

Exploring Infant Feeding Choices in the Northern NSW Aboriginal Community



Final Report

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Abbreviations

AMIHS	Aboriginal Maternal and Infant Health Service
AH&MRC	Aboriginal Health and Medical Research Council
AHW	Aboriginal Health Worker
AVO	Apprehended violence order
HETI	Health Education and Training Institute
NSW	New South Wales

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ABSTRACT

Aim

To explore the factors that impact on infant feeding choices in the Northern New South Wales (NSW) Aboriginal Community.

Methods

Yarning style, semi-structured interviews were conducted with eight first time Aboriginal mothers, five Aboriginal Health Workers and two community breastfeeding champions. The resulting themes were integrated with an extensive literature review and with a summary of historical events which have impacted infant feeding decisions in this community. Indigenist methodology guided the study design, implementation, thematic analysis and the dissemination of results.

Results

Three key themes were identified from analysis of the interviews. These were “I’m doing the best thing for....” which encompasses the expressed and perceived motivations underpinning infant feeding decisions; “this is what I know...” which explores the sources, quality and gaps in knowledge regarding infant feeding; and “ a safe place to feed” identifying the barriers that shame and negative societal messages pose for women as they make infant feeding decisions. An exploration of the impact of historical factors on the Northern NSW Aboriginal community provides a deeper understanding of the cultural context.

Conclusions

Compassionate and holistic maternity care which takes into account the social and cultural lives of Aboriginal women will be the most effective in supporting this group of women as they make their infant feeding choices. Aboriginal people value and trust knowledge passed to them from extended family members and within their community. Programs to increase the knowledge base of Aboriginal women in the whole community may have greater impact on health outcomes than a reliance on expert health professionals.

Keywords: *Aboriginal, Indigenous, Australian, infant feeding, breastfeeding, rural.*

Breastfeeding is one of the simplest ways of improving the health of Indigenous children (1)

EXECUTIVE SUMMARY

The Study

The study 'Infant Feeding choices in the Northern NSW Aboriginal Community' provides a greater understanding of the cultural, historical, socioeconomic and personal factors that influence the way that Aboriginal mothers make decisions about whether to breastfeed or formula feed their infants in the first months of life.

The stories shared by these eight first time mothers, two community breastfeeding champions and by five Aboriginal Health workers who support them provide a greater depth of understanding to the barriers to breastfeeding and possible factors that may be the most supportive for these women.

A very important aspect of this study is its commitment in design, implementation, analysis and dissemination to ensure that the voices of participants are heard and interpreted clearly without being contaminated by a non-Indigenous researcher's potential cultural bias.

The Motivation

The literature review undertaken for this study demonstrates the immense benefits that breastfeeding provides for women, infants and general community health. Many of the common childhood illnesses and chronic diseases experienced by Aboriginal people would benefit from the health advantages of breastfeeding.

We know from international literature that women who are adolescent, have lower levels of education, have a lower socioeconomic status, are overweight and are smokers are less likely to breastfeed. All of these factors are common in the target group for this study. Data collected within Australia consistently reports that Aboriginal women in rural and urban areas have lower rates of initiating and continuing to breastfeed than community averages.

A greater understanding of the experiences and decision making processes of young Aboriginal mothers may provide direction for health care providers and policy makers in future health promotional planning.

The Message

This study aims to synthesise the impact that historical events, current socioeconomic conditions and cultural factors have had on many generations of Aboriginal women which flow through to the young mothers of today. Since the debilitating effects of colonisation in which some women were removed from the community, children were removed from their families and traditional knowledge and practices were discouraged by governments of the day, the knowledge and practice of breastfeeding has slowly been diminished in this Aboriginal community.

The health system strategies for promoting breastfeeding have a limited capacity to reach this group of young mothers as they tend to value knowledge provided by their Elders, extended families and peers above that provided by unfamiliar health professionals. This may go some way to explaining why the breastfeeding rates in this community remain lower than the national averages.

Case studies with extensive quotes from participants demonstrate how complex these Aboriginal women's lives are. All of these new mothers are strongly dedicated to providing the best possible care for their infants. As they make their choices in the first two months to move from breast feeding to formula feeding, doing the best thing

for their baby remains their primary motivation. There is not one outstanding factor that leads to the cessation of breastfeeding amongst these mothers. Change in infant feeding practices and education will require a slow, culturally considerate approach which is informed by the unique needs of Aboriginal women.

One of the key barriers identified in this study is the challenge is in accessing a safe, comfortable place for breastfeeding. This is partially related to over-crowded housing but is also largely the result of negative attitudes within the Australian community regarding breastfeeding in public.

The Next Step

It is important health care providers to have a patient, individualised approach to the care of Aboriginal mothers, one which holds a place for the social and cultural factors that influence their parenting decisions.

Current practice in breastfeeding support tends to be a one size fits all model, based on the global standards of 'Ten Steps to Successful Breastfeeding' (2), attachment theory and direct parent education. The women in this study had access to optimal care in these areas and yet the recommended breastfeeding rates are far from being met. It seems that Aboriginal women require a targeted approach based on the cultural and historical norms of their community rather than those of mainstream Australian society.

Strategies to improve the acceptance of breastfeeding in the Aboriginal community as well as Australian society in general will minimise the conflict felt by mothers about the issue of breastfeeding in public.

Further exploration, discussion and the continued development of culturally focused education and services to support these young mothers as they make their infant feeding decisions may improve the potential health outcomes derived from breastfeeding in the Northern NSW Aboriginal Community.

INTRODUCTION

This study aims to capture the unique voice of Aboriginal women in the Northern NSW area as they make their choices about whether to breastfeed or formula feed their newborn infants. This information can be used to enhance the understanding of maternity care providers.

The knowledge contained in this research report will be shared with maternal and child health care providers in the local Aboriginal Community Controlled Organisations, local Maternity service providers and with interested parties throughout NSW through oral and written presentations.

The mortality and morbidity of Indigenous people throughout Australia is of great concern. All efforts towards 'closing the gap' between health outcomes of Aboriginal people and national averages are important. Increasing the rates of breastfeeding would provide benefits for both mothers and infants that would last throughout their lives. For this reason a clearer understanding of health practices based on knowledge shared directly by the community is a timely and valuable resource.

BACKGROUND

Exploring factors that influence infant feeding choices in the Northern New South Wales Aboriginal Community

Infant feeding choices in the first six months include breastfeeding, feeding with infant formula or some combination of these (3).

Breastfeeding provides well established benefits to infants, mothers and society (3, 4). A small proportion of women in Australia choose not to breastfeed at all and for every month after birth the number of breastfed infants declines rapidly (3). The NSW Breastfeeding policy recognises three groups of women who are less likely to breastfeed; mothers under 25 years old, those with less than a tertiary education and Aboriginal mothers (5). The protective health factors in breast milk would be of great benefit to Aboriginal children because they have a disproportionate number of hospital admissions for respiratory, gastrointestinal and otitis media infections than the general population (1, 6).

The reasons women chose to breastfeed or formula feed are complex and involve personal, cultural, historical and social reasons (7). Many studies have been conducted in Australia and internationally attempting to understand the factors that influence women's infant feeding decisions (8, 9). These have given a solid basis from which to begin an exploration of the experiences of Northern NSW Aboriginal women.

This literature review will provide a detailed exploration of:

- the government policies related to infant feeding targets and recommendations
- current rates and trends for infant feeding in Australia and within Australian Aboriginal populations,
- published literature regarding the benefits of breastfeeding,
- barriers to breastfeeding in the general population, with a focus on the findings of studies that specifically address or relate to the experiences of Australian Aboriginal women,

Research undertaken regarding breastfeeding and health outcomes is often descriptive or epidemiological. It can be challenging to demonstrate a causal relationship between breastfeeding and a particular outcome as there may be other influencing factors, such as age, partner and family influence or education.

Policies and Programs Regarding Breastfeeding Practice

The World Health Organization promotes the message that breastfeeding is the normal way of providing young infants with the nutrients they need for healthy growth and development (10). Exclusive breastfeeding is recommended up to 6 months of age, with continued breastfeeding along with appropriate complementary foods for up to two years of age or beyond (10).

In Australia infant feeding guidelines at the federal level are outlined in the Australian National Breastfeeding Strategy 2010-2015 (3). This policy was developed in response to *The Best Start: Report on the inquiry into the health benefits of breastfeeding* in 2007 (11). The recommendations from this report which are relevant to this research topic include commitments to i) implement a national strategy to promote and support breastfeeding, ii) increase monitoring and provide greater research funding into breastfeeding related programs and iii) funding of a national education campaign to promote breastfeeding (11).

Two of the recommendations relate specifically to the needs of Indigenous women. The Department of Health and Ageing are committed to provide leadership in the area of monitoring, surveillance and evaluation of breastfeeding rates and practices in Indigenous populations in both remote and other areas and to promote breastfeeding within Indigenous Australian communities as a major preventative health measure (11).

The 2010 the Australian National Infant Feeding Survey (12) provides data about the rates of breastfeeding and indicates that 1.4% of respondents were Indigenous. However the transitory nature of many young Indigenous families, variable literacy levels and reluctance to participate in research processes may have led to an unrepresentative sample being collected for Indigenous families as this was a mailed questionnaire which required completion and return in a prepaid envelope (13).

The most recent national data collected specifically in Aboriginal communities about breastfeeding rates identifies that 85% of Aboriginal children aged 0–3 years in remote areas and 73% in non-remote areas were breastfed in 2008. This indicates that longer breastfeeding duration which is more in keeping with traditional cultural practices is more readily achieved in remote communities (14).

Within NSW, 2009 figures indicated that on discharge from hospital 80% of babies across the state were being breastfed while only 62.4% of Aboriginal babies were receiving any breast milk (13).

Aboriginal specific programs in NSW offer support in a culturally respectful environment to Aboriginal women and families (16-18). The federal government has supported the development of Aboriginal Mothers and Babies centres through their New Directions Program (14). In 2012 the Federal government funded more than 80 programs aiming to increase targeted mothers and babies services for Aboriginal and Torres Strait Islander women (15). There are three sites for these services in the Northern NSW Local Health District located at the Ballina, Lismore and Casino Aboriginal Medical Services (18).

A NSW program that has evaluated effectiveness in improving the engagement and health of Aboriginal mothers and babies is the NSW Aboriginal Maternal and Infant Health Service (16). Supporting and promoting breastfeeding is a key reporting target area of these programs. The 2004 AMIHS data indicates slightly improved rates were seen from 67% initiating breastfeeding and 59% breastfeeding at 6 weeks in 2003 to 70% initiating and 62% at 6 weeks in 2004 by women engaged with AMIHS programs across NSW (19).

Benefits of Breastfeeding

Breastfeeding is an unequalled way of providing ideal food for the healthy growth and development of infants (17) with well demonstrated benefits for babies, mothers and society (1, 3, 6).

The American Academy of Pediatrics in 2012 (3) stated that based on the documented short- and long-term medical and neurodevelopmental advantages of breastfeeding, infant nutrition should be considered a public health issue and not only a lifestyle choice.

Benefits to babies include reduced incidence of upper and lower respiratory tract infections, otitis media, gastrointestinal tract infections, as well as protection against asthma, atopic dermatitis and eczema (4, 18, 19). Long term benefits for breastfed infants include reduced obesity, lower incidence of type 1 and type 2 diabetes, less hypertension and high cholesterol in later life, protection against coeliac disease, inflammatory bowel disease and childhood leukaemia and lymphoma (3, 9). A study published in 2013 finds a causal relationship between breastfeeding duration with receptive language and verbal and nonverbal intelligence (20, 21).

Women who have breastfed have a reduced risk of ovarian and breast cancer, cardiovascular disease, rheumatoid arthritis, hypertension throughout their lives and are less likely to develop Type 2 diabetes (3). The society and community benefit from the reduced burden of disease (22).

Barriers to Breastfeeding

We know from international literature that women who are adolescent, have lower levels of education, have a lower socioeconomic status, are overweight and are smokers are less likely to breastfeed (9, 23-26). These are factors which are commonly seen in young Aboriginal women and partners of Aboriginal men, however the 'why' of these barriers is not so well understood. This is the potential value offered by this qualitative study. Table 1 summarises barriers to breastfeeding identified in the published literature. Each of the women in this study experienced at least ten of these barriers in their lives at the time of the study.

- high levels of antenatal stress (27, 28)
- age less than 25 (5, 28-31)
- first time mothers (31)
- pain or discomfort associated with feeding (32)
- baby is perceived to be more settled and sleep more when formula fed (31, 33, 34)
- Perceived lack of supply/ Perception that the infant is not satisfied (25, 29, 31, 34-37)
- lack of partner and family/ grandmother support (28, 38-40)
- postnatal anxiety and depression (27, 41-44)
- lack of (self-efficacy) antenatal confidence in her ability to breastfeed (39, 45-47)
- smoking (24, 25, 28, 30, 48-51) and alcohol use (52)
- peer norms (53, 54) and lack of community support (37, 55)
- embarrassment feeding in public (32, 54-56)
- sole parent/ father not being in the home (43)
- poor maternal nutrition especially anaemia (57)
- low socioeconomic status (25, 29, 58)
- wanting or needing to leave the infant with someone else (35, 59)
- wanting father to be involved with feeding (59)
- impact of infant formula advertising (60)
- negative media messages about breastfeeding (61)
- interruption of breastfeeding culture (62, 63)
- Idealism versus realism (64)

Table 1: Recognised published barriers to breastfeeding

Infant Feeding in the Australian Aboriginal Population

Previous studies exploring the rates of breastfeeding amongst Aboriginal women include one study which found that the breastfeeding rates of Indigenous women in Perth are similar to those of women in the non-Aboriginal population (65). However, studies in Melbourne (66), Sydney (26) and Brisbane (67) Aboriginal communities have all found much lower breastfeeding initiation and duration rates amongst the Aboriginal population.

Focus group discussions in the Melbourne study identified gaps in culturally targeted breastfeeding education and resources and inspired the development of a video, booklet, posters and antenatal education classes for local Aboriginal women (66). A follow up study to assess the effectiveness of these measures has not been published to date.

The Australian Breastfeeding Association conducts a course training Aboriginal health workers and community members to become Community Breastfeeding Mentors (68). This course was completed by three of the Aboriginal Health Workers who were interviewed for this study and they were all very enthusiastic in their confidence with promoting breastfeeding. This recently established course is yet to be formally evaluated.

Research Aims

The published literature provides comprehensive statistical data regarding breastfeeding rates and demographics but it does not give clear insight into the reasons for women's infant feeding choices.

The aim of this research was to develop a greater understanding of the intentions and experiences of first time Aboriginal mothers as they make decisions about infant feeding in pregnancy and the first months of parenting. The 'yarning' style interviews(69) allow the voices of these young mothers to be heard directly. Synthesis with existing literature, historical records and the insights of the health workers who support women, add to the understanding of participant's experiences.

A further aim of this study is to inform health care providers in the most effective ways to provide infant feeding support and education to this particular group of women.

METHOD

Indigenist Methodology

The challenge for a novice non-Aboriginal researcher exploring issues occurring within the Aboriginal community is to avoid repeating the mistakes of researchers of the past. Academics would descend on a community, collect data and leave, with little or no feedback to the community and no lasting community benefits (72).

The principles of Indigenist Research (73) have been used as the guiding methodology of this study in order to ensure that the ownership, interpretation and dissemination of the research findings remain with and benefit the local Aboriginal community in all stages of the study.

My first question in undertaking this study was to identify whether, as a non-Indigenous woman I could conduct the project with the wholehearted support of Aboriginal colleagues, mentors, participants and Aboriginal Community Controlled Organisations (ACCO). This required me to reflect deeply on whether I possessed the cultural experience and the capacity to undertake Indigenist research, holding true to the guiding principles. My extensive experience working as a Midwife in the local Aboriginal Community along with a high level of support from a senior Aboriginal mentor and guidance from the ACCOs and AH&MRC made me feel confident that I would be able to achieve this goal.

This interview based qualitative study, using Indigenist methodology endeavoured to examine the experiences and pathways for decision making in this group of young Aboriginal first time mothers. The knowledge that emerged will be utilised by local services in improving support for these women as they make their infant feeding decisions.

Recruitment

Key points of data collection were during the pregnancy and at eight weeks postpartum.

Eight women were recruited from Ballina, Lismore, Casino and Kyogle and the Aboriginal communities of Cabbage Tree Island, Box Ridge and Muli Muli.

The Socio-Economic Indexes for Areas (SEIFA) indicating relative social disadvantage ranks Ballina as close to NSW state averages while Lismore, Casino and Kyogle sit below average. Two of the Aboriginal communities Cabbage Tree Island and Muli Muli are ranked as the two most socially disadvantaged areas in New South Wales (71). These communities have high rates of housing insecurity and overcrowding, low household incomes, high rates of unemployment, crime, incarceration and suicide, poor school attendance and low rates of drivers licence and car ownership (71).

Aboriginal women as well as non-Aboriginal women who are partners of Aboriginal men were included. After consultation with a number of Aboriginal health managers and clinical staff regarding this inclusion it became clear that it is important to include all Aboriginal babies whose mothers met the study inclusion criteria. Women who are partnered with Aboriginal men tend to live cohesively within the Aboriginal community with similar norms and experiences and are accepted as part of community.

After 20 weeks gestation ten women expecting their first child (primigravida) were invited to participate by their primary health care provider with two adolescent mothers choosing not to participate. Primigravidas were sought to prevent previous breastfeeding experiences from influencing infant feeding decisions.

Recruitment for this study was via an introduction from the Midwife, Practice Nurse or Aboriginal Health Worker who provides primary care through the Aboriginal Medical Services and AMIHS program.

Exclusions

There were several exclusions to recruitment;

- Twins or Triplets- these women are less likely to breastfeed not because of their perceptions or desire but due to the increased demands of having more than one baby.
- Maternal mental or developmental delay. These women may find it difficult or stressful to engage in the interview process.
- Women under 16 years of age.
- Known birth defect. If a defect has been detected in pregnancy these women may have greater stress about their pregnancy and concern about the wellbeing of their baby and also greater uncertainty about their choices for infant feeding.
- Previous breast surgery which may interfere with breastfeeding success.
- Families who have had involvement with child protection services during the antenatal period. There is often added stress on these families and this topic area may be too sensitive for families who have concerns about whether baby will remain in their care.

Data Collection

The three main data sources were eight participant interviews, seven key informant interviews and historical data.

In addition to these, a senior Aboriginal Health Worker was the cultural mentor for this study scrutinising the behaviour of the researcher as well as supporting data analysis throughout the study.

This study occurred in cycles of collaboration, with participants, key informants, mentor and published literature adding progressive depth, breadth of view and accountability to the study.

Participants

My initial contact with the expectant mothers involved a brief description of the study, the timing and duration of interviews, an opportunity to develop a relationship, to answer any questions and to seek informed consent to undertake the antenatal interview.

At the first interview the participant information sheet was provided and all aspects of the study were explained. A copy of the participant information sheet is provided in Appendix 1.

All interviews were conducted in a setting that was comfortable for the mother and in the presence of whom she chose. One interview in this study was conducted in an Aboriginal Medical Centre all of the others were in the woman's home.

Two interviews, antenatal and postnatal were conducted with each of the eight participants. Their ages ranged between 18 and 26 years old, seven identified as Aboriginal and one was the non- Aboriginal partner of an Aboriginal man. One of these women was in paid employment during the pregnancy. Two women identified as single throughout the pregnancy.

The eight participants were interviewed during the last month of their pregnancy and again when baby was between six and eight weeks old. None of the women were still breastfeeding at the time of the second interview. Interviews averaged 25 minutes duration. Field notes were also taken.

The interviews were conducted in a semi-structured, 'yarning' style (69) aiming to cover several core topics. A copy of the interview questions at the antenatal and six to eight week interviews is provided in Appendix 2.

The interviews were audio recorded and I transcribed them verbatim. At two of the postnatal interviews a family member was present at the participants' request. Babies were also present at all postnatal interviews.

Participants were presented an interview transcript for review of accuracy. None of the women chose to read them.

Key Informants

Aboriginal Health Workers

One interview was conducted each with five Aboriginal Health Workers (AHWs) with whom I have worked for many years. They were chosen for their extensive experience working with Aboriginal mothers and babies. Each had a deep knowledge of the cultural and social norms of local families. The context and aims of the study were explained to them prior to their participation and they all felt that the study was a worthwhile undertaking.

The topics discussed were related to emerging themes in the participant interviews as well as their perceptions of the norms and barriers to breastfeeding in their community. These interviews were conducted at the AHWs workplace and were approximately 30 minutes in duration, they were audio recorded and I transcribed them. Field notes were also taken.

Breastfeeding Champions

These two women were well known to me as they received Midwifery care through AMIHS service for each of their pregnancies. One was the mother of three and the other of four children and each of these infants had been breastfed for at least a year. Their inclusion in the study was unanticipated but highly valuable. One was the result of a waiting room discussion at the Ballina ACCO. In the course of a general discussion the study was mentioned and this mother expressed a strong desire to share her observations about the reasons women stop feeding as many young women came to her for advice when making their decisions. The other approached the researcher while undertaking a clinical visit with her cousin who was a participant in the study. She was also very open and insightful about her perceptions of women's infant feeding choices. Their verbal consent to make some notes

about their views was obtained and they expressed an interest in being informed of the study conclusions. Each of these discussions was about 20 minutes in duration.

Their views of Key Informants provided valuable knowledge arising from many years of watching and considering the parenting choices made by mothers in their community. Their ability to express big picture views adding valuable cultural insights to this study.

Historical Data

An understanding of historical events as they impact on current breastfeeding rates adds depth of understanding to the complexities of infant feeding choices. This data was collected from historical documentary sources and expanded by local key informant interviews.

Analysis

Thematic analysis of the data from participant interviews was conducted using an inductive approach based on the six phases as outlined by Braun and Clarke (73). Interpretation and analysis was led by the content of the interviews and regular consultation was undertaken with the Aboriginal mentor during the analysis process. Maintenance of a reflective journal by the researcher and ongoing review of published literature were strategies used to maintain veracity of the analysis.

Analysis started with the broad familiarisation of the thoughts and feelings shared by participants in the interview transcripts. Initially many possible themes or concepts were identified and these were refined and clarified by revisiting transcripts and finding key statements expressed by the participants. For example all comments related to *conversations with others* about infant feeding were clustered together. The main people mentioned in the conversations and the stated influences this had on the women's choices were examined for commonalities.

Key informant interviews allowed for some refinement of interview questions for later participant interviews and provided a greater understanding of the cultural and historical influences on the participants.

Ethics approval for this study was obtained from the Aboriginal Health and Medical Research Council ethics committee and the Northern NSW Human Research Ethics Committee. Site Specific Assessment was also granted by the NSW Northern Local Health District.

FINDINGS

Complex lives

It is not possible to understand the decisions made by these Aboriginal mothers without understanding the context of their lives. Included throughout the discussion of themes are case studies. Summaries of five of the women interviewed which are shared as representative stories. The lives of all of the women in this study had a high level of social complexity.

It is important to bear in mind that all of these women had excellent support from the AMIHS Aboriginal Health Worker and Midwife. This included private antenatal classes and home visiting at least once or twice a week until the time of the postnatal interviews at six to eight weeks. They also had unrestricted access to medical, dental and allied health professionals at the Aboriginal Medical Service. Various non-government organisations such as

housing, disability services, intensive family based services and Aboriginal legal aid were also available to participants as required.

These support services were well utilised but they alone were not able to ameliorate the impacts of the complexities of these Aboriginal women's lives.

Case Study - Jamie

Jamie is 22 she is thrilled about being pregnant, she has a supportive partner and a large supportive extended family. She is very well informed and excited about being the best mother she can. At the morphology scan the sonographer tells her baby has defects with its brain and its heart. So she sees the GP in the afternoon and when asked the likely outcome is told baby will probably be profoundly disable or will die. Absolutely distraught for the four days until she can get to the foetal medicine specialist, Jamie is relieved to be told that all looks perfectly normal. She and her partner move from a share house to their own place during the pregnancy. He is working but takes time to support her when she is having a tough day in the pregnancy. Jamie has experienced anxiety in the past but has been okay for the past three years. After a long hard birth a healthy baby is born and is breastfeeding perfectly *" he latched on perfectly by himself and like he just found it naturally, like I put him near it and cause I didn't want to force him on it, just wanted it to find it naturally, he latched on perfectly and fed really, really well."*

Jamie is very relieved as she had doubts about whether baby would be normal since the morphology scan. The first week was great then increased demand for feeds in the second week was very distressing and tiring for Jamie. Her sisters and mum suggested maybe there was something wrong with her milk. She persisted and then in week four her baby started refusing the breast on some occasions when he was over tired. *" He just stopped taking it, like he'd scream and scream and scream and I'd put him on the boob and he'd just scream and scream and like I persisted through it...and I'm like this can't be healthy obviously he's not happy with it, so I tried him on organic formula and he loved it "*. By five weeks he was refusing the breast every feed but happily feeding on formula. Jamie *"cried for a couple of days"* about ceasing breastfeeding but then she realised *" I've got to do what's best for him and not what's best for me ."* She was very proud that she was giving him organic formula *"I didn't want to resort to formula feeding...then when I found the organic formula you know it eased my mind a little bit because it's got you know all the natural stuff and it doesn't have the added chemicals in it"* she was also happy with his increased weight gain and that her *"partner gets to spend so much more time with (baby) now"*.

Themes

Three key themes emerged from analysis of participant and key informant interviews.

These are:

"I'm doing the best thing for...." This includes discussion of the expressed *intentions and motivations* of women during pregnancy and as they make the switch from breast to formula feeding. In this theme the perceived motivations of about maternal behaviour by key informants is also discussed.

"This is what I know..." the importance of and lack of *knowledge* about breastfeeding is identified by both groups. Barriers to the effective transfer of knowledge to these women and their fears and doubts arising from negative stories are explored.

"A safe place to feed" the perceived and experienced *shame* of breastfeeding in front of others and in public is a concern expressed by all participants and key informants.

Theme 1

“I’m doing the best thing for....”

Antenatal

All of the mothers interviewed stated that they had a strong intention to breastfeed. The main reasons given were the desire to do the best thing for baby and believing that breastfeeding is the healthiest option. Reduced cost and convenience were other reasons cited. Breastfeeding is perceived to be easier for night time feeding, not having to get out of bed to make bottles and the incentive of getting back into shape after the birth was mentioned by five women.

Doing the best thing for their baby is identified as the key driving force for these women’s decisions about infant feeding. The pathways, through which the perception of “best for baby” changed from breast milk to formula in the early postpartum period, are complex and very individual. The case studies included in this report give some insight into this.

Postnatal

These eight mothers moved from breastfeeding to formula feeding in the first two months for the following reasons. Three women expressed that the desire for baby to visibly gain weight and to be assured that baby was getting an adequate volume of milk was their primary motivator. One woman ceased breastfeeding as she had ringworm on her breast which transferred to her babies face. One participant believed on advice from a relative that her infants’ restlessness indicated he was not satisfied by her breast milk. Another of the mums grieved as her infant rejected the breast. One didn’t want her smoking to affect her baby and another was concerned that her postpartum depression would affect the baby through her milk.

The stories shared by this group of eight newly birthed women strongly indicate that the reasons for commencing formula feeding were primarily baby centred. All of the participant’s stories expressed that the choice to commence formula feeding was motivated by the desire to do the best thing for their baby.

Key Informants

In contrast to the information gathered through participant interviews, the Aboriginal Health Workers and community breastfeeding champions universally expressed the perception that the main reasons for mothers choosing to formula feed were mother centred rather than baby centred. They are too busy *“Keeping up with their man... and their friends”* (Sally) was seen to be the main factor that makes women change from breast to formula feeding. Key informants believed that the primary motivator for most women is the desire to go out, to be with their partner or resume social interactions including drinking alcohol. They shared the perceptions that

“they want to breastfeed, but then it comes down to when they want to go out, or keep up with their man” Annie

“these girls are worried about their partner and what he is doing, they need to be mobile to follow him, check on him” Tammy

The influence of friends is also strongly identified

“Their friends are all going out and they encourage the mum to go out and leave the baby with Aunty or mum” Sally

“I reckon more than half of our mums give up feeding so they can go drinking” Deanne

Theme 2

“This is what I know.....”

Antenatal

Most of the women in the study expressed a lack of knowledge about breastfeeding and stated that they haven't really thought much about it. Six of the women had not spoken to their mother about it and did not know whether they were breast fed. Of the two who had spoken to their mothers one said,

“I know like my mum, she's had six of us and she's never breastfed not one of us” Katie

Five participants named the brand of formula used by their peers and knew which brand they would use if necessary. All participants had given younger relatives formula bottles.

Formula advertising is banned in Australia. The legislation does however allow for toddler formula to be advertised which probably explains comments like this

“There's so many good formulas you can get these days. Like I watch all them ads and I've been taking it all in which one I might get and stuff.” Katie

“I've seen it (formula advertising)..., but I didn't even notice its toddler, I just presumed it was formula.” Donna

Also incorporated in the theme of ‘**this is what is I know....**’ are the negative experiences and messages from friends and family that are regularly shared with these first time mums. Most of the women could recount potential problems described by other women about breastfeeding. This introduced doubt in the women about whether they would be successful in their attempts to breastfeed. All of the participants made statements such as “if I can” or “I'm going to try”, when asked if they intended to breastfeed.

When asked what might happen that would stop her from being able to breastfeed one woman responded

“I've heard heaps of stories about like...I've known people that their breasts have got infected and it's just like yeah, some of their babies have bitten them and...I've heard the milk can go all wrong and stuff...just like I've heard heaps of bad stories.” Katie

Postnatal

Participants expressed being influenced by societal norms rather than health messages. The quotes and stories shared in the case studies identify the strength of societal influences in determining infant feeding methods at each step of the decision making process.

Participants identified that partners and family members questioned their choice to breastfeed. They also express the perceived benefits of formula feeding arising from formula advertising and peer advice.

Existing pathways for knowledge transfer and education regarding infant feeding choices are not effective in reaching these women. The messages that arise within the extended family and the Aboriginal community are the most influential source of information.

“I really only talk to my family about it ...cause they're the only ones that I would listen to” Jacqueline

The current norm in these communities is to formula feed infants so this is the knowledge that is being transferred to new mothers.

“They all talk about the best kind of formula everyone has one they swear by as the best, like they are doing better for their kid by getting the most expensive formula” Katie

Mainstream health promotion messages are conveyed through brochures, posters, antenatal classes, midwives and doctors at the point of contact with the health system. These have far less impact than the conversations with elder women and peers in the community.

Case Study -Amy

Amy is 20 years old and moved to the area with her partner during the pregnancy. She doesn't know many people and states she has agoraphobia/social phobia so she is happy to have her maternity care at home to avoid the big clinics. Her partner is not the father of this child, she conceived when they had separated temporarily but he is very supportive of the pregnancy and Amy. She developed pre-eclampsia at 39 weeks and had an emergency Caesarean section. The baby had difficulty latching to the breast in the first few days and Amy found the help of Midwives at the hospital were excellent and consistent. Baby breastfeed well every two to three hours for two weeks but then seemed to be unsatisfied after feeds and wanted to suckle all the time. Amy demand fed frequently until five weeks and then *"I decided to try her on the bottle just to see if...cause she wasn't getting full enough anymore, getting satisfied enough off the milk"*. She became settled between feeds and *"seems so much happier"*. And although she was gaining good weight while breastfeeding *"she's filling more now, so it's a lot better, like I pick her up and she's not all skinny and before I felt nervous picking her up without a top on cause she felt all skinny and not really like got enough fat on her. But now she's putting on the weight and it makes me feel a lot better"*. When asked how it was when she was breastfeeding in public places she recounted an incident *"...people just stare at you and you just feel so uncomfortable and you feel too uncomfortable to go and sit on a toilet to feed your kid, cause it's like a toilet. One time we were down town, I was just with two of my friends and we went around to these little benches so it wasn't like full out in front of everyone and I was just going to put the blanket over me and everyone, old ladies and everyone just started staring at me....it wasn't just a look you know like stare and then look away ,it was like a full on just keep watching stare...so I was just like, nup, we'll go to the park."* *"...with bottle feeding you can just make the bottle and feed baby wherever and no-one can discriminate against you or make you feel that it's wrong."*

Key Informants

'Education is the key' Sally

This was a strongly expressed sentiment amongst the key informants who also identify that the main sources of infant feeding information come from the Aboriginal community and a woman's relatives.

"Women's main influence is their mothers grandmothers and aunties and these women might not be well informed themselves, they might still have old school ideas, stuff from the missions" Deanne

"Other family members or other parents tell them to use formula, they say 'they're just as good as breast milk'. It says on the side, it's got all these vitamins in it." Wendy

Regarding the benefits of education being provided by AHWs and trust health professionals

"These women won't call a mainstream service or a help line, they only get support from people they know well and they trust" Deanne

"...besides us educating our clients we talk to our kids, we talk to our nieces and that and then they talk to their friends so, it's all about the word of mouth, you know blackfella grapevine. You only have to tell two or three of your family members and they'll tell someone else...they'll say 'well my mum learnt it' and then they go 'Oh yeah...their mum's an Aboriginal Health Worker' and then they'll go like that..." Tammy

AHWs identified the link between learning and education levels and a woman's confidence with infant feeding choices.

“some of the women have poor schooling and can’t read and write so they don’t have a good idea about pregnancy and infant care” Wendy

Case Study - Katie

Katie is a 21 year old woman who is living in supported accommodation usually alone but sometimes one or several of her six sisters come to stay. The father of this baby was someone she met not long ago and he lives in another town. During the pregnancy he comes up several times but they end up mostly fighting and he ends up going out with mates and is constantly asking Katie for money to go out. She has a wide network of friends but is not close to her mother. Katie went into spontaneous labour and her tiny girl was born by forceps at 39 weeks. She weighed only 2.2kg or 4lb 14oz but was healthy with good apgar scores. She wouldn’t latch to the breast at birth *“ they sent me over to a room and we kept trying but she wouldn’t attach and that’s when they said if she doesn’t start attaching they’ll have to take her to the nursery, so they came in with the little syringe and they got some of the colostrum in the syringe and she had some of that.....the nurse was really good, she kept sitting there and like kept doing it and she was like come on we want her to take this, we don’t want her to go to the nursery, I want her to stay with you so keep trying.”* Baby started attaching to the breast well the next day and breastfed beautifully from then on. There were several situations that challenged Katie’s breastfeeding at around three weeks when her partner returned. There was encouragement from both Katie’s mother and partner to give baby formula so they could care for her... *“when I left her here once for five minutes with him and went to McDonalds and she was cracking it and he said like....‘See I don’t have a tittie, that’s why you should put her on the bottle so I can watch her’.”* Katie also found the body image changes that occurred from the pregnancy challenging.... *“ I didn’t really like doing it (breastfeeding) in front of him, cause I’ve got stretch marks on my boobs now and that’s just why I was more...I don’t want you to look at my boobs and see my stretch marks.”* When baby was about three weeks old Katie and her partner were fighting a lot so Katie was stressed. And.... *“ I did have a couple of drinks at about three or four weeks after she was born...., and that’s when I stopped breastfeeding then too....I wanted to still keep breastfeeding plus bottle feeding cause if I had a couple of drinks I could just give her the bottle.”* The other challenging thing for Katie was people saying how small her baby was and that formula would be better because it would make her put on weight more quickly. *“A lot of people were saying she was small and that really started to piss me off....I was at the stage where I was like....the next person that asks me how much my daughter weighs I’m going to punch them.”* It did introduce doubt into Katie’s mind... *“ I just felt like you know cause she’s was still so small and just thinking...she’s not getting enough. Then as soon as I put her on the formula you just see how much she’s put on more weight”* This cocktail of challenging factors led to Katie’s decision to commence formula feeding at about three weeks.

Theme 3

“A safe place to feed”

Antenatal

Shame about breastfeeding in front of other people is a frequent concern mentioned by women. All of the women interviewed expressed a strong reluctance to feed in public. Three of the participants mentioned that their partners’ main concern about infant feeding was that they didn’t want them to breastfeed in front of other people especially other men.

When participants were asked during the pregnancy about how they feel about feeding in public the responses were consistent.

“I’ll get too shamed out ...I’ll probably just put milk in a bottle” Allison

"... especially in the media, a lot of people disapprove of mothers breastfeeding in public...just a lot of judgement on you know breastfeeding out in public...cause I'm one of those persons I'm like really shy"
Jamie

Several would not feel comfortable in front of male family members.

"I wouldn't do it in front of my brothers, they'd be like.....Oh, what are you doing?!" Allison

One participant told her partner that she was producing milk late in the pregnancy he said

"Ew, that's disgusting change the subject" Jacqueline

This added to her sense that breastfeeding is a very private and somewhat unacceptable thing to do. She also shared that she intended to breastfeed alone not even in front of her mother or her partner.

Postnatal

The two women who attempted to breastfeed discretely in public felt judged by passers-by. One moved to public toilet and the other to a car to complete feeding their infant.

These women strive to do the best for their baby with very little breastfeeding knowledge within a community encouraging formula feeding as providing greater privacy, flexibility and social acceptability.

Key Informants

All key informants expressed concern about the challenges faced by mothers in communal housing, in a society which makes them feel ashamed to breast feed in public.

"They need a safe comfortable place not a clinic but a community space where they can sit and feed and chat and get support from health workers" Sally

"These young girls are often in overcrowded houses, some of them might be sleeping in the lounge room you know, so there is no privacy" Annie

The Aboriginal Health Workers identified the challenges of breastfeeding in public

"they don't want to firstly bring their boob out in public and secondly they don't want to bring it out because they know that their partner would feel really uncomfortable if they were doing that in front of other people where they could see their missus's boobs" Deanne

The two women who are both known in the Community as breastfeeding advocates expressed that they have achieved this by their own positive experiences of breastfeeding and their lack of concern for the opinions of others in the community for whom formula feeding is the norm.

These three themes are very much in line with the barriers to breastfeeding identified in Table 1. Lack of knowledge, low confidence, minimal exposure to positive, successful breastfeeding experiences and concerns about where breastfeeding will be acceptable for them and those around them were key themes. They point to some of the strategies that could be employed to providing targeted education to encourage and support the women's strong intention to breastfeed. Antenatal discussions that allay some of the doubts women feel about their ability to succeed and promote strategies for overcoming the challenges of breastfeeding may increase confidence in the antenatal period. Discussions about ways to manage discrete feeding in public places with women and their partners may help with the perceived reluctance and shame about this concern along with the provision of culturally appropriate, comfortable and supportive spaces for breastfeeding.

The key informants identified that the knowledge base of new mothers regarding infant feeding is poor. They identified several of the key barriers including a lack of partner, family, community and societal support for breastfeeding and the absence of safe spaces for feeding.

Case Study - Louise

Louise is 21 years old; she has had two miscarriages and a medical termination of pregnancy at 19 weeks last year as her foetus was developing without a brain. Her partner is in an ongoing legal battle with his previous partner over their three children. This at times has involved episodes of family violence (from the ex- partner), severe slander on social media with multiple court appearances for custody and AVO's throughout this pregnancy. At 39 weeks gestation on a Friday afternoon Louise had ruptured membranes, which was confirmed by hospital medical staff. She was not given prophylactic antibiotics but was told to go home and check her temperature every two hours and return over the weekend if febrile. Otherwise return for induction of labour on Monday. She returned on Sunday with elevated temperatures and baby was born with an infection due to the prolonged rupture of membranes. Baby required admission to the special care nursery for five days for intravenous antibiotics which was extremely distressing to this mother who had been preoccupied throughout the pregnancy with her fears related to the loss in her previous pregnancies. The early breastfeeding experience was challenging *"he wouldn't take to the breast...like they would try and force him on, he'd have like two sucks but I think he got frustrated because there wasn't enough.....they kept trying it for two days, for two days after birth he never had a decent feed and he was even more upset on the third day and I went around and I tried it again and I just broke down crying, cause he wasn't getting fed and I was getting frustrated within myself cause I just wanted him to have my milk.....cause I knew that he needed a feed that was my main thing and they weren't offering me a bottle or formula, just forcing us to breastfeed.....one of them was like fully just grabbing his head and latching him onto my nipples and closing his jaw to try and latch on...and it come to points I just wanted to yell at her cause I was saying like it's not working and you're making him more upset by forcing it.....and then I just broke down and there was another lady and she was good she said look, I'll give him a bottle, we'll give him a bottle cause he needs something to eat. And then he had that one bottle and I just felt a whole relief, cause he was getting what he needed. I let him have the bottle that day and that night and then I began breastfeeding him again, then he took to my breast, it was like he had more patience, cause he wasn't so starving."* By the time baby was three weeks Louise was experiencing significant depression and constant anxiety, very teary, staying awake at night fearfully watching baby sleep, not eating adequately *"...when I came home I suppose I had a bit of that postnatal depression....like when he cried, I didn't want him to cry cause I thought that like he was hurting, I just wanted him to have what he wanted cause he did enough crying from being sick"* and *"I was just real paranoid with him cause how he got sick, I'd lay him in the cot but I'd be in there just watching him like...and crying every day cause I was just scared."*

Louise was also required to attend court two weeks postpartum related to ongoing conflict with her partners ex. At this time her family encouraged her to leave baby with them so that she could have some time out and they started to give bottles of formula to baby while Louise continued to breastfeed most of the time. She felt much better with the occasional time out. *"Then like a month went by and I started getting better. And I knew he wasn't going to get sick again."* Louise was still giving formula and breast feeds until about five weeks, she found the discomfort of her full breasts untenable especially when baby was not on the breast every feed. *"Then it came to the point when I was just...I can't handle my breasts like this cause it was so uncomfortable, I couldn't even cuddle my partner or anything, it just hurt....so I just took him off the breast altogether."*

When asked how she felt about making that decision Louise replied. *"I felt bad in a way cause I wanted him to have my milk, but I knew at the same time cause I was going through that depression and I didn't want it to come through my milk. And I got real paranoid about breastfeeding, like is he getting enough and things like that...I knew that if I could see the milk in a bottle I knew what he was getting and I felt a lot more secure and just a big relief off, cause I knew he was getting it."*

The starkest contrast in views between participant and key informant interviews was the perceived motivation for ceasing breastfeeding. Participant interviews indicate it is to do the best for baby while key informants perceive it

is to return to socialising or *“keeping up with their man”* (Sally). There is no clear answer for this discrepancy. Discussions with Aboriginal colleagues suggest either the participants chose to share only certain aspects of their infant feeding choices with the researcher, holding back information about some aspects of their social and relationship choices. Or that the general perception in the Aboriginal community is unduly harsh on these mothers and that perhaps the social and partnership issues do not arise until baby is older.

Case Study - Joanne

Joanne is a 24 year old woman who was raised by two alcoholic parents in a highly dysfunctional community setting. She cannot read or write which brings her frustration and shame. She would like to get her drivers' licence but she cannot read the manual, she is currently going through court for repeated offenses of driving without a licence. Joanne has significant dental health problems and has been approved for dentures but has not returned for further extractions as she found it too painful last time. Joanne's partner has schizophrenia and is a frequent cannabis user. They are both aware that he will not be capable of looking after baby independently, even for short periods. She has been given the opportunity of temporary housing through a youth housing program during the pregnancy. It is only supposed to be her and her partner living there. However there are usually at least six other family members staying at the property including Joanne's mother and her stepfather. These visitors do not contribute to the household, they drink and smoke and sleep until late. The police are regularly called to the house for reports of noise disturbance and violence. Joanne has tried to get them to leave but they have no-where to go and so she will be evicted and have a black mark against her name shortly after baby is born. After a normal birth baby has trouble attaching *“I kept trying and like every time she would get hungry like it wouldn't work so it took like 8 hours and then I told the nurse and they said no, we've got to put her on the S26 formula.”* Joanne kept trying to breastfeed at home *“I kept trying and trying her but I'm kind of guessing it's the smoking, cause I was smoking and when I squeeze it out and give her a taste she goes...(pulls a funny face).”* Joanne was disappointed *“I felt kind of let down cause she's not getting the nutrition”*. Within two weeks baby is covered in scabies. Joanne does not have a washing machine and with so many people in the house it is not possible for her to maintain the recommended cleaning processes to protect baby for re-infection. One of her frustrations is the others in the house *“...and my mother, her man, he doesn't wash his hands, he don't like to have showers, he wants to come and touch baby and that and I'm like don't touch my daughter, no one touch my daughter without washing their hands. And when I'm gone he'll touch her, while I'm gone you know”*. At the hospital doctors hand her leaflets explaining how to treat scabies. She is too embarrassed to explain she can't read them. She treats baby as best she can and receives another fine for driving without a licence when going to use her Aunties washing machine for babies' linen. The court notice which she cannot read indicates she may be sent to prison this time. The house remains over-crowded and one of the main implications of this is food *“when I go down to the shop or for a walk ...I'll come back and only have like two slices of bread out of a full loaf. And I'll go ...where's all my ham gone, where's all my cheese and tomato. It's just like they eat it all when I'm not there...and I get really cranky and wild when I've got nothing in my gut .”* By three weeks postpartum Joanne is evicted, she is arguing constantly with her partner, she, baby and all household members have scabies and she is facing court with possible sentencing.

Historical Impact

Colonisation, subsequent government policies and discriminatory societal attitudes in Australia have influenced every aspect of the lives of Aboriginal people up to the present day.

The Historical Impact Chart aims to provide a brief summary of the impact that events of the past continue to have on the mothers of today in their infant feeding choices.

The following chart was inspired by an interview with one of the Aboriginal Health Workers in the first two months of undertaking this study after she related a childhood memory about her grandmother:

"I reckon that a lot of it (breastfeeding knowledge) was lost definitely in settlement but, when all the older women had to go and be housemaids and that to white settlers and there were no older women helping the younger women raise kids or educate them so they were on their own..... I remember my Nan went and worked in a hospital in Queensland yet my mum and all the kids stayed in Tenterfield. And my oldest Aunty who's nine years older than my mum basically raised all the kids because my Nan was made to go to work. So there was no adult, there was no mother or Aunty, they were gone..... and a lot of those older women were abused and they were made to feed the masters kids and that so they hated the breastfeeding process, cause they were made to feed....taken their own kids away to feed somebody else's..."

"My Nan never spoke about what happened to her. She used to smack us with a ruler every time we used to ask about it. She'd get this ruler and smack us and said 'leave it alone'. So all we knew.... she was made to go and work in a hospital in Queensland and we don't know nothing more. And my Aunties and that said she'd come home you know once or twice a year for a couple of days and she'd be gone again. And she never spoke about it so no-one knows." Deanne

Infant Feeding Choices in the Northern NSW Aboriginal Community

Date	Events		Impact on Infant feeding	Generations
At least 40,000 years until 1788	Traditional life and cultural practices thriving in the harsh Australian conditions. Caring with great skill for family and country. Approximately 750,000 Aboriginal people inhabiting the country(70). Arrival of 1,373 settlers from Great Britain - the First Fleet in 1788 (71).		Reports of Aboriginal practices prior to colonisation indicate that <i>'Small children are breastfed on demand, and they continue to suckle for three to five years. In spite of this breastfeeding is not a burden on the mother since a number of female relatives often participate in multiple nursing arrangements. In baby's early months, many women nurse and care for it. Older women, especially grandmothers, often have older infants suck a clear fluid that women can produce even after menopause.'</i> (72)	1793 1823 1843
1840's	First white settlers populate Northern NSW area in the 1840's due to the abundance of high quality timber (73).		Aboriginal people died in large numbers from massacres, diseases, malnutrition, poisoning and lack of access to traditional hunting lands (73). Moved to Missions or informal camps. Family dislocation, starvation, loss of ability to maintain traditional lifestyle. By 1911 there were 115 Missions throughout NSW; no land remained available for traditional lifestyle. The adaptations to this lifestyle reduced practices such as communal breastfeeding of infants.	1863 1883
1880's-1960's	Aborigines under protection of NSW Aborigines Protection Board (74). The Director is the legal guardian of all Aboriginal children, whether or not their parents are living, until 1965.		Some female children were removed and sent to Cootamundra Domestic Training Home for Aboriginal Girls which ran from 1911-1968. (75) At the age of 14 they were sent to work as domestic servants. Many girls became pregnant in service only to have their children remove (74). They would then become wet nurses for the family they served (76). This oppressive practice disrupted the generational transfer of breastfeeding knowledge (63). Under the Child Welfare Act of 1939 child-rearing by extended family members were regarded by courts as indicative of neglect (74).	1903 Great- great grandmother 1933 (80)
1930's-1970's	Assimilation-between 1 in 3 to 1 in 10 Aboriginal children removed. Fostered by white families or placed in institutions. (74)		Segregation, decimation of traditional knowledge, cultural practices, social and family structures, child rearing practices and languages. During this time the prevalence and marketing of infant formula led to significant decline in breastfeeding throughout Australian society (77). As part of 'assimilation' Aboriginal women were discouraged from the 'primitive' practice of breastfeeding particularly on some Christian missions. (74)	Great grandmother 1953 (60) Grandmother 1973 (40)
1970's-present	Referendum in 1967 recognised Aboriginal people as full Australian citizens. Native Title Act proclaimed in 1993. Formal Apology to stolen generations by Prime Minister in 2008.		Trans-generational trauma from community dislocation over several generations leading to 'dysfunctional community syndrome' (78). Rates of breastfeeding in remote areas remain closer to traditional practices (79). In rural and urban communities the skills and benefits of breastfeeding traditionally passed on from older women to new mothers have been severely diminished.	Mother 1993 (20) New baby

Figure 2 Historical Impact Chart

It is hard to quantify exactly how this history has impacted on each individual, family and community. History of colonisation including the removal of some Aboriginal girls from their communities for domestic service, wet nursing practices, stolen generations and influence of western cultural practices can be seen to have created negative experiences and dislocation extending to the current generation regarding infant feeding practices.

The strong impact of disruption to the intergenerational transmission of knowledge and practice related to breast feeding was also identified in a recent study as a major factor in a Sri Lankan migrant community in the United Kingdom (80).

This is recent history for Aboriginal families, not distant memories it is only about ten generations since Europeans arrived in Australia. The young Aboriginal mothers of today speak to their own grandmothers about their painful life experiences. The fear and pain of the removal of children continues to be a current as well as an historical issue for these families (81). These experiences have vastly shaped how these women construct themselves as doing the best for their children.

DISCUSSION

The complexities of a woman's childhood experiences, historical factors, cultural influences, societal norms and the events of daily life all effect infant feeding decisions.

The infant feeding method of choice would be breastfeeding if desire for greatest health outcome was the only consideration.

The stories of these eight Aboriginal mothers demonstrate that infant feeding decisions are not based solely on the level of breastfeeding education offered, the model of care available or the mechanics of correct breastfeeding technique.

Professional advice, support and policies have had very limited effectiveness in increasing the breastfeeding rates in this rural community. For the past twelve years the women in this Aboriginal community have had access to continuity of carer by an experienced Midwife and Aboriginal Health Worker team from early pregnancy until two months postpartum. They have frequent home visiting, one-on-one education sessions and they birth in a facility that adheres closely to the global standards of 'Ten Steps to Successful Breastfeeding' (2). A lactation consultant volunteers her time to support these Aboriginal women and access to medical care is available without restriction and at no cost through Aboriginal Medical Services.

If professional care was the key determining factor in breastfeeding success these women would have reached all national breastfeeding targets.

The social and cultural circumstances of women in this study produce stronger barriers to breastfeeding than the benefits offered by professional best practice. The impact of disrupted intergenerational transfer of knowledge, the strength of mainstream societal norms including the pervasive presence of infant formula and socioeconomic disadvantage leading to such problems as overcrowded housing are some of these barriers.

Inclusion of partners, grandmothers, and other family members when possible in discussions about breastfeeding will widen the circle of support for the pregnant mother. The importance of respecting cultural norms by including both female and male Aboriginal Health Workers in education sessions provided to women and their partners may create a deeper community support for breastfeeding.

Infant Feeding Choices in the Northern NSW Aboriginal Community

Greater flexibility of care which encompasses rather than questioning or rejecting the advice of family and community members may facilitate engagement and trust. This may at times mean working with families in developing personalised feeding plans, allowing for strategies to managing the challenges of overcrowded housing, the desire of relatives to care for infants and breastfeeding in public places.

Reducing discrepancies between health provider's advice based on best practice and that of family would ultimately create less confusion and provide better outcomes for mother and baby.

Conclusion

Knowledge and cultural norms are a shared resource within Aboriginal communities. To increase the knowledge base of individuals regarding the benefits and practice of breastfeeding, community members of all ages and reproductive phases would ideally be involved.

Individuals do not operate in the silo of a nuclear family. Providing breastfeeding education guided by community consultation to older women, adolescents and partners as well as to expectant mothers may achieve change in infant feeding practices over time. Knowledge has greater power when it is based within the Aboriginal community. Not imposed but supported by health professionals and government policy.

Respect for relatives who are older and more experienced are powerful principles in this community and if this is well understood and embraced it can offer a community led pathway through which positive infant feeding messages can be conveyed to these new mothers.

The wider problems of negative perceptions of breastfeeding in public and the pervasive presence of infant formula will require a complex cultural shift in Australian societal attitudes over time. Australia has had success in changing social behaviour and attitudes with such public health concerns as smoking, road fatalities and immunisation rates. If the multifaceted approach of public advertising campaigns, legislation, and media support were applied with greater vigour to normalise, promote and support breastfeeding in Australian society it would ease the conflict and burden of individuals who face the negative societal attitudes regarding public breastfeeding.

Study Limitations and Recommendations

Study limitations include the small sample size, limited time period for completion and formal data coding by only one researcher. From an Indigenist perspective it would have been ideal to have an Aboriginal researcher employed in the project to increase the knowledge and skill base of the local Aboriginal community.

Although the sample size in this study was small with only eight participants it does represent a majority of those who met the inclusion criteria within the study area and time frame $n=10$.

Further studies in this area could involve the inclusion of Aboriginal fathers and of older women in the Community. Focus groups may allow for deeper discussion as participants explore issues within a safe group environment. Ideally any follow up studies would be conducted by Aboriginal researchers.

Evaluation of existing initiatives such as the Australian Breastfeeding Association Aboriginal Community Breastfeeding Mentor program would help to assess if programs of this type will make an impact on breastfeeding rates.

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Appendices

Appendix 1 – Participant Information Sheet

Participant Information Sheet

Infant Feeding Choices in the Northern NSW Aboriginal Community

I have been working as the Midwife with Aboriginal Maternal and Infant Health Service in Ballina for the last 8 years. I provide pregnancy and postnatal care to women and families in the local Aboriginal community.

Health care providers strongly encourage women to breastfeed their babies. This is because research shows that breast feeding provides health benefits to both babies and mothers.

However, a lot of women make the choice to bottle feed their babies from birth or in the first few weeks for many different reasons. I am interested to speak with women who are having their first babies to find out how they intend to feed their baby when it is born and what factors have led them to make this decision.

You are invited to participate in this project which is entirely voluntary and anonymous.

If you agree to being involved in the project, I will hope to talk with you in the last few months of your pregnancy about whether you plan to breastfeed or bottle feed your baby and how you have made this decision. I would then hope to talk with you again when baby is 2 months old and at 6 months to see how infant feeding has progressed for you.

I would record these interviews and make a written copy of what is said which you will be able to check to make sure you are happy with the information.

Eventually I will put all the information from the interviews into a report to help health professionals and members of the community understand more about how Northern NSW Aboriginal women chose their infant feeding methods. Your real name will not be used in any written report.

Any information collected is confidential. If you choose not to participate in this survey, this will have no effect on any future involvement that you may have with any of the local health services.

If you should experience any distress while participating in this interview process and you feel you would benefit from further support, assistance is available by contacting the Social Worker at Ballina Community Health on 6686 8977 or you may contact your local Aboriginal Health Centre for counselling services.

Ballina- Bullinah Aboriginal Health- 6681 5644

Casino/ Kyogle - Casino Aboriginal Medical Service - 6662 3514

Lismore - Gurgun Bulahnggelah - 6620 2741

I am a Mandatory reporter which means that I will need to make a report to Family and Community Services (FaCS) if anything discussed in the interviews causes me to have any concerns about whether a child may be at risk of significant harm.

Inquiries

If you have any questions, please feel free to speak with the Project Officer – Catherine Helps on (w) 6620 6136 or (m) 0427 947 367

This Project has been reviewed and approved by the North Coast NSW Ethics Committee and the AH&MRC Ethics Committee.

If you, at any stage have a complaint about the project you may contact the North Coast NSW Ethics Committee, Research Ethics Officer or the Aboriginal Medical Health and Research Council Chairperson on:

The Chairperson
AH&MRC Ethics Committee
P.O. Box 1565
Strawberry Hills NSW 2012
Telephone: 9212 4777

Research Ethics Officer
North Coast NSW Human Research
Ethics Committee
PO Box 821
MURWILLUMBAH NSW 2484
Ph: 0266720269
Email: EthicsNCAHS@ncahs.health.nsw.gov.au

Appendix 2 – Interview Questions

Antenatal interview

This interview will be conducted after 20 weeks gestation. It will take between 30-60 minutes.

Informed consent regarding subject matter, use of recording equipment, location and duration of interview will have been obtained on a previous visit.

- The initial conversation will be to build rapport. This may include questions about the pregnancy and how it is going. Identifying family connections between the participant and family or community members I have cared for has been an effective way to quickly build rapport with unknown clients. Identification of who the woman has to support her and who she lives with- her partner, parents, Aunties, sisters, friends etc. will help to guide the conversation.

The things I would like to explore according to what is appropriate for each woman are:-

- Have you thought about whether you plan to breast feed your baby or give your baby a bottle while you are in hospital after the birth?
- If you breastfeed, how long do you think would like to do that for?
- How did your mother feed you and your brothers and sisters when you were born? How do you think she wants you to feed bub? Do you know whether your grandmother breast or bottle fed?
- Do you know any friends, sisters or cousins who have had babies? What have they said to you about how they chose to feed their newborn babies? Are there any unique or interesting words you use when talking about it with them?

Infant Feeding Choices in the Northern NSW Aboriginal Community

- Have you talked to your partner about whether to breast or bottle feed? What does he think?
- How do you think breastfeeding would affect your life? Do you think it would be easy or hard to do?
- What do you think would be good about bottle feeding your baby?
- What have Aboriginal Health staff, Midwives and Doctors said to you about feeding bub? Have you seen any posters, booklets or ads on TV that you can think of about breast or bottle feeding?
- Is there anything else you think will help you decide about how you will feed baby?

6-8 week interview

General discussion about how things are going with baby. How the birth was, how things have been going since then. If there have been any complications or problems with mum or babies health.

General topics to be explored:-

- Are you still breastfeeding baby at all? /Did you give it a go in hospital? /How long did you do if for?

If not breastfeeding – Explore if bub was breastfed at birth? Identify any challenges complications and reasons for ceasing. How does the woman feel about how things have progressed? How do the main support people feel, what have they said and what advice have they given? Have health professionals been supportive and understanding of her choices? Is she happy and enjoying parenting? Is bub settled and healthy?

If breastfeeding – How has it been? Have there been any challenges? Has she thought about putting baby on the bottle? What advice has been given and by whom? Is she enjoying it? How long does she think she will keep breastfeeding? Why? Does she think it is harder or easier than bottle feeding? What advice have family and friends given? Have health professionals been supportive? Is she happy and enjoying parenting? Was the experience of breastfeeding different to what she thought it would be? Is baby settled and healthy?