠ ثانية بعد بداية الإرضاع، عليك باستشارة أخصائي. إنّ الرطوبة تسبب ألماً في الحلمتين أيضاً، ووضع قطع قماش قطنية ولبادات جافة (وليس المانعة لنفوذ الماء) داخل صدريتك يساعدك. إنّ الألم الحاد في الحلمتين الذي يستمر أثناء الرضاعة قد يعني وجود تشقق في الحلمة. حاولي عصر نقطة حليب بعد الرضاعة واطريها لتجف على الحلمة. إذا كانت رضاعة الطفل تؤلم بشدة، إبدأي بعصر القليل من الحليب باليد لتسهيل جريانه قبل وضع طفلك الى صدرك. وإذا استمر الألم زوري ممرضة عياده الطفولة المبكرة أو الطبيب - إنّ تشقق الحلمة يمكن أن يؤدي الى التهاب في الثدي.

إلتهاب الثدي Breast infection

إذا كنت أنت وطفلك قد اعتدتما على نظام إرضاع روتيني من الثدي، وشعرت بأعراض شبيهة بالإنفلونزا (شعور بالمرض مع بعض الحرارة) مع وجود ألم أو احمرار أو تحجر في الثدي، قومي بزيارة الطبيب فوراً. إنّ المساعدة المبكرة على شفاء الإلتهاب ستمكنك من متابعة الإرضاع بشكل متواصل.

الى أين تذهبين لطلب المساعدة؟ Where to go for help

الى «مركز الطفولة المبكرة» (Early Childhood Health Centre) المحلي أو الى القابلات (الدّايات) في قسم الامومة في المستشفى الذي وُضعت به. ويمكن لقسم الامومة أيضاً أن يسللك بمستشارة إفرار الحليب أو بموظفة إرتباط إثنية مختصة بالولادات - وهي قابلة قانونية ثنائية اللغة تستطيع مساعدة النساء من خلفيات غير ناطقة بالإنكليزية. إسألني «مركز الطفولة المبكرة»، إذا كان يوجد مترجمة مدرّبة متوفرة. وهذه الخدمة هي مجانية وسريّة.

Evaluating antenatal strategies

CONTENTS

1. Introduction	134
2. Program evaluation	134
3. Program evaluation strategies	135
4. Self-evaluation	137
5. Peer review	138
6. Handbook and video evaluation	138
7. Conclusion	138
Evaluation hand-out	139

1. INTRODUCTION

As you approach the end of this handbook and you think the journey is soon to end, you may be surprised to learn that in reality another is about to begin. To keep pace in our ever-changing world educators need to constantly monitor their practice and make changes as and when appropriate.

Monitoring or evaluating programs/sessions does not have to be a laborious task, but with some planning and creative thinking you can gather useful information quite simply. The depth and complexity of the information required primarily depends on the purpose of the evaluation.

1.1 Learning outcomes

Upon completion of this module you should be able to:

- discuss the value of program evaluation;
- describe the benefits of self evaluation;
- identify evaluation strategies you could use in your program/sessions.

2. PROGRAM EVALUATION

Evaluation is the process of measuring the value of a program or an activity. It involves looking critically at the aims and objectives of the program to determine whether or not they have been met.

It is a process which may be undertaken to;

- determine the appropriateness of a program and in particular whether it is meeting the needs of the participants;
- assist in the development of new, or revision of current programs;
- justify the acquisition of resources or provide support for the continued use of current ones;
- obtain feedback on the ability of an educator to facilitate a group;
- determine the long-term impact of the program on the participants.

2.1 Types of evaluation

There are three aspects of a program which can be evaluated – the process, the impact and the outcome.

Process evaluation measures the effectiveness, efficiency and the adequacy of the program. It is normally performed at the completion of the program or a segment of the program.

Impact evaluation measures the short-term effect/s of the program. This is performed several weeks after the completion of the program.

Outcome evaluation measures the long-term effect of the program. The timing of this evaluation will depend upon the outcomes that need to be measured.

2.2 Data collection methods

Program evaluation can be subjective or objective, performed on an ongoing basis or at the end of the learning experience, and there are a variety of methods and tools that can be used. The data collection methods/strategies listed in this module are examples of those used by members of the project team in their professional practice. As we do not know the aims or objectives of your antenatal programs /sessions, nor the composition of your target population, it is inappropriate to provide specific strategies for use in your groups.

Just remember that the purpose of an evaluation primarily determines the data collection method/s. To determine the purpose you should ask yourself three simple questions:

- Who is the evaluation for?
- Why am I doing the evaluation?
- What do I want from the evaluation?

Once the data collection method has been determined, take a minute to think about how the data will be analysed. Do you have the required resources? You need to check this before the data is collected.

3. PROGRAM EVALUATION STRATEGIES

3.1 Program evaluation questionnaire

A common way to evaluate a program is to give participants a questionnaire at the end of the program. This provides only a limited response, however, as participants rarely write how they 'feel' or respond at a very personal level to an issue. They comment on recent topics and strategies, and the 'halo' effect can be a problem.

A questionnaire does, however, provide a written record of the participant's initial response to a program and it is a time-saving way to obtain information. Questionnaires should be easy to read, succinct and each question should focus only on one issue. For example if you want to know whether participants valued the discussion on community resources for new parents, you could simply phrase it as question – 'Did you value the

discussion on community resources for new parents?' If, however, you want more comprehensive information you could ask an open question, such as 'How useful was the discussion on community resources for new parents?'

To maximise the response to a program evaluation questionnaire distribute it at the completion of the program and allow time for participants to respond.

3.2 Session evaluation questionnaires

To rectify some of the problems mentioned above, session evaluation questionnaires can be used. They are distributed at the end of each session in a program. They are useful when several facilitators participate in a program as each topic and each facilitator can be evaluated separately. However, they are time consuming to complete, collate and compile into a document which gives an overall impression of the program.

3.3 Impact evaluation questionnaires

To determine the impact of a program you can send a follow-up questionnaire to participants several weeks or months after completion of the program. The distribution time is determined by the outcomes to be measured. Enclose a self-addressed envelope and a brief covering letter to maximize the response rate. Ethics Committee approval may be required. The Handbook and Video Evaluation provided at the end of this module, is an example of an impact evaluation questionnaire.

3.4 Postnatal reunions

Postnatal reunions provide an opportunity for debriefing and they give a wealth of information about the antenatal program. They can be informal or formal and feedback can be obtained from mixed or single gender groups. A comments/ suggestions book/bowl can be useful to obtain written feedback.

3.5 Focus groups

A focus group is a special form of group discussion commonly used in the needs assessment process, but can be used for a program evaluation. Six to ten people who have at least some characteristics in common are required for a focus group and they participate in an unstructured interview moderated by a facilitator. Trigger questions are pre – determined, the dialogue is usually tape-recorded and the facilitator ensures that the focus of the discussion remains on the program/strategy being evaluated.

3.6 Ongoing program evaluation

Program evaluation can be ongoing and designed to meet the specific needs of a group. It does not have to be written, in fact it is probably the tediousness of the written type that turns many educators away. Why not simply ask a group an open ended question at the end of a session or ask for individual responses to the question on a sheet of paper.

The dart board technique, where participants place dots around a target, is another simple, yet effective evaluation strategy. Concentric circles are drawn onto a large piece of paper so as to resemble a dartboard on a wall. The circles are then divided into sections with the dividing lines coming from the centre, as with the spokes on a wheel. The number of sections will depend on the number of issues/topics you want to evaluate. For example, if you want the participant's response to the amount of time spent on small group discussions, practical activities and lecture-style input you should divide the dartboard into three sections. At the end of the session ask participants to place a dot in each section of the dartboard with the middle being the target or their most favourable response.

3.7 Attendance records

Many educators do not think of these as being an evaluation tool, but what would you think about your program if 20% of participants did not return after the first session? Did they have a legitimate reason for not returning, did you scare them away, or were they bored and found the content was not useful to them? Keeping accurate records is important.

3.8 Letters and telephone calls

These strategies provide useful feedback and each one should be documented in an program evaluation record book. Phone interviews are another way to evaluate the impact of the program. Once again, check whether you need to submit to an Ethics Committee for approval.

Think



The evaluation strategies listed in this section primarily evaluate the process and/or impact of a program.

How would you evaluate the outcome of your program?
Would you need approval from an Ethics Committee?

If you do not know the answer to these questions you should contact the Quality Improvement Coordinator in your area.

4. SELF-EVALUATION

Given the pace of modern life there is a tendency for educators to move from session to session with some time allocated to planning, but little or no time given to reflection or self-evaluation. A learning journal, as discussed in Modules 1 and 4, promotes reflection, but ideally it should be used in combination with other self-evaluation strategies. For example, a self-assessment questionnaire or a feedback session with a colleague.

Three steps are necessary for effective self-evaluation.

Step 1: Current behaviour must be scrutinized. The facilitator must be aware of what they are doing verbally and non-verbally in the session.

Step 2: Strengths need to be acknowledged. Ineffective behaviours need to be identified and strategies for improvement determined.

Step 3: New ideas are integrated into current practice and the cycle recommences.

Self-evaluation is a continuous, on-going process not a single, one-time event.

5. PEER REVIEW

Peer review is an evaluation strategy which can complement both program and self-evaluation. It is not frequently used because educators tend to feel intimidated with an observer in their session. Peers, however, provide objective feedback as they 'view' the session from a distance and if you trust the person providing it, the feedback should be honest. For peer review to be effective you need to establish a working relationship with the reviewer and you need to agree on the purpose of the exercise.

6. HANDBOOK AND VIDEO EVALUATION

As mentioned earlier, this handbook has taken you on a journey. The writing of it took us on a journey also, so just as you need feedback from your participants, **we need feedback from you**. Please take time to complete our impact evaluation questionnaire and return it to the address provided within **six months** of receiving this handbook.

7. CONCLUSION

Congratulations, you have now completed Module 10 – Evaluating antenatal strategies. In this module we have explored:

- the value of program evaluation;
- the benefits of self evaluation;
- evaluation strategies you could use in your program/sessions.

16. How appropriate is the video to your target group?

1 2 3 4 5 6 7 8 9 10
Not appropriate at all Very appropriate

17. How receptive are the women in your groups to the video?

1 2 3 4 5 6 7 8 9 10
Not receptive at all Very receptive

18. How receptive are the men in your groups to the video?

1 2 3 4 5 6 7 8 9 10
Not receptive at all Very receptive

19. Please list the scenes of the video which you find most useful?

20. What ideas do you have for future breastfeeding videos?.....

About yourself

Place of employment

- Public hospital
- Private hospital
- Early Childhood Health Centre
- Maternal & Child Health Centre
- Private practice
- Other

Region of work

- Rural
- Metropolitan

Your role

- Program Coordinator
- Session Facilitator
- Other

How long have you been conducting antenatal programs?

About your antenatal programs

How long is the program/session you facilitate?.....hours

What format is the program/session?

.....
(e.g. 1 x 2 hour session weekly for 6 weeks)

How many participants are in your groups?

.....

Are the groups mixed or single gender?

What is the cultural background of the participants?

Note: We would be very happy to receive any additional comments you would like to make. Please feel free to add an extra page. We look forward to hearing from you!

Today's date:

Your work postcode:.....

Please return the completed questionnaire to:
Jane Svensson, Health Education Centre
Royal Hospital for Women,
Locked Bag 2000, Randwick NSW 2031

Appendices

CONTENTS

Appendix One – Project Advisory Committee	142
Appendix Two – The impact of migration on breastfeeding practices	143
Appendix Three – The Ten Steps to Successful Breastfeeding	146
Appendix Four – Still Best Commentary	147
Appendix Five – Strong Personalities Fact Sheet	149
Appendix Six – Program Planning Fact Sheet	151
Appendix Seven – Gaining and Maintaining the Attention of Participants	152
Appendix Eight – Connection and Pleasure, Disruption and Distress: Women’s Experience of Breastfeeding	153

Appendix One – Project Advisory Committee

Breastfeeding Education Resource Project

A Commonwealth Department of Health and Aged Care Funded Project

The Antenatal Breastfeeding Education Package was developed, with funding from the Commonwealth Department of Health and Aged Care, by a consortium of health professional and experts in the field. It is part of the Commonwealth Government strategy to promote and support breastfeeding in Australia.

An independent Advisory Committee was established at the commencement of the project to oversee the project and approve the materials developed. The members were representatives of organisations with an interest in the antenatal education and breastfeeding.

The Advisory Committee consisted of:

Ms Kathleen Graham,
Commonwealth Department of Health and Aged Care: Primary Prevention. Chairperson

Ms Leticia White,
Commonwealth Department of Health and Aged Care: Primary Prevention

Dr Jan Dudley,
Royal College of Obstetricians and Gynaecologists

Ms Deborah Galloway,
National Association of Childbirth Educators

Ms Paula Jarman,
Nursing Mothers' Association of Australia

Ms Ruth Worgan,
Network of Australian Lactation Colleges

Dr Maria Cigolini,
Royal Australian College of General Practitioners

Appendix Two – The impact of migration on breastfeeding practices

By Athena Sheehan RN CM BN MN

This paper provides an overview of the impact of migration on breastfeeding practices. A cross-section of literature exploring the breastfeeding beliefs and experiences of non-English speaking background (NESB) women in Australia has been summarised and the findings of a series of focus groups on this issue are presented.

The literature was identified through a literature search conducted by the Lactation Resource Centre and by conducting a CINAHL and Medline search using the subject parameters of Ethnic, Breastfeeding and Australia. The author's personal library was also used.

The purpose of the focus groups was to explore the breastfeeding beliefs and experiences of NESB women in Australia. The focus groups were conducted by the NSW Multicultural Health Communication Service on behalf of the Family Health Coalition and were held at a number of different locations across Sydney. Bi-lingual resource staff recruited the focus group participants. Contact was made with interested women through relevant organisations. Letters of invitation outlining the time, date, venue and topic were given out to women who had agreed to be involved. The cultural groups represented were Chinese, both Mandarin and Cantonese speaking, Korean, Vietnamese and Arabic. Each focus group consisted of women who were of childbearing age, had limited English language proficiency, had been resident in Australia for a minimum of two years and were not known to each other.

Australia and Immigration

Australia has one of the largest immigrant populations in the world, with more than four million people born overseas. Its immigrant population when measured as a proportion of the total population is the largest immigrant population of all Organisation for Economic Cooperation and Development (OECD) countries except Luxembourg. In 1996 the overseas-born population of Australia constituted 23% of Australia's total population. Sixty-one percent of the overseas born population were from non-English Speaking Countries (NESC)¹ and 10.8% of these speak poor or no English.² A significant number of overseas-born Australians are women of childbearing age.¹

In the first part of last century, the majority of overseas-born settlers were from the United Kingdom and Ireland. After World War II Australia also began to accept displaced persons from Europe, in particular Eastern Europe, the Netherlands and Italy. In the 1950s and 60s European immigration increased with large numbers of people migrating from Greece, Germany and Yugoslavia.¹

In more recent times there has been a decrease in the number of European immigrants and an increase in

the number of Asian immigrants. In 1996, 22% of all people born overseas were born in Asian countries. Five of the top 12 birthplace groups in Australia were from Asian countries and included Vietnam, China, Hong Kong and Macau, Malaysia and the Philippines. The Vietnamese population is Australia's largest Asian birthplace group. Asian immigrants have a mean age below 35 years placing them firmly within the childbearing age group.¹

Feeding practices of NESB women in Australia

Although the multicultural nature of Australia's society is well recognised, there has been very little research into the childbearing needs of NESB women and their infant feeding practices.^{3,4} Some authors have found NESB women are less likely to breastfeed than women born in Australia.^{5,6,7,8} Even where breastfeeding is considered normal in their country of birth, early weaning and artificial feeding is common following immigration to Australia.^{9,10} Others have found specific NESB groups, such as Middle Eastern and North African women, are more likely to initiate and maintain breastfeeding.¹¹ It has also been suggested that the breastfeeding rates of immigrant women parallel the existing social milieu,¹² and others consider they are related to issues such as lower education levels,⁷ and lower socioeconomic background.³ Recent immigrants are more likely to be of lower socioeconomic status when compared with Australian born families.¹³

The NESB women in the studies reviewed were aware of the value of breast milk, were able to name the benefits of breastfeeding and wanted to breastfeed.^{14,15,4} However, perceptions of what is considered normal in Australia can restrict breastfeeding practices. Rossiter¹⁰ found Vietnamese women believed Australian women did not breastfeed because they were not seen to do so in public. This concept is further exacerbated by limited facilities in the community, such as feeding rooms in shopping centres to support breastfeeding mothers.¹⁵

Cultural impacts on breastfeeding

Apart from socio-demographic issues, cultural health beliefs also influence breastfeeding practices. For example, Vietnamese, Chinese and Korean women have traditional confinement foods and rituals to be followed,^{16,17,18} Vietnamese and Chinese women believe breast milk is dependent on the woman's health and that childbirth disturbs the balance of hot and cold, which impacts on health.^{18,17}

Confinement foods and rituals are important to successful breastfeeding and an inability to practice traditional rituals can influence breastfeeding initiation and duration.¹⁵ Generally female relatives, in particular mothers and mothers-in-law, support women to maintain these rituals and prepare their traditional foods.¹⁶ Variations of traditional rituals amongst specific

cultural groups can occur according to the woman's country of birth.^{14,19} When women immigrate they practise traditional customs in varying degrees,^{15,16} for a number of reasons, including lack of social support and a need to work in paid employment.¹⁵

It needs to be emphasised that women are individuals and that within immigrant groups a diversity of biographical, cultural and personal backgrounds will also potentially influence their health beliefs.¹⁹ Caregivers need to be sensitive to the reality of women's lives and the difficult choices women face based around their cultural, social and economic situations.⁴

Support for NESB Women

Social support is very important to facilitating breastfeeding within immigrant groups.^{15,7,4} Studies amongst NESB groups have found the family and extended family, especially the woman's own mother, are the most important people in influencing infant feeding choice.^{14,7,20,3} Because of this, Fok¹⁷ recommended that significant others/helpers within the extended family be included in antenatal breastfeeding programs. Amongst professional groups, the Early Childhood Health Centre Nurse and Infant Welfare Nurses have been found to be influential.^{14,7} In Australia it has been demonstrated that there are a lack of appropriate services and staff to provide programs to promote breastfeeding amongst NESB groups.⁶

Poor communication skills and lack of interpreter services are significant handicaps to breastfeeding initiation and duration.^{15,7,16} Women from NESB groups have identified that programs in specific languages would be beneficial to support and promote breastfeeding.^{14,15} One study recommended that although not essential, health care staff with language fluency were preferable to using interpreters.¹⁴ One culture and language specific program to promote breastfeeding tested amongst Vietnamese women was found to be effective in increasing knowledge, positive attitudes, intended and actual behaviour about breastfeeding. Positive breastfeeding duration rates were, however, unable to be sustained for six months.²¹ Vietnamese women's suggestions for programs included providing information on how to breastfeed, advice on managing breastfeeding difficulties and weaning.¹⁵ A study on infant feeding practices amongst Arabic women, although not specific to breastfeeding, included suggestions for education programs such as information on infant weight gain and the introduction of solids.¹⁴

Recommendations to promote attendance at culture specific groups include publicity through specific language media, people and organisations and the provision of written material so 'women can show their husbands'.¹⁴ In one study, pamphlets in the women's own language were considered useful with the most useful pamphlets being those initially written in their own language and not translated from English.¹⁴ Another study found that pamphlets and books were of little or no value in helping

mothers in the nutritional care of their infants.⁷ This study did not indicate whether the written material was translated into specific languages. Another project 'Birth in a New Country' suggested the use of birth plans and postnatal care plans. It was suggested these could be used to discuss their fears, needs and preferences and cultural practices for both labour and the postnatal period.²³

Leininger stresses the importance of understanding cultural differences and similarities to provide appropriate care.²² This knowledge prevents and avoids conflicts. Those conducting programs and providing care for NESB women should, therefore, have a knowledge and understanding of the cultural,^{14,3,16} and health care beliefs,^{15,16} and the social, cultural and economic context of infant feeding practices of ethnic women.^{15,4,3} Effective communication, appropriate counselling and social support have been shown to be overriding determinants of breastfeeding initiation and duration.¹⁵

Summary of focus group results

The focus groups found a number of important similarities in the experiences of the women, particularly the women of Asian background. In each of the five cultural groups who participated there was a good knowledge of the health and practical advantages of breastfeeding. Each of the groups believed that women and their infants have a closer relationship if the baby is breastfed. Women in each of the focus groups considered it to be normal practice to breastfeed in their country of origin, for between one to two years on average.

The Arabic-speaking women participating in the focus groups believed that in general it was easy to breastfeed in Australia and that there were adequate public facilities. For these women, the main difficulty with breastfeeding related to the tiredness that a mother, particularly a second-time mother, can feel while breastfeeding and the lack of social support available in Australia. In contrast, each of the four groups of women from Asian countries perceived social barriers to breastfeeding in Australia. Although in their country of origin women breastfeed their babies for up to a year or more, these women did not think that this was appropriate in Australia. They did not see many women feeding in public and there was a perception that formula is readily available and the 'norm' in Australia.

One of the most important issues arising from the discussion groups with all these women is the social situation that they experience as immigrants to Australia. Many of these women are having their babies in isolated situations with no family and few friends. Without the support and cultural knowledge it is very difficult to initiate and maintain lactation. Some women are reluctant to use the support services available for new mothers, as they are not always linguistically or culturally appropriate. In addition, many of these women have to return to work as early as one month after the birth of

their baby, making it difficult to establish and continue feeding. Interestingly the Cantonese group mentioned that in China they are able to take 'breastfeeding time' at work, but this is not the case in Australia.

Overall, it seems that the decision to breastfeed is influenced by factors associated with migration such as low social support and the need to earn an income, as well as the social context within which women breastfeed in Australia. In order to increase the breastfeeding rates in this population there will need to be changes in work place practices, as well as additional support and resources provided by peers and professionals who understand the culture of these families. Considerable attention needs to be paid to changing the perception among these women that Australian women bottle feed.

Conclusion

Australia has a large multicultural population with a significant number of NESB women of childbearing age. Despite this, there have been very few studies to determine the specific needs of NESB women in terms of infant feeding. There are a number of similarities between the findings of the literature reviewed and the focus groups. Both the literature and the focus groups confirm that although NESB women are aware of the value of breastmilk, they breastfeed for longer durations in their country of birth compared with in Australia. Low breastfeeding initiation and duration rates also occur because of economic constraints requiring some women to return to or seek paid employment soon after birth. Particularly amongst Asian groups, breastfeeding is not seen as the normal mode of infant feeding in Australia. In Australia there is a lack of linguistically and culturally appropriate services and a need for professionals caring for NESB women to understand cultural differences and their effect on infant feeding. Importantly there is a need for social support to facilitate breastfeeding.

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Appendix Three – The Ten Steps to Successful Breastfeeding

Every facility providing maternity services and care for newborn infants should:

Step One: Have a written breastfeeding policy that is routinely communicated to all staff.

The policy should be available so that all staff that care for mothers and babies can refer to it. The policy which covers the Ten Steps should be displayed in community languages. No posters or material promoting breast milk substitutes should be displayed. Health facilities should not accept free or low-cost supplies of breast milk substitutes and should not allow gift packs to contain the same.

Step Two: Train all health care staff in the skills necessary to implement this policy.

Staff with up-to-date skills must be available to assist breastfeeding mothers. Managers of health facilities and their staff should be able to provide documentation of breastfeeding refresher training annually.

Step Three: Inform all pregnant women about the benefits and management of breastfeeding.

A written description of the breastfeeding component of antenatal education programs or sessions should be accessible to all staff. The input provided in the antenatal period should include the importance of exclusive breastfeeding for the first six months, the benefits of breastfeeding and basic breastfeeding management. Mothers interviewed should confirm they were not given group education or written promotional material on the use of infant formula.

Step Four: Help mothers initiate breastfeeding within a half-hour of birth.

During the first hour after birth mothers are given their babies to hold, with skin contact for at least 30 minutes, and they should be offered help to breastfeed within the first hour. For caesarean section mothers this is within the first hour of them being able to respond.

Step Five: Show mothers how to breastfeed, and how to maintain lactation even if they should be separated from their infants.

Staff assisting mothers, and the mothers themselves, should be able to demonstrate good positioning and attachment of mother and baby during a breastfeed and how to express and store expressed breast milk.

Step Six: Give newborn infants of breastfeeding mothers no food or drink other than breastmilk unless medically indicated.

An acceptable medical reason should be recorded, and a written informed consent obtained, before a newborn baby is offered a supplementary or complementary feed of any thing other than the mother's own breast milk.

Step Seven: Practise rooming-in – allow mothers and infants to remain together – 24 hours a day.

Rooming-in has beneficial effects both on breastfeeding and on the mother-infant relationship. This should begin within one hour after birth, or with a caesarean section mother one hour of being able to respond. After that separation can be for up to one hour for a hospital procedure or at the mother's request.

Step Eight: Encourage breastfeeding on demand.

There should be no restrictions placed on the frequency or length of babies' breastfeeds. Mothers should be advised to feed their babies whenever they are hungry, or as often as their baby wants. They should wake their babies if they sleep for too long or the mother's breasts are overfull. This flexible feeding is also referred to as 'baby-led feeding' or 'feeding according to need.'

Step Nine: Give no artificial teats or dummies, also called pacifiers or soothers, to breastfeeding infants.

There is growing evidence that the use of artificial teats and pacifiers is associated with early cessation of breastfeeding. The alternate method for feeding infants who cannot breastfeed is by cup or spoon. Hospitals should actively discourage the use of pacifiers while breastfeeding is being established, however, the mother's choice should always be respected.

Step Ten: Foster the establishment of breastfeeding support groups and refer mothers to them on discharge from hospital.

Mothers should be referred to community breastfeeding support services on discharge from hospital. This can be Early Childhood/Maternal and Child Health centres, telephone counseling or the hospital follow-up clinics. It should also include the local Nursing Mothers' Association of Australia group.

Appendix Four – Still Best Commentary

The Guardian Archive - Wednesday July 14, 1999



Reports this week about contaminated breast milk may have made you reach for the bottle, but don't panic, says Sarah Boseley.

Breast is best. Yes, breast milk contains 350 toxic substances, including dioxins, which may cause cancer, but please don't stop feeding your tiny, perfect, innocent and uncontaminated baby these traces of industrial waste. Breast is best.

What a nightmare. To give the World Wide Fund for Nature its due, it was not aiming its broadside at the anxious ranks of breast-feeding mums, but that's where it exploded. 'Breast Milk Poison Alert' screamed the front-page headlines of the Express on Monday. Just what you need while trying to satisfy a hungry baby and grab some breakfast for yourself at the same time.

The research from WWF was presented in such a way that mothers would either reach for the bottle immediately or would get to the paragraph, somewhere low down, which stated that breast-feeding was still recommended and start to tear out their hair. Perspective is badly needed on this issue. First of all, the dioxin content of breast milk is regularly measured not to assess whether breast or formula is better, but just because the fat content of breast milk makes it possible. It is easy to assess the dioxin content of breast milk and hard to do it for blood or tissue. So what is being scrutinized by environmental scientists is the dioxin level in the whole human body, not just in a mother's milk.

Secondly, putting your baby on formula milk will not ensure that he or she will be dioxin-free. There are dioxins in breast milk because we are eating, drinking and breathing dioxins all the time. They are in the environment. They are in our air and in our water. Formula is made up with boiled water. Boiling may get rid of bacteria, but it has no effect on dioxins. So there are dioxins in formula milk as well.

Andrew Radford, of Unicef's Baby Friendly Initiative, is angry about the presentation of the dioxins message. He acknowledged that all the coverage pointed out that breast-milk is better than bottle-feeding but feels that it was less than sincere. 'It is one of those nice warm things you can say which you can then destroy by undermining the entire message, which is fundamentally what is going on here,' he said. 'The dangers of contamination in breast milk are unproven and possibly non-existent for the levels at which they occur. The benefits of breast-feeding are so well established and enormous that if mothers decide not to breast-feed because of this they are putting their children's health at risk. Dioxins are a pollutant and we don't want them, but they are everywhere.'

Three years ago, he points out, the Chief Medical Officer produced a report into dioxins in breast milk which found low but significant levels of contaminants which were not a cause for concern in terms of exposure over a lifetime. The WWF report, which is full of frightening details of the chemicals - such as those used in UV sunscreens - which are absorbed by the body, acknowledges that 'the levels of organochlorine pesticides and dioxin-like compounds in UK breast milk appear to be declining,' although, it insists, 'there is no room for complacency.'

The report estimates that a two-month-old baby is getting 42 times the WHO acceptable limits of dioxin-like compounds, and a 10-month-old breast-fed baby is ingesting 10 times the permitted amounts. That would send most of us reaching for tin of formula, but, the report then adds, the WHO's total daily intake figure 'is based on lifetime exposure' - and breast-feeding rarely continues beyond a year of our notional average three score and 10. In fact the majority (58%)

are no longer being breastfed at six weeks. The report goes on to say that 'because of convincing evidence of the benefits of breast-feeding to the overall health and development of the infant, experts still recommend that breast feeding should be encouraged.'

The government has commissioned a study into dioxin levels in breast milk - set up before the WWF report became public. Researchers at Leeds university are recruiting 1000 women to help put together an 'archive' of levels of pollutants in breast milk to find out why there are different levels of chemicals in different women's milk, and what impact social groupings, diet and the position of the breast-fed child in the family have.

Toxic waste scandals like the one at Seveso in Italy have made dioxin a fearsome word. But the full impact of dioxins on human health is unclear. The International Agency for Research on Cancer has classified dioxins and DDT as 'possibly carcinogenic' and PCBs as 'probably carcinogenic' to humans. Scientists have attempted studies of the dangers of breast milk and concluded 'about three days of life expectancy would be lost because of cancer attributable to contaminant exposure through breast milk.'

This becomes a statistical dance. The chances of a UK breast-fed baby getting dioxin-induced cancer are clearly much less than those of a baby in a highly toxic industrialised environment somewhere in the developing world. On the other hand, that developing world baby will probably die if he or she is not breast-fed, thanks to contaminated water and unsterile bottles.

'We are at the mercy of our sophistication in being able to statistically attribute the very smallest risk,' said Peter Poore, a senior health adviser to Save the Children Fund. The risks of dioxin exist, 'but we have got much more solid data on the hazards of not breast-feeding.'

Baby Milk Action, the organisation behind the Nestle boycott, points out that formula milk is as subject to scare stories as breast milk could ever be. According to the organisation, 'Artificial milks have been shown to contain high levels of aluminum, lead and other heavy metals.' One formula manufacturer, Milupa, a subsidiary of Nutricia, was asked last year by the UK's Department of Health to withdraw its powdered infant formula Milumil from sale in the UK because of salmonella contamination. Breast milk contains antibodies to bacterial infections.

What we are being told, basically, is that we are all contaminated. Bottle-feeding our babies will not stop them from being contaminated, too. Indeed, the WWF report suggests dioxins pass through the placenta, so our innocent babes already have a dose at birth. All we can do, says every single expert, is carry on breast-feeding while moving heaven and earth to clean up the planet.

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Appendix Five – Strong Personalities Fact Sheet

Participants in a group can behave in ways that are inappropriate or detrimental to the functioning of a group. The behaviour is sometimes an exaggeration of their personality, or it can be a reaction to the group or the issues being discussed. It is important, therefore, to consider the possible reason/s for a behaviour if you are to deal with it effectively. In this fact sheet we have identified several common behaviours, the reasons they may occur and strategies to help you deal with them.

The talker or monopolizer

This person may be:

- anxious.
- seeking attention.
- seeking approval.
- very enthusiastic or eager.

You could:

- reduce or avoid eye contact with them.
- reward only their relevant and useful contributions.
- give them a job to do. For example, they could organise the refreshments.
- sit beside them.

You could say:

- 'Thanks Mary, I hate to cut you off, but I feel it's important for us to hear from everyone.'
- 'Emma, that is a very interesting and valuable idea. We only have a short time to meet today so I think we should move on. Who else would like to comment on...?'
- 'We've heard from a couple of people quite frequently. What do the rest of you think?'

The challenger

This person may:

- disagree with the concepts and information being presented/discussed.
- feel their values, attitudes and beliefs are under threat.
- have come under pressure from their partner.
- be seeking attention.

You could:

- try to relieve the tension in the group. For example, you could move on to another learning activity.
- ask for other points of view on the issue.
- quote other sources of information that give credibility to the comment/issue that is being challenged.
- offer to discuss the issue further in the refreshment break.

The person who is continually wrong

This person may:

- have incorrect or no information/knowledge on the issue.
- have spoken impulsively without thinking through their opinion.
- have responded before all the information was given.

You could:

- highlight and build on correct points made and disregard the rest.
- avoid direct criticism.

You could say:

- 'That's interesting, Peter. My own experience has been.../My understanding was that...'
- 'Everyone's experience is different. What have other people experienced/done about this?'

Shy person

This person may:

- feel inadequate.
- be unused to learning in groups.
- feel they have nothing of value to say.
- have trouble formulating ideas quickly enough to be able to contribute.
- be socially reticent.

You could:

- have non-threatening activities so they can contribute.
- value their contributions by rewarding them with a nod or thanks.
- build on their contributions with further comments to show them you value their ideas.
- help them meet others through using small group activities.
- join them for a drink during the break.

The know-all

This person may:

- want recognition as a person who brings a wealth of experience to the group.
- be quite informed. They can stifle discussion as they are usually not interested in others' opinions.

You could:

- restate one or two relevant points made by the person, thank them and then ask others for their opinion.
- decrease your attention to their contributions and their participation.

You could say:

- 'That's a good point, Rose. What do others think about that issue?'
- 'It's interesting to hear the different ideas people have. Would anyone like to add their thoughts?'

The distracter

This person may:

- miss the point.
- be distracted by personal problems.
- have poor learning or social skills.
- like to discuss minor points at length.
- be thinking ahead of the group and curious about issues that will not evolve till later.

You could:

- identify relevant points and bring discussion back to the group.
- check their personal expectations of the group.
- redirect the discussion to the needs of the group. If the group is not meeting their needs, suggest an alternative.

You could say:

- 'That's a good idea Helen, can we keep that in mind until later?'
- 'We seem to have got off the track here. Now, let's get back...'

One who uses the group to gain sympathy

This person may:

- have had a genuinely hard time.
- want attention.
- have unresolved feelings about a personal problem.
- be in need of specialised help.

You could:

- watch the group reaction to one person being the centre of attention for a long time. The verbal and non-verbal language of the group should tell you when the situation is a problem.
- acknowledge their experience by giving them some attention during the refreshment break.
- have a private discussion with the participant to determine whether support/help is required and refer them to appropriate resources.

You could say:

- 'I gather it has been difficult for you Sara. We could discuss this further at the end of the session.'

Talks to neighbour

This person may:

- be bored.
- have a hearing impairment.
- not understand.
- be distracted by outside noise.
- need an opportunity to discuss an issue with someone.

You could:

- refer to the group agreement that one person speaks at a time.
- vary the learning activities.
- encourage them back into the group by asking their opinion about the last idea of the group.
- use group activities to change the composition of the subgroups.
- remove or acknowledge a distraction.
- clarify or rephrase the point.

You could say:

- 'It might be best if we have one point at a time. Now John what were you saying?'

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Appendix Six – Program Planning Fact Sheet

Planning and designing an education program does not have to be a slow, tedious process if it is done systematically and you enlist the help of your colleagues. The steps outlined below are provided to help you create an innovative program incorporating a range of learning strategies.

Step 1: Gather information from your target population and from your key informants. For example, organise a focus group of representatives of the target population and ask them questions relating to the content and the structure of the program.

Step 2: When you have a list of topics to be included in the program, write them on small coloured cards with one topic per card. Notes on the card colours are provided at the end of this fact sheet.

Step 3: Decide how long the program will be and number heading cards accordingly.

Step 4: Place the numbered heading cards in a line on the floor or table.

Step 5: Place the topic cards under the heading cards.

Step 6: Add additional topic cards if necessary.

Step 7: When all your cards are in place, check that the colours are balanced and adjust as needed.

When you have completed this stage ask yourself the following questions:

- Are the coloured cards distributed through the program?
- Do the topics and learning strategies flow?
- Have I been realistic with the number of topics I want to include in a session?

The only way to truly answer the third question is to proceed to the next stage – *writing your session plans*. Session plans are the tool from which an educator should work as they contain the topics being covered, the learning strategies and resources to be used, and the time allocated for each activity. They should be concise and yet written so others can understand them and use them if need be.

In completing your planning you need to think of pragmatic issues such as the resources required, the environment you will use and how your program will be marketed.

The overall aim of a program should be to meet the needs of the clients by providing a logical progression of the topics they believe are relevant, with a good balance of learning strategies. Problems can arise if more than one educator facilitates a program. Client's desires and needs may be forgotten and topics are slotted in to suit the facilitator's time, availability and their area of expertise. This is a particular problem with the use of guest speakers.

When the program has been designed pin the cards to a board or keep them in sequence in a box/container.

They are useful for future reference and are useful for keeping track of where you are up to in a program. For example, if you cover something out of sequence, simply move the relevant cards and adjust the order of your topics.

Using coloured cards

Small coloured cards are used to help you develop a program that is balanced. The colours chosen in this example are not of significance – use whatever you have access to.

Green cards = practical sessions

These cards are for topics that will involve the group in a physical activity. For example, positions for labour, relaxation, baby massage and breastfeeding positions. Practical sessions can even include a quick break to get up and stretch. Plan to have the group doing something at least once in each session. If they sit for too long they will lose concentration.

Blue cards = discussions

Anything which could be described as a discussion starter can be included. For example, fears of labour, relationships with health professionals, beliefs about breastfeeding and changing roles.

Yellow cards = small group activities

Include all topics that will be covered by games/small groups activities on these cards. For example, how labour begins and the myths and half-truths about breastfeeding.

Red cards = information

If you write these cards last you will probably find that a considerable amount of information has already been covered in discussions and small group activities. These cards are for topics that need to be presented as a mini lecture. For example, normal newborn behaviour and the anatomy of the breast.

Points to remember

- Aim to have a mixture of colours in each session.
- Aim for a logical progression of topics.
- Allow time for participants to unwind at the beginning of each session.
- Include at least one opportunity for participants to move around during each session.
- Refreshment breaks are good for socialising and they give you a chance to talk to participants who are distracting or behaving inappropriately.
- Avoid ending a session on a flat topic.
- As the group progresses through its lifecycle decrease the amount of formal input you provide.
- Be flexible and creative.

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Appendix Seven – Gaining and Maintaining the Attention of Participants

A productive group discussion or information session requires the attention of the participants in the group. Gaining and maintaining attention can sometimes be a challenge, so this fact sheet provides guidelines you may like to use.

When starting a group, you can gain their attention by:

- making eye contact with everyone as they settle into the group.
- giving a signal that indicates it is time to start. For example, you could shut the door and then stand/sit in an alert manner in front of the group.
- making an introductory comment, such as *Welcome to the “Breastfeeding a Skill to Learn” workshop*. You may need to speak loudly initially, but don't continue in a loud voice. People will make the effort to listen.
- creating interest in the group early. Ways to tantalize and excite curiosity include:
 - showing an object or picture, which may seem at first to bear no relationship to the topic;
 - stating the main topics for the session and how the group will tackle them;
 - asking a key question. It can be rhetorical and may not need an immediate response;
 - presenting a challenging statement.

Once the attention of the group has been captured, you should be able to maintain it by:

- being animated. Use your eyes and appropriate gestures to enhance your presentation.
- varying the volume and speed of your voice. Pauses and silence can enhance a presentation as they allow time for reflection and absorption of information.
- using visual aids. Make the session visually exciting and varied with a range of posters, articles, objects, worksheets.
- varying the learning strategies. Constant listening can make participants bored. Change the way the group is participating in their learning by having group discussions, activities and demonstrations.

As the session progresses there may be occasions when you lose the concentration of the group. If this happens you could:

- refocus the attention on the topic. Any of the suggestions made above should help, but as you gain confidence you will develop attention-getting tricks that suit your style of presentation.
- take a break. If people begin talking among themselves during an explanation or discussion, don't talk over the top of them. You will find it exhausting and the group will become restless and distracted. If you feel you have lost their attention and you feel out of control, have a refreshment break and start afresh after!

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Appendix Eight – Connection and Pleasure, Disruption and Distress: Women’s Experience of Breastfeeding

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Abstract

Interview data collected in a recent study of first time motherhood were used to explore the experience of breastfeeding. Twenty-five Australian women participated in a series of semi-structured interviews begun during late pregnancy and continuing until 6 months postpartum. Discourse analysis was used to examine the transcribed data. The analysis revealed that breastfeeding was central to these women’s experience of motherhood. The majority of women were strongly committed to breastfeeding. Their decision to breastfeed was influenced by a range of public and professional discourses. Breastfeeding was also an embodied experience that was difficult to articulate. For some, this embodied experience was connected, harmonious and pleasurable and for others, disruptive, unpleasant, and violent. This paper describes the embodied experience of breastfeeding and highlights the complexity of the relationship between embodied experience and contemporary meanings and context of breastfeeding. *J Hum Lact* 1999; 15:325-334.

Keywords: breastfeeding, women’s experience, embodiment, feminism, discourse analysis

Introduction

The advantage of breast milk for the newborn infant is undisputed in the professional and popular literature. For practitioners, researchers, and mothers alike, including mothers who decide not to breastfeed, breast milk is considered best for the baby.¹⁻³ Each year, however, many women decide not to breastfeed or breastfeed for only a short time. Breastfeeding policies, research, education, and practice are therefore focused upon education campaigns encouraging more women to breastfeed and to breastfeed for longer.

The professional literature is inundated with breastfeeding rates,⁴⁻⁸ identifying the characteristics of women who do not feed,^{1,4,6,9-15} examining the impact of institutional practices and policies on breastfeeding,^{7,9,11,16-18} as well as implementing promotional strategies to increase breastfeeding initiation and duration.¹⁹⁻²³ Empirical work that focuses on women’s social and emotional experience of breastfeeding is less common.²⁴⁻²⁷

Critics concerned with the direction that research on breastfeeding practices have taken insist that women’s decisions regarding infant feeding are complex, related to their health, the health of their babies, the needs of other children and family members, living conditions, and other demands on their time and energy.^{2,25,28} It is argued, and this study supports, that most research fails to acknowledge the interdependence, interaction, and complexity of the total breastfeeding experience.^{24,26}

Issues of social class and ethnicity, as well as personal experience, are often lost in accounts of the health advantages of breast milk, the influence of multinational companies marketing breast milk substitutes, and the portrayal of breasts in society.

There are few studies by health professionals examining the experience of breastfeeding and the breastfeeding relationship. Leff, Gagne, and Jefferies²⁹ describe the notion of “working in harmony” and its relation to “successful” breastfeeding. These authors found the categories of maternal enjoyment and desired maternal role attainment, rather than infant satisfaction, were considered more important by women describing breastfeeding as “successful.” In a phenomenological study, Bottorff,³⁰ identifies the need for many women to “persist” with breastfeeding in order to achieve personal goals. Wrigley and Hutchinson³¹ identify the importance breastfeeding women give to “surrendering” to their infant and “re-orientating” their personal needs and goals. They describe the “secret bond” some women establish with their infant when choosing to breastfeed for longer than 12 months. These studies all highlight the emotional and social significance that breastfeeding may have for women.

There are even fewer studies that emphasize the dissatisfaction or distress women may experience with breastfeeding. McNatt and Freston³² found that women who had not felt successful or satisfied in their feeding experience listed discomfort, inconvenience, and lack of pleasure in breastfeeding as reasons they were not “successful.” These women expressed feelings of self-doubt and guilt when they decided to discontinue breastfeeding. Maclean²⁷ also describes the dramatic changes breastfeeding brings to women’s lives, their dislike for their lactating breasts, and the challenges breastfeeding presents for independent women in contemporary western societies.

The limited research by health professionals into the experience of breastfeeding has not been compensated for by other disciplines. Indeed commentators are puzzled by the lack of critical debate from sociologists and feminists in the topic of breastfeeding.^{25,28,33,34} Feminist and anthropological writings mainly articulate the potential for breastfeeding to express women’s power, providing new ways to view gender, and being.³³⁻³⁷ Accounts such as those by Carter²⁵ or Maclean,²⁷ who canvas the diversity of the breastfeeding experience or examine the resistance that women have shown over many years to the imperative to breastfeed, are rare.

This paper explores the experience of breastfeeding in a group of 25 Australian women. It draws upon data collected in a longitudinal study of new motherhood, which explored the way in which women constructed their lives as mothers. In the analysis, breastfeeding proved to be central to women’s sense of identity as a mother.

Method

Twenty-five women participated in this study of first-time motherhood. Each woman was interviewed once in the last 4 weeks of pregnancy and 4 times after birth: within the first week (median 6 days, range 2-12 days), and at 1 month (median 5 weeks, range 4-6 weeks), 3 months (median 12 weeks, range 10-14 weeks) and 6 months (median 25 weeks, range 20-30 weeks) following birth. These interviews produced 125 hours of audiotape recorded data that were transcribed verbatim. The selection of these times for interview reflected known changes in women's experience of motherhood.³⁸⁻³⁹ For example, within the first week after birth women want to discuss their birth experience, and they also go home from the hospital and begin to recognize the overwhelming responsibility of motherhood. They may face many difficulties with breastfeeding and can lack confidence in their ability to care for their baby.^{38,39} Toward the end of the first month, women begin to articulate a sense of maternal identity, believing that they know their baby better than anyone else.³⁸ Later, women may return to paid work and face the dilemma of child care. We used open-ended prompts to capture the diversity and changing nature of the women's experience in the first 6 months of motherhood. These prompts encouraged women to describe how they constructed their lives as mothers, exploring for example, the images that they had of motherhood, the "good" mother and the "good" baby, and how these changed over time. Emphasis was placed on issues around infant feeding, settling, and sleeping as these proved to be focal areas of concern for new mothers and are issues strongly influenced by others, presenting many contradictions for parents. (See Table 1 for examples of questions that provided a framework for the interviews.)

Table 1. Examples of questions used during interviews.

Prior to the Birth

What picture or image do you have of motherhood?

Describe a good mother. Describe a good father.

Have you planned how you will feed the baby? What has influenced your decision?

Following the Birth

Tell me about the baby.

What is it like providing care for your baby?

Are there things that you really enjoy doing and things that you really don't like doing for the baby?

Last time we spoke you told me about the decisions that you had made in relation to feeding your baby, are you still going by these decisions or has this changed? How has this changed?

You have also described your thoughts about your baby's settling and sleeping pattern, are you still going by these decisions or has this changed? How has this changed?

Describe the way in which you and the baby communicate.

Describe the relationship that you have with your baby.

Describe a good mother. Describe a good father.

Who do you go to if you need help or advice?

The first time that we spoke together, you described the picture/ image that you had of motherhood, how do these images compare with your experience?

Recruitment

Ethics approval to recruit participants from the hospital was obtained from the Southeastern Sydney Area Health Service and the University of Technology Sydney Ethics Committees. Women consented to participation in writing. Seventeen women were recruited from prenatal classes held at a Sydney metropolitan hospital. Towards the end of the series of prenatal classes, couples were provided with information about the study and a contact telephone number. This recruitment approach maintained participants' confidentiality and was successful with between 1 and 3 couples willing to participate from any 1 prenatal class. Recruitment was carried out over a period of 18 months and a total of 17 couples were recruited in this way. Four couples were approached on the prenatal ward of the same hospital. These women were either attending the Pregnancy Day Assessment Program or had been hospitalized for hypertension. Recruiting women who had been hospitalised for a period during pregnancy increased the diversity of participants. A further 4 women were recruited through personal contacts. Participation was limited to women who were expecting their first baby, fluent in English, and over 18 years of age. A parallel study of new fatherhood⁴⁰ required that the women's partners participate, and thus it was important that the women were in a stable relationship with the father of the baby. The average age of the women at first interview was 28.2 years (range, 23 years to 35 years). The majority were Australian born or had lived in Australia for most of their lives, but 4 had moved to Australia in early adulthood. Twenty-three women were married and 2 were in long-term de facto relationships. On average, the women had been in their relationships for 7 years (range, 18 months to 12 years). Twelve of the women held university degrees or diplomas. Prior to the birth of their baby, they had worked in a variety of occupations such as teaching, speech therapy, nursing, podiatry, health promotion, management, and business. Of the remaining 13 women, 4 had completed 6 years of high school, 4 held trade certificates, and 5 had completed 4 years of high school. These 13 women were employed as administrative assistants, bank officers, customer service operators, or were in secretarial work.

Data Analysis

Discourse analysis is an interpretative methodology that examines the way in which people "construct" experiences through language and visual imagery. The term discourse refers to specific structures or organized sets of statements, terms, categories, and beliefs,^{41,42} or a patterned way of describing phenomena. Language and discourse are seen as providing ways of describing and categorizing historical, social, and institutional worlds. A useful example of discourse is seen in the current popular understandings of a "natural" discourse of childbirth as opposed to a "medical" discourse of childbirth. In a natural model of birth, words such as "choice," "control," and "women-centred" are common, whereas, in a medical model of birth, words and phrases

such as “risk,” “ensuring a healthy mother and baby,” and “active management” of birth are used.

As a qualitative, interpretative methodology, discourse analysis is characterized by a detailed or “close” reading and rereading of textual data to develop themes or categories.^{43,44} The analysis in this study of motherhood consisted of an initial coding of data into groupings of “discourse types,”⁴⁴ such as “public discourses of the good mother” and “professional discourses of breastfeeding.” Particular samples of text, for example segments of text that discuss “the decision to breastfeed” were highlighted. These pieces of selected text were then examined more closely, looking for patterns in the language used, examining the words, phrases, figures of speech, metaphors, concepts, and belief systems that women draw upon when talking of their experience of motherhood and breastfeeding. Contradictions, ambivalence, and paradoxes in the data proved to be critical points for our analysis of the data. The data were also examined to ascertain what other texts parents drew upon to express their notions of reality: for example, self-help books, the news media, medical explanations, conversations with family and friends. Transcribed data were read by the 2 authors and another researcher involved in the larger study. There was strong agreement evident on the developing themes and analytic interpretation. This type of analysis is best supported by extensive use of extracts from transcripts woven together with analytic interpretation.^{43,45} The reader is thus allowed to make their own interpretation of the rich descriptions and determine the plausibility of the interpretation presented by the authors.^{43,46}

Discourse analysis is often described as a sociopolitical endeavour, identifying the powerful and dominant discourses or accounts that individuals draw upon to give meaning to particular events, phenomena or practices. More recently, however, Lupton⁴⁷ has argued that “language and discourse constitute subjectivity (or self-identity) in a complex relationship with sensuality and the unconscious,” that is, through embodied experience. The analysis of these data revealed the importance of personal embodied experience for breastfeeding women.

Results

The analysis revealed that breastfeeding was central in the women’s experience of motherhood in the 6 months following birth. Prior to birth, all these women intended to breastfeed and the majority were strongly committed to breastfeeding. The women believed that breastfeeding was “natural,” crucial to the relationship with their baby and best for a baby’s health as well as the environment. Furthermore, breastfeeding represented “good” mothering. Most were prepared to “persevere” with breastfeeding to achieve their identity as a breastfeeding mother. Breastfeeding was an “identity project.”⁴⁸ They wanted to achieve, to master, to get breastfeeding under control. In taking this position, these women resisted the perceptions and common negative accounts of breastfeeding as socially unacceptable, compromising the sexual attractiveness of the breasts,

inconvenient, and a problematic practice. Even the 3 women who, in pregnancy, were less committed to breastfeeding were prepared to “give it a go.”

All of the women participating in this study began by breastfeeding their babies. Three months after birth, 20 of the 25 women were continuing to breastfeed, and at 6 months 18 women were still feeding. The women talked in great detail about breastfeeding during interviews after birth. They reiterated their commitment to breastfeeding and the discourses of bonding, relationship and the child-centred account of “breast is best.” Most importantly, and surprisingly, breastfeeding was not simply a discursive construction where women’s beliefs and practices were shaped by public or professional discourse. Breastfeeding was also sensory and perceptual, it was a “nondiscursive,” “embodied” experience that was difficult to describe in words.

Many of the women in this study worked very hard to articulate to the researcher this experience of breastfeeding. Phrases such as “nobody told me breastfeeding would be like this,” “it’s hard to explain it,” and “I can’t describe it” were common. None of these women had been able to imagine or prepare for the embodied nature of breastfeeding. Sally captured the nature of this “strange” experience particularly well:

Because you don’t have that much sort of physical, not contact physical um ... association with things that you do in life so much.... Yeah, but that [breastfeeding] is one thing that is so ... that’s all there is to it, it’s so physical that ... well, I don’t think that I have ever done anything that makes you feel so much a part of what you are doing ... it’s very strange.

For some women this embodied experience was pleasurable, sensual, and intimate, and for others it was difficult, unpleasant, and disruptive.

Breastfeeding as a Connected, Harmonious, and Intimate Embodiment

Breastfeeding was a wonderful experience for 8 of the 25 women. It represented a continuing close connection with the baby, similar to that developed during pregnancy. These women struggled to describe their increased awareness of their own body as a “shared body,” joined to the baby in a harmonious way. Breastfeeding offered intimacy, a sense of being needed and a reward of ownership. As Kerry described, she and her baby were “a package.”

Kerry went on to describe with pleasure the presence of hormones associated with lactation, “breastfeeding’s unreal ... the hormones are great.” She felt as though she was “in another world” when she breastfed. Christine also really liked the physical feeling, describing it as “nice feeling.” These women talked of thriving on their calm and relaxed state, attributing these feelings directly to the presence of the hormones.

Some women enjoyed the feeling that they were sharing their body with their infant during breastfeeding. Kerry, for example, described with excitement the amazed look on her baby’s face when at about 5 months he realized, “I was connected to the breast.” Women highlighted the baby’s recognition of the breast, not

merely as a separate object, but as something that was either an extension of their mother or alternatively an extension of themselves. The notion of the breast as something shared between mother and baby was also illustrated in women's descriptions of their great efforts to clear a blocked milk duct in their breast. Even when they spoke of foods eaten or medications taken, there was a sense of satisfaction in recognizing that this may, or indeed did, impact upon the baby and emphasized their own importance to the baby.

These women found personal reward in the dependence that their baby had upon them. They were central to their baby's survival. It was a "nice" feeling as Eve stated, "that it is my milk satisfying him." Lyn described a mutually satisfying dependence or connection, "... that's a special kind of moment, when you breastfeed, when you look up and then you look down and they're down there looking at you and you think, 'Oh, this is when they need you the most'... they REALLY need you ... it's a wonderful thing to breastfeed." Eve also recognized the enabling power of this total feeling of being needed. "I suppose it's a bit of an ego trip. ... I like feeling that ... I'm responsible for him ... I feel really needed ... crucial." Many of the women saw themselves as crucial to their baby's survival. They were the baby's "lifeline." Donna, for example, constructed a very close relationship with her baby based around the dependence on breastfeeding: "nobody else can feed him."

The dependent breastfeeding relationship appeared to provide some women with confidence in their body and a sense of superiority. Anna described with pleasure her baby's refusal to take the bottle when it was offered to him, stating, "He likes the real thing." Within these discussions, a certain disdain for feeding with formula crept in. Sally believed that she would feel "odd" or "alien" if she did not breastfeed.

Ten women in this study described a sense of harmony and synchronicity in their relationship with their baby. At an early stage Kerry described the way she communicated with her baby and could read his needs. She knew when he was tired or hungry, and vividly told how she had learned to recognize the intense stare that her baby gave her when he wanted a feed and added proudly, "Nobody else would be able to pick it." Lyn also described a harmony or flow between herself and her baby; they could, "read each other like a book."

Some women described their embodied experience of breastfeeding as sensual, intimate, and pleasurable. They cherished "special times" when they were alone with their baby and often talked of a desire to share "skin-to-skin" closeness with their infant. Kerry, for example, particularly enjoyed getting into the single bed with her baby when he wouldn't settle in the middle of the night. She stressed, "It's me that wants to go to bed with him." Megan described the pleasure she gained from gazing at her baby while he breastfed: "There's just some really beautiful moments just looking at them ... it's the closeness, that intimacy."

A desire for "skin-to-skin" closeness prompted Christine to bathe with her baby. She elaborated on the

sensual nature of her breastfeeding experience: "I fed him in the bath. But it was such a nice feeling ... I was lying in the bath and I thought well ... oh, this is lovely. Their bodies are just so perfect." Cecily also savoured some of the pleasurable moments of breastfeeding. "I love the closeness, the warmth, and I love looking at his little face as he comes down to the breast, and he's got it in his view and even his mouth gets ready. He latches on, gets his mouth in the position and he starts to breathe and get excited."

This sensual and intimate relationship was very powerful, and women were sometimes cautious in choosing words to describe it. Because breastfeeding was so pleasurable, these women often participated in practices that would maintain this embodied connection. Most commonly this consisted of establishing special times with the baby where they were alone. Lyn talked at great length about the "special times" that she enjoyed with her baby. "I like the morning feeds; he lays up in bed with me, and I feed him in bed and then ... take all his clothes off ... and he'll have a kick and we talk. That's my favourite time ... when it's just me and him now."

Finally, these women also described a sense of personal ownership or possession over their infant. Kerry talked often of the possessive nature of her relationship with her baby. Even during pregnancy, Kerry constructed the baby as "mine" and when her baby was 6 weeks old Kerry announced proudly, "The best bit about motherhood is that he's mine."

Breastfeeding: The Disrupted, Distorted, and Disconnected Experience

Only 35% of the 25 women in this study experienced breastfeeding in a connected, harmonious, and sensual way. Forty percent of women in this study talked of having mixed feelings about breastfeeding. They struggled with the ambiguities and contradictions between the embodied experience of breastfeeding, the probreastfeeding discourses of professionals and public rhetoric, and the prominent notions of rational autonomy that prevail in contemporary western societies. For a further 25% breastfeeding was a disappointing and distressing experience. At varying times, these 2 groups of women found breastfeeding to be demanding and disruptive of bodily routines, distorting of the known body and breasts and, sometimes, the need for proximity to the infant was overwhelming and the women wanted separation.

Many of the women in this study spoke vividly of the demands and intensity of breastfeeding, portraying this using metaphor and humour. The woman as a breastfeeding mother was objectified – she was a "feeding machine," "a walking and talking cow," or "the milk bar." Breastfeeding necessitated their constant proximity to the infant. The baby was always with them and occupying their thoughts. Kate for example, realized her entire day revolved around the baby and her need to breastfeed, whereas, her partner, "takes it as it comes." Walzer⁴⁹ has identified this constant thinking about the baby, or "worry work," as gender differentiated work. Kate knew her partner did not think or worry about

the baby in the same way.

This group of women felt that, despite the rhetoric, there was little reward or recognition for their efforts. They cast the ever demanding breastfeeding infant as “uncivilized.” The women felt restricted from participating in activities they previously enjoyed. The demands of the infant were made upon the rational, autonomous, and independent self of the woman, and these demands were often unacceptable and “disrupting.” Many women described a sense of loss of self Maggie explained, “I feel like ... I’m sort of just hanging around waiting for him to wake up and be fed, to a certain extent my life’s gone on hold at the moment.” Donna described herself as “not my own person, I am his person.” Marianne saw herself as being “separate” from her partner and the outside world. For Petra, having a baby was “such an alien thing,” and she “wanted to have her old life back.” She talked of “having to be on tap all the time,” but she was prepared to put up with this because she was adamant that breastfeeding was crucial for her baby’s health. Alternatively, Jenny was not prepared to put up with the constant demands of breastfeeding. “She was always at me” and weaned the baby from the breast at 8 weeks. For some women the contradictions of being a breastfeeding mother were emphasized by their partner’s comparative freedom to do as they wanted. “His life had not changed.”

For 8 women in this study, breastfeeding was marked by searing pain and discomfort. Despite receiving information and support from health professionals, some women talked of their breastfeeding experience in the early weeks and months as “agonizing,” “horrendous,” and “violent.” Breastfeeding was described as a “battleground,” “a fight.” The baby’s behaviour or actions were cast as “uncivilized,” with the baby “latching on,” scratching, biting, and chewing on the nipple. The women also spoke about their breasts in an objectified way, describing how the breast “deflated,” the milk “curdled,” and “the stuff” poured out of their breasts.

The embodied experience for this group of 8 women was “distorting.” The term “distorted bodies” refers to the pain, discomfort, and disconcerting changes that breastfeeding may bring to a woman’s known “breasted” experience.³⁷ It was difficult for these women to talk disparagingly about breastfeeding or disclose changes to their breasts and nipples that they felt were not only very personal, but repulsive.

In interviews between 1 week and 8 weeks after the birth, many women began with “I’m surprised how painful it is.” Petra described how she dreaded feeling her breasts become tense and full with milk as this signalled that the baby would soon feed again and the first few minutes of feeding were “unbearably painful.” Jane described crying in pain with every feed, and Louise experienced breastfeeding as “agonizing when he first hops on ... sort of excruciating, really.” Christine described the “huge gash” she had on her right nipple stating, “Every time I put him on I cringe.” Sally particularly disliked the sensation associated with her let down reflex. “I had no concept that it would actually pinch and the let down would even be painful ... that

tingling, it’s not even a nice tingling, it’s like an electrical sort of tingling ...”

The “soreness,” the “agonizing,” and “excruciating” pain was most often attributed to the attachment behaviour or sucking action of the baby, what could be described as the “uncivilized nature” of a baby’s feeding behaviour. Donna elaborated, “I like breastfeeding but... from time to time he’ll grab a good hold of the nipple and sort of just grabs (it) between his jaw and squishes his jaw around or something.” In moments of severe discomfort, Donna felt justified in considering an alternative to breastfeeding. “In the middle of the night, you’ve just woken up and you’re half asleep and suddenly you get this sharp pain ... I almost was tempted to go and make up a bottle of formula.” Sally described how her baby would sometimes “hang on, like there is no tomorrow, as though he was going to rip it off.” Petra vividly described how her daughter used to scratch at her breast and “fight” her when feeding. She experienced the baby’s scratching at her breast as “violent” resulting in bodily mutilation, the scratches evident on her breast and damaged nipples.

Few women were pleased by the breast changes due to lactation. Most did not like the size and shape of their lactating breasts. Trisha was concerned that she was going to end up with “lopsided” breasts, and if her baby’s “feeding frenzy” did not subside, she imagined herself looking like “one of these haggard wives with droopy breasts whose babies cry all the time and drain them.” Commonly, the women, and importantly also various health professionals, would objectify their lactating breasts and milk in some way, as though separating their breasts from their body. For example, Cecily described the way she had been “taught to squeeze them to get the smallest bits into his mouth,” and Sally found her engorged breasts “atrocious” but added, “Now that they have really gone down I feel a bit more comfortable with them [her breasts].”

The notion that breasts produce milk and that it flows freely from the breasts was both “taken for granted” as the “naturalness” of breastfeeding and simultaneously amazing,” something to marvel at. Women were awed by the ability of their breasts to produce milk so soon after birth, but later, some became disconcerted or even “disgusted” as milk flowed from their breasts in a way that was outside their control. When her baby was 4 weeks old, Cecily said the only thing she did not like about breastfeeding was the leaking, “sticky” breast milk that goes everywhere and unable to be contained by the cotton breast pads. She lamented she was still unable to wear most of her prepregnancy clothes because of her leaking breasts. Jenny appeared removed from her breasts, talking about her breasts, breast milk, and baby in an objectified or disembodied way: “The stuff just pours out of you.” Petra described how distressing she found leaking breast milk, particularly at night. The soaking wet clothes and bed shattered her image of peaceful, calm, and relaxed night time feeds where the satiated baby would “detach” itself and fall asleep. She was also annoyed by the amount of care that she had to take with appropriate dressing for breastfeeding. This

was the final straw for Petra—"It sucks" (no pun intended).

Some women persevered through great difficulties. Pain and discomfort only ceased when they stopped breastfeeding. Jane persevered with breastfeeding for 6 weeks through enormous difficulties, experiencing badly cracked nipples and 2 bouts of mastitis. The cracked nipples were so painful that she cried every time she fed the baby and the pain continued for about half an hour after the feed. Professional discourse would suggest that this baby was not positioned correctly at the breast and that "attachment" to the breast was poor. While this may have been so, Jane had consulted a number of people during this time, including lactation consultants. Jane talked in detail about her embodied experience of breastfeeding. Through her talk of pain, even mutilation, experienced through mastitis and cracked nipples, Jane represented breastfeeding in a disembodied and distorted way. This is clear in her reflections after ceasing breastfeeding, "... it was nice to have my body back, too ... just to go into the shower and come out and be able to put a towel around myself without going 'ouch, ouch, ouch' ... it was really painful ... and be able to let Jeff cuddle me ... without going 'Oh stay back there.'" When Jane decided to stop breastfeeding she was able to regain her known "breasted" body, bodily comfort, and control.

The "disrupting" and "distorting" experience of breastfeeding gave 8 of the women a sense that they were somehow "separate" from their baby and working in opposition to each other. At times these women felt alienated from their baby. Here the mother and baby appear in the interviews as separate, autonomous individuals, each with competing needs and desires. Conflicts and contradictions arose between the needs or desires of the mother and the baby. In some instances, the woman described feeling hurt or rejected by her infant's behaviour and actions and at other times feeling extraordinarily "put upon" or intruded upon by the demands of her newborn.

Marianne, Jane, and Cecily for example, desperately desired a connected, harmonious, and intimate relationship with their infant through breastfeeding. These women continually presented their infants as "good" babies and presumed the difficulties with breastfeeding lay with them as inadequate mothers.

Women such as Petra, Naomi, and Prue, on the other hand, described a need to "disconnect" from the infant. These women worked for separation and individuation from their baby. In describing their baby they used metaphors of intrusion and devourment, talking of being "suck(ed) dry" and the baby as "The rotten sucking little leech," "The child from hell." In their descriptions of the baby that "latched" on, scratched the breast, bit or clenched with their jaw, or grabbed the nipple, the women often implied such behaviours were "uncivilized." The baby needed to be "tamed" or trained to behave in a civilized manner.

Here the baby was positioned as an "antagonist," working against the mother. These women felt as though they existed to be used by this "uncivilized" creature. The demands of their uncivilized infant for constant

attention and proximity encroached on these women's sense of self, their autonomy, and independence.

Discussion

Breastfeeding brings new sensations and new ways of experiencing one's body and self. During these interviews women worked hard to articulate breastfeeding as an embodied experience. For approximately one third of these women, breastfeeding was the connected, harmonious, and intimate experience they had anticipated. Yet for others, breastfeeding was a disruptive, distorting, and a disconnected experience. The level of personal distress associated with breastfeeding described in this paper is rarely presented in professional or popular texts. Findings from Carter,²⁵ Maclean,²⁷ and this Australian study, demonstrate the idiosyncratic nature of breastfeeding and some resistance to the demands of the probreastfeeding rhetoric and the child-centred discourses of mothering.

For some, the embodiment of breastfeeding represents a continuity of mother and baby, an uncertainty, or blurring of boundaries between mother and child, self and other, that many women experience during pregnancy.^{37,50-52} For these women, breastfeeding provided a sense of "oneness" or "completeness" with the baby that was pleasurable and satisfying. This analysis challenges the notion of separation of mother and baby at birth or within the first postpartum month, as described by Deutsch,⁵¹ Bibring,⁵⁰ and Rubin.⁵² These women not only tolerated the uncertainty or blurring of their body boundaries, they enjoyed this connectedness.

The imagery and metaphors of harmony, intimacy, giving of self, and exclusivity used by the women in this study have been noted by others.²⁹⁻³¹ This persuasive imagery reflects the personal rewards that motivated these women to persevere with breastfeeding. Similar to the findings of Wrigley and Hutchinson³¹ and Bottorff,³⁰ some women enjoyed the dependence of their breastfed baby and were confident to rearrange their lifestyle to focus on the child and its needs. It is this experience of breastfeeding that is promoted in many of the professional and popular texts on breastfeeding. Here the pleasurable and sexual nature of breastfeeding is cast as a source of female empowerment.^{33,34,36,37}

Notions of intimacy and connectedness were not described by all of these women. For over half, breastfeeding was disruptive, unpleasant, and distressing. These women found the intense closeness and continuity between themselves and their baby intolerable. The uncertainty of boundaries between mother and child, or self and other, was difficult to reconcile, as this uncertainty or ambiguity conflicts with contemporary notions of autonomy, independence, and control.

Women in this study became aware of the distinction between their private and public worlds. Following birth, many women became ambivalent about commitment to "intensive" mothering.⁵⁴ They started to realize how much their lives had changed, talking of being "confined" to domesticity and the private world. They recognised that mothering and breastfeeding centred on

the private world and received little recognition. As Maclean²⁷ indicates, in rational management discourse breastfeeding cannot be evaluated in terms of effective time management or “efficiency.”

Many women yearned to have time away from their baby, to be part of public life again. It is important to emphasize that, in contrast to Carter’s²⁵ analysis, these women did not feel restricted from public activities purely because they were breastfeeding. They did not demonstrate confusion over the nurturing and sexual function of the breast. Rather, it was their personal bodily routines and patterns that were “disrupted” by the demands of their breastfeeding baby and their commitment to “intensive mothering.” As Balsamo et al.⁵⁵ describe, breastfeeding on demand is often “chaotic and dangerous” for women, and the baby described as an “encroachment” on a sense of self.

It is rare to find detailed personal accounts of women’s experience of pain or discomfort associated with breastfeeding. Professional discourse often attributes discomfort to incorrect positioning of the infant at the breast, while probreastfeeding accounts in the popular literature attribute women’s discomfort to the sexualization of the breast in our society. Professional accounts gloss over distress, to focus on how difficulties may be resolved and a happy breastfeeding experience established. In this study some women “persevered” through the “distorting” experience of breastfeeding and established a connected, harmonious, and intimate breastfeeding relationship. Others, however, sought to regain control over their lives and over their bodies by ceasing to breastfeed and reestablishing predictable feeding and sleeping routines.

This research not only identified the powerful discourses that currently position breastfeeding as crucial in the construction of maternal identity, it confirmed breastfeeding as a powerful nondiscursive or “embodied” experience. Understanding and accepting the wide range of women’s personal, embodied experience of breastfeeding must be taken into consideration in clinical practice.

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