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Breastfeeding experiences of Aboriginal and Torres Strait Islander mothers in an urban setting in Brisbane

ABSTRACT

Study aim This study examined urban Aboriginal and Torres Strait Islander mothers' breastfeeding experiences to inform support for mothers and their families.

Study design The research took a strengths approach, using qualitative methodology. Twenty semi-structured in-depth face-to-face interviews were conducted and analysed thematically.

Setting and participants Indigenous mothers of infants 3 to 12 months were recruited through a Brisbane Indigenous health service.

Key findings All mothers recounted considerable physical and emotional energy invested in breastfeeding. Although early introduction of formula made sense for some mothers under stressful circumstances, timely pro-breastfeeding support from family and health professionals facilitated continued breastfeeding. Professional and social/family contacts play key roles in steering infant feeding outcomes.

Conclusions Mothers' experiences strongly influence infant feeding strategies. Aboriginal and Torres Strait Islander community strengths are underutilised in supporting breastfeeding mothers.

Future implications Indigenous mothers, family and community strengths present points for engagement in future breastfeeding promotion and support initiatives.

Keywords: *breastfeeding, Aboriginal and Torres Strait Islander, Indigenous, urban, qualitative*

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INTRODUCTION

There is concern about the lower prevalence of breastfeeding of non-remote Indigenous infants (Australian Health Ministers' Conference 2009) due to the excess health risks associated with not being breastfed and the higher burden of disease experienced throughout the lifespan. Despite the impact of maternal experiences on breastfeeding, limited research has specifically explored the experiences of Aboriginal and Torres Strait Islander mothers as they negotiate infant feeding. Papers about Aboriginal and Torres Strait Islander breastfeeding usually prioritise breastfeeding prevalence, duration and

factors associated with breastfeeding (Binns et al 2004; Craig et al 2011; Cromie et al 2012; Hayman, Kanhutu & Bond 2000; Holmes, Phillips & Thorpe 1997; Mackerras 2006), though mothers' experiences constitute a minor part in some studies (Eades & Bibbulung Gnarneep Team 2000; Gilchrist et al 2004; Holmes, Thorpe & Phillips 1997). Australian research on mothers' experiences of breastfeeding is dominated by mainstream studies (Noble-Carr & Bell 2012; Schmied & Barclay 1999; Schmied et al 2011; Sheehan, Schmied & Barclay 2009). The aim of this paper is to draw upon interview data to explore the breastfeeding experiences of urban Aboriginal and Torres

Strait Islander mothers to inform antenatal, postnatal and child health services which provide nutrition support for Indigenous mothers and infants.

RESEARCH METHODS

We approached this research taking a strengths-based approach in order to develop a nuanced understanding about infant feeding in Aboriginal and Torres Strait Islander families. A strengths approach helps to identify and work with strengths in individuals and communities (Foley & Schubert 2012), rather than identifying only barriers and problems related to breastfeeding, which are common foci in the literature. This required that we look beyond the mother/infant unit and breastfeeding prevalence to the wider context of their lives. We looked not only for 'success' in terms of traditional markers such as breastfeeding duration and exclusivity and to understand how these achievements were reached, but also to construct honest and holistic accounts of women's infant feeding practices and how they were shaped by the social/historical and health care contexts. A strengths approach to research is solution-focussed and therefore the purpose of describing the breastfeeding experiences in this community is to inform enhanced breastfeeding support, using the identified strengths.

Community support for this research was given by the Inala Community Jury for Aboriginal and Torres Strait Islander Health Research. Ethics approval was obtained from Queensland Health's Metro South Human Research Ethics Committee.

Twenty Aboriginal/Torres Strait Islander mothers of infants 3–12 months were recruited through the Inala Indigenous Health Service in 2011. The women were not recruited on the basis of breastfeeding initiation, which was unknown by the first author, who recruited in the clinic waiting room and at community activities. We used maximum variation sampling (Palys 2008) to ensure variation by family size, age of mother and baby, and baby's sex. Mothers were invited to participate during clinic consultations, via clinic nurses phoning to invite participation, recruiting in the waiting room and through community activities. Flyers placed around the clinic and waiting room elicited little response, but there was a high response when mothers were invited in person to participate. Two mothers declined because they had resumed work and one mother was unavailable for two scheduled appointments and could not be contacted by phone. At the completion of the interviews, the mothers were given a \$25 gift voucher to thank them for participating.

In-depth, semi-structured, face-to-face interviews (25 to 75 minutes) were conducted in either the mother's house or the health service. Usually the babies, and sometimes older children, were present, with several babies being

breastfed during interviews. One father participated in the interview with his partner. Interviews focussed around the mothers' perceived influences on infant feeding, their experiences of infant feeding, advice and support received. A timeline, spanning past experience, pregnancy, birth experience, hospital stay, return home, the first months post-partum, 3–6 months and 7–12 months, was used as appropriate to prompt discussion.

Interviews were recorded, with consent, and transcribed verbatim. Codes replaced mothers' names: M1 and M20 being the first and final mothers interviewed, respectively. Transcripts were analysed thematically using NVivo 9 software (QSR International Pty Ltd 2010). Codes were created inductively by the first author and refined as further data were collected and analysed. To improve the reliability of the analysis, coding was checked by the second author and further refined on discussion.

FINDINGS

Study participants

Table 1, presenting characteristics of the study participants, indicates that all mothers in this study initiated breastfeeding and there was a high prevalence of women with birth or feeding complications.

This paper is organised around the five main themes identified: infant feeding as a socially embedded practice; establishing breastfeeding; mums' feelings about breastfeeding; switching to formula and addressing feeding challenges. Through the paper we use the breastfeeding definitions of Labbok and Krasovec (1990).

Infant feeding as a socially embedded practice

Infant feeding strategies develop to fit within the mothers' and babies' circumstances, rather than simply from knowledge about the 'best' way to feed an infant. Narratives from three mothers below demonstrate the close connections between social circumstances and infant feeding approaches.

M9 lives with her partner and seven children (see Table 1). When we met them, she was partially breastfeeding, mainly at night: M9 was an experienced breastfeeder, having breastfed all her previous children. With a large household, she chose to introduce formula when the baby was about 2 months and used it as a coping tool in her situation:

I think I made the decision at that time because I realised with so many children in the family — I have another child that's almost a year and a half — I need to have time for all of my children so therefore I put in the bottle to allow ... two of my older girls to help with the baby so I could ... do other chores in the house. So I wouldn't be taking up four times a day sitting down an hour feeding. So it worked out well for me.

Table 1. Participant characteristics and feeding patterns.

ID	Mum age	Infant age (months)	Complications	Children in family	Breastfeeding pattern this child
M1	33	8	Heart condition & reflux	4	Partial medium breastfed until 3.5 months then formula
M2	32	6	Caesarean, premature twins, special care nursery	5	High partial breastfed at 6 months
M3	33	12		4	Fully breastfed till 5 or 6 months, low partial breastfed at 12 months
M4	34	9	Special care nursery	4	Low-medium partial breastfed to 6 months
M5	25	12	Mastitis	2	Fully breastfed for 3 weeks then exclusive formula
M6	25	5	Tongue tie	2	Fully breastfed for 4 weeks then exclusive formula
M7	19	11	PPH & severe anaemia	1	Formula introduced by nurse in hospital. Fully breastfed at 2 weeks, then high partial until about 1 month, then exclusive formula
M8	30	12	5 weeks premature jaundice	1	Fully breastfed to 2.5 months then exclusive formula
M9	39	11		7	Low partial breastfed at 11 months — mainly at night
M10	19	3		1	Fully breastfed at 3 months
M11	27	3	PPH, womb infection & readmission to hospital	4	Low partial breastfed first week then exclusive formula
M12	23	6	Caesarean	1	Fully breastfed to 6 months, then formula & weaning foods
M13	24	6		2	Fully breastfed at 6 months & intends to feed 1 or 2 years
M14	22	7		1	Fully breastfed for 2 months, then exclusive formula
M15	16	3		1	Low partial breastfed for 2 weeks then exclusive formula
M16	20	3		2	Fully breastfed to 1 month, partial medium breastfeeding till 2 months, then exclusive formula
M17	29	3.5	Caesarean	1	Fully breastfed at 3.5 months
M18	29	3		3+4	Fully breastfed at 3 months
M19	26	7.5	Baby 5 wks premature heart murmur	3	Fully breastfed till 4.5 months then partial breastfeeding as solids introduced
M20	35	4		2	Fully breastfed at 3 months

M17, a mature first-time mum, loved breastfeeding. Although she knew her mother-in-law would like to help with bottle-feeding, M17 was very committed to breastfeeding, particularly after she and her partner learned at antenatal classes about the health benefits for their baby. Just back at work after maternity leave, M17 had nowhere there to express milk, so her unemployed partner drove their baby to her workplace at lunch so she could feed him and express more milk — in the car. M19 acknowledged the importance of her partner's strong support for breastfeeding:

I couldn't do it without [partner], honestly. ... he is like my right hand man. He is always there, especially — I find expressing very time consuming and at times it's really hard. So it's just good to have that support from that extra person. ... my friends ... went on to formula because it is just so much easier. Because if you don't have someone that's there helping you out, because when you are feeding baby you can't. You've got to stop and you can't ... I know that there are mothers that can run around and feed their baby, but I have not mastered that yet.

M7, a teenage primipara's story shows that despite starting with the best of breastfeeding intentions, a difficult birth, feeding problems and a nurse offering formula at a critical time, led to formula becoming a solution to her difficulties:

It was like hell! I had a caesarean. I ended up losing 1.5 litres of blood. ... And I don't think that my milk came through, because my body was trying to [recover]. ... Because I was [anaemic] for ages. ... I didn't see [baby] straight away because they were stitching me up and I had the shakes. ... and they were trying to get me to breastfeed but I was too out of it. ... And I think it just went bad from there, really. It wasn't really the way I planned it. I'm like, 'I'm having a natural birth with no painkillers, nothing, and I'm going to breastfeed' and it just went different. ... But after the fourth night, I was crying and it was hurting, because my nipples got grazed. And then the lady [nurse] just said, 'Oh, I'll let you have a bottle ... She said that she's not really allowed to suggest that I give her a bottle, but she felt sorry for me because ... it was the middle of the night and we were both tired and crying and stuff. ... And I tried really hard for about, yeah, about a month. ... Just that it wasn't really coming easy to me. And I don't know, it was just easier to make a bottle.

The feeding style adopted by each mother was intimately connected with her circumstances and represents socially embedded practices rather than simply health behaviours.

Establishing breastfeeding

The mothers gave birth in four different hospitals, not all of which had Baby Friendly accreditation. Attempts to initiate breastfeeding varied. Some mothers and babies adapted quickly while others took longer, or didn't manage to establish a comfortable breastfeeding pattern:

He had a feed pretty much as soon as I was out [of theatre] ... and that was just — I don't know, it was really deadly, it was — I just — yeah it was a very deadly time, right from the start. [M17]

He wouldn't latch on all the time, like, the nurses and stuff tried to help me but then it would be all frustrating. ... He didn't really know what to do. He tried and then they gave him formula. He really loved it. [M15]

Specific mother and infant circumstances impacted on establishing breastfeeding. M1 described her problems trying to initiate breastfeeding when her baby was ill:

... it became a bit annoying, like, she [lactation consultant] kept saying to me, 'Drink more water,' which I knew, 'eat more food,' which I did. ... like, it's easy to say that until you're going through watching your baby — eyes roll back and like, they're laying there like they're dead ... It's — you know, it stays in your head.

Two mothers initiated breastfeeding only after returning home from hospital. M11, who was feeding her 4th child, had difficult life circumstances and had mainly formula-fed previous infants. She told nurses in hospital she would formula-feed:

[in hospital] they never really asked [if I would breastfeed] because I said I was going to bottle-feed him ... so I could have a rest, but then when I got home [2 days later] I put him on the breast ... because I was at home, comfortable.

Although some of the mothers felt well supported in hospital, for reasons similar to those identified by Fenwick, Barclay and Schmied (2001), the hospital environment was disempowering for some mothers and this made breastfeeding initiation challenging. Some mothers found that the treatment was not always pro-breastfeeding and spoke emotionally about the lack of breastfeeding support:

... so there was one time I came down and this woman was already feeding formula to the babies and I got really annoyed because ... my decision [was to breastfeed] and she was very dismissive of me ... And I was kind of, like, 'Well, I'm here, wanting to offer my breastmilk and feed my baby and these people are not wanting me to. I'm just in their way,

it's a nuisance to have to ring me to come down to breastfeed or to bring the milk down' and stuff, so it was really — a really terrible experience. [M2]

This mother explained that she felt she was treated differently because of her Aboriginality by some hospital staff and this contributed to the challenges of feeding a baby in the special care nursery.

M13 might easily have given up her initial breastfeeding attempts as she did not feel well supported in the hospital:

I was trying to, like, put her on the breast, but she just kept mucking up, you know? So I just, sort of, left her cry for a minute, that's when I just buzzed the nurse. But the nurse — midwife — didn't hardly, like, do anything. She just said try on the breast again. ... I was wild, really wild, you know? That's why your midwives are there for. [M13]

M13 managed to negotiate the difficult first stage with the mother-centred support she received from her local Indigenous health service, which she contrasted with the impersonal breastfeeding support experienced in the hospital. Hospital experiences like this became tipping points for abandoning breastfeeding, unless the mother was very determined or had strong, pro-breastfeeding support beyond the hospital.

Most of the mothers mentioned having a couple of home visits from a hospital midwife in the first couple of weeks after leaving the hospital. Sometimes it was an unfamiliar midwife and this distressed the mothers who had expected a familiar midwife.

Uncertainty about milk sufficiency while establishing breastfeeding was a common experience and most mothers needed reassurance during the initial weeks:

But [by] a couple of days old I sort of got the hang of it but I was still worried that he was not getting enough milk even though it [breast] was full and it was coming out right. And so just to make myself feel good to know that he is getting what he wants, I expressed a bottle for him so that he could have a bottle like twice a week. [M12]

By the time the babies reached one month, the mothers had developed varied feeding approaches. Breastfeeding establishment took some mothers up to 3 months:

I had heaps of trouble at the beginning ... But once you get through that little bit of the first bit where it's hard, it's easy now. [M10]

Establishing breastfeeding led to a range of emotional responses from the women. These responses, along with considerations of their social circumstances and

the mothers' or infants' physical complications or health problems, need to be acknowledged as important contributors to early infant feeding trajectories.

Mum's feelings about breastfeeding

Breastfeeding evoked emotions from pleasure to stress, fatigue, shame, self-blame, disappointment and displeasure. Most mothers enjoyed the closeness with their infants, although some worried also about milk supply and saggy breasts. About half of the mothers expressed pleasure in breastfeeding but disgust was also experienced by some. These feelings influenced feeding practices:

You feel good when you breastfeed too, you know. You've just got this feeling I can't explain. When they're drinking the milk, you feel there's a good sensation through your body as well. [M4]

Well I just felt yuk, when it was leaking. Like I don't like that feeling and then that's when I put her on the bottle. It was just easier for her. She loved it and it was quite easy hands down for me. [M16]

Some mothers also expressed ambivalent feelings towards breastfeeding:

The very thing that [I enjoy about breastfeeding] frustrates me with it; it's the intimacy and that time and that bonding and that connection, but at the same time there's times where I need to do stuff and I haven't got the time to do it, you know. [M2]

Frustration came from breastfeeding itself and also from breastfeeding advice:

I was frustrated because I really wanted to breastfeed but, yeah, just actually frustrated that I couldn't do the job that I was told I had to do. [M8]

Although some mothers reported that they loved the convenience of breastfeeding, some also found it inconvenient, especially when it came to feeding in public.

Regardless of negative feelings, all mothers tried very hard to breastfeed:

I didn't really like it from the start, but then I just got the hang of it. [M13]

While some mothers established satisfying breastfeeding relationships, by 3 months circumstances had led 7 (35%) mothers to cease breastfeeding. The experiences leading to the often abrupt transition to formula were described as very stressful.

Switching to formula

Mothers gave a range of reasons and, sometimes, multiple reasons, for ceasing breastfeeding. These included a

hungry/unsettled baby (6), losing milk supply when on medication (2), concern about milk supply (3), difficulty adjusting to breastfeeding (5), tongue-tie (1), baby losing weight (1), getting teeth (1) and the mother having had enough (2).

When breastfeeding was too uncomfortable, difficult or experienced as inconvenient, formula provided a familiar alternative. Many mothers perceived formula to be easier. Sometimes the formula decision was not the mother's decision alone — a grandmother, a significant other or a health professional may recommend formula to solve the problems being experienced by the mother and/or baby. Seven of the mothers recounted *redemption narratives* related to introducing formula *which feature* a struggle where the baby was unsettled, 'hungry' or crying and end with a settled and happy baby:

He started getting — like he wouldn't bring up his wind and crying; just constantly screaming ... So my mum just went and got formula and made him a bottle. He drank the whole thing, done a big burp and went to sleep for like five hours. [M14]

Having an unsettled baby was stressful — for the mother and baby and the rest of the household, often including extended family. The need to have a sustainable solution underpinned the rationale for introducing formula. Some mothers persevered with breastfeeding, following the advice they were given, and only resorted to formula if problems did not resolve:

She wasn't feeding properly and I wasn't producing enough milk ... the (clinic) told me to keep on persisting, but I knew she was hungry. ... She'd keep on crying and she'd still be trying to drink and I would squeeze my breast and there's no milk in there. [M8]

Formula-feeding's widespread visibility makes it a normalised alternative to breastmilk and this is often reinforced by social networks. The common belief that formula is equivalent to breastmilk was supported by some mothers' experiences:

Once I got over the fact that I couldn't really — I didn't get to breastfeed, I was fine. But I was a bit disappointed for a while. But I'm not now, because I know that a lot of people have to [formula feed]. And the babies grow up as healthy as other babies. [M7]

Common narratives of family members and friends 'who could not breastfeed' serve to portray breastfeeding difficulty as insurmountable, while formula's easy accessibility discourages mothers from seeking professional support. In contemporary Australia, formula-feeding is seen as more acceptable in many

contexts (Berry, Jones & Iverson 2012; Schubert 2013). Health professionals are sometimes complicit in this, advising mothers to start using formula, or as we have already seen, providing formula to babies while they are still in hospital:

[Nurse said] 'And if you're really, really stressed about she's not getting enough, well, give her a little bit of formula if you want to fill her.' And so I did. [M4]

[Paediatrician] said to me, nine mums out of ten mums have difficulty. It's either the mum or baby. He said, 'At least you gave it a go.' [M14]

These last two examples illustrate health professionals, either overtly or inadvertently, normalising formula-feeding in their interactions with new mothers.

Addressing feeding challenges

Feeding challenges experienced by the mothers spanned initiation problems as already described, dealing with breast pain, unsettled babies, sleeplessness, negative extended family attitudes towards breastfeeding, leaving the house with or without the baby, feeding in public and returning to work. Mothers addressed these challenges according to resources available to them.

Good preparation to deal with breastfeeding challenges helped mothers continue breastfeeding. This preparation included reading about breastfeeding, antenatal education sessions, which few attended and discussing feeding options with health professionals and peers:

He did start fussing at about 6 weeks and that was kind of hard because I thought, 'No, I have got this perfect now, and he has started to muck up'. But then I read, because I had those booklets and I read that sometimes they — at a certain point — they get a bit fussy and you just have to work through it. [M17]

Some mothers read voraciously about breastfeeding while others either preferred to get information in other ways, didn't have time or reading resources. Several mothers indicated that they did not find out things they needed to know about feeding their infant unless they asked:

I didn't get much [advice]. I never asked much questions or anything like that. [M19]

M13, who only briefly breastfed her first child, was fully breastfeeding her second child at 6 months and intended to continue breastfeeding after the introduction of other foods. A local clinic nurse helped her by advising:

Well, if your baby's hungry you should never be shame¹ to where you breastfeed ... If your baby's hungry just give them a good feed, don't be shame of anything,' you know? ... I didn't feel so shame ... but yeah, something like that [nurse] come out with ... And that made a difference.

1 Aboriginal English use — meaning 'ashamed'

M10, a teenage primipara, had difficulty establishing breastfeeding, but with the consistent support from her mother and multiple home visits from a child health nurse, she became confident in her breastfeeding. Although this level of support was not available in each case, mother-centred health professional support was experienced by most mothers who continued breastfeeding. This included early support in the hospital and continuity of care during the first few months after the birth:

I know [child health nurse] pretty well, she's known me since I was a kid. She was supportive through the pregnancy and then after '... she was like — 'breastfeeding's good for bub, keep it like that. Keep it — make sure you breastfeed for 2 years' and I'm like, 'I can't do that for 2 years!' She's like — really supportive. [M19]

Various experiences facilitated 11 of the mothers to continue breastfeeding beyond 3 months. Being in a stable relationship was an enabling factor as was acknowledged by M17 in her narrative in the first section of this paper. While some of the mothers did not have a supportive partner at home, the support and encouragement from extended family was also helpful. The mother's own determination was another important factor, sometimes inspired by previous experiences or from antenatal breastfeeding education:

... she was going to be breastfeed, no matter what. [M20]

While the local clinic provided strong support for some mothers, family support, a strength we identified, was the most immediate support for mothers, though it was not necessarily pro-breastfeeding:

I wouldn't have needed that [telephone support] because I have so much family and so much help. [M7]

In this group of mothers, we observed the 'give it a go' approach to breastfeeding that has been observed elsewhere (Bailey, Pain & Aarvold 2004):

They, like, tell you that it's better and stuff and I really wanted to do it. Like, I did it, but it didn't really work ... Most of the time I had formula with me to offer when [breastfeeding] didn't work. [M15]

This 'give it a go' breastfeeding approach, together with the common narratives in the community about breastfeeding difficulties, may dissuade some mothers from seeking support to resolve problems and has the potential to compound the problems. Few mothers had looked for support beyond family and the staff at health facilities they attended. Out of the 20 mothers, only one had contacted the Australian Breastfeeding Association's Breastfeeding Helpline:

I gave them a call and asked them a few questions. ... and with certain questions their best advice is go to your doctor, so obviously I go to the doctor for most of my advice. ... They just said, 'Keep on breast — try to breastfeed, try to breastfeed,' and I just took it upon myself to say, 'It isn't working I've tried my best.' Yeah, so I put her on to bottle. [M8]

Few mothers felt confident to seek phone support:

... I need the support in breastfeeding when I was on my own. I know there's a lot of [phone] lines for breastfeeding. There's an association isn't there? But yeah, I was just probably too frightened to ring up. [M4]

Some mothers however, like M4, continued breastfeeding through the challenges and, with clinic and family support, gained satisfaction from their achievement.

CONCLUSIONS AND FUTURE IMPLICATIONS

This research presents information about mothers' breastfeeding experiences from one urban Indigenous context. While all mothers in this study initiated breastfeeding, this is a higher proportion than that recorded by nurses for the overall clinic population in 2012 (85%). By 3 months many had ceased breastfeeding (35%) or introduced complementary formula (30%). Although findings from this small study may not be generalised to all urban Indigenous contexts, our findings resonate with other urban Indigenous studies from around Australia, which show the importance of trust in health professionals and continuity of care (Homer et al 2012), low participation in health promotion activities about breastfeeding (Eades & Bibbulung Gnarneep Team 2000; Gilchrist et al 2004; Holmes et al 1997)) and the high breastfeeding initiation followed by rapid declines in breastfeeding (Australian Institute of Health and Welfare 2011; Craig et al 2011; Eades et al 2010).

The mothers' experiences seen in this study shed some light on this pattern. They experienced many feeding challenges and their decisions were made in complex circumstances. Breastfeeding experience was enjoyable and affirming, but also frustrating, painful, and difficult. Decisions about feeding, even when they were against breastfeeding, made sense within the mother's situation.

Breastfeeding support, including preparation, appeared to be inconsistently available and only some experienced high levels of support, including multiple home visits that met their specific needs. Help-seeking among the mothers also varied. When breastfeeding support did not solve problems, mothers drew on the resources available to them. If mothers, and indeed extended family, could not resolve breastfeeding problems, formula was substituted to solve the immediate problems. On the other hand, continuity of care, mother-centred support from health professionals, which took into consideration the emotional responses and needs of the mothers, as well as pro-breastfeeding support from family were common elements in cases where successful breastfeeding relationships were established.

A challenge suggested by this research is to use the mothers' experiences to create an environment more conducive to breastfeeding and sensitive to family needs at pivotal times to support continuing breastfeeding. This is a universal challenge (Hoddinott et al 2012; Perrine et al 2012) and needs to be addressed through multiple strategies. As many mothers cease breastfeeding in the first months, it makes sense to focus intensive support at this stage. Adequate staffing levels are therefore important for health care services to achieve this level of culturally safe and mother-centred continuity of care.

Health professionals need to offer proactive infant feeding support, so that mothers who are uncomfortable asking are offered support in sensitive ways. Continuity in maternity care and good communication with mothers facilitates building their trust and is important in delivering health care to indigenous women (Homer et al 2012). As postnatal peer support programs, face-to-face support from health professionals, antenatal education and postnatal home visiting support have been shown to reduce cessation of exclusive breastfeeding (NACCHO/RACGP 2012), interventions strengthening these strategies could benefit this community. Given young Indigenous mothers' use of social media, peer support for breastfeeding (Homer et al 2012), incorporating social media into the mix of interventions also promises to complement clinic services. Participatory research involving primary health care professionals and mothers could be used to develop appropriate models of breastfeeding support for this population group. This methodology could provide richer information than was possible to gather in the single interviews used in this study.

The mothers in this study demonstrated a variety of strengths. They all wanted to do the best for their babies. They demonstrated persistence in adversity and resilience under stressful circumstances to ensure their babies were cared for. The knowledge of the benefits of breastfeeding and intentions to breastfeed, demonstrated by all mothers, are also strengths. The extended family and social networks that participated in infant care and

trust in the local health service also need to be recognised as strengths in this community. These strengths each present points for engagement in future breastfeeding promotion and support initiatives in the community.

REFERENCES

- Australian Health Ministers' Conference** 2009, *Australian National Breastfeeding Strategy 2010–2015*. Australian Government Department of Health and Ageing, Canberra.
- Australian Institute of Health and Welfare** 2011, *2010 Australian national infant feeding survey: indicator results*. (Cat. No. PHE 156). AIHW, Canberra. URL: <http://www.aihw.gov.au/WorkArea/DownloadAsset.aspx?id=10737420925>
- Bailey C, Pain RH, Aarvold JE** 2004, A 'give it a go' breastfeeding culture and early cessation among low-income mothers. *Midwifery* 20(4): 240–250.
- Berry, NJ, Jones, SC, Iverson D** 2012, It's not the contents, it's the container: Australian parents' awareness and acceptance of infant and young child feeding recommendations. *Breastfeed Rev* 20(2): 31–35.
- Binns, C, Gilchrist, D, Gracey, M, Zhang, M, Scott, J, Lee A** 2004, Factors associated with the initiation of breast-feeding by Aboriginal mothers in Perth. *Public Health Nutr* 7(7): 857–861.
- Craig PL, Knight J, Comino E, Webster V, Pulver LJ, Harris E** 2011, Initiation and duration of breastfeeding in an Aboriginal community in south western Sydney. *J Hum Lact* 27(3): 250–261.
- Cromie E, Shepherd C, Zubrick S, Oddy W** 2012, Breastfeeding duration and residential isolation amid Aboriginal children in Western Australia. *Nutrients* 4(12): 2020–2034.
- Eades SJ, Bibbulung Gnarnep Team** 2000, Breastfeeding among urban Aboriginal women in Western Australia. *Aborig Isl Health Work J* 24(3): 9–14.
- Eades SJ, Read AW, McAullay D, McNamara B, O'Dea K, Stanley FJ** 2010, Modern and traditional diets for Noongar infants. *J Paediatr Child Health* 46: 398–403.
- Fenwick J, Barclay L, Schmied V** 2001, Struggling to mother: a consequence of inhibitive nursing interactions in the neonatal nursery. *J Perinat Neonatal Nurs* 15(2): 49–64.
- Foley W, Schubert L** 2012, Applying strengths-based approaches to nutrition research and interventions in Australian Indigenous communities. *J Crit Diet* 1(3): 15–25.
- Gilchrist D, Woods B, Binns CW, Gracey M, Scott J, Smith H** 2004, Breastfeeding and health promotion: the experience of Aboriginal and non-Aboriginal mothers. *Health Promot J Austr* 15(3): 226–230.
- Hayman N, Kanhutu J, Bond S** 2000, Breast-feeding and weaning practices of an urban community of Indigenous Australians. *Asia Pac J Clin Nutr* 9(3): 232–234.
- Hoddinott P, Craig LCA, Britten J, McInnes RM** 2012, A serial qualitative interview study of infant feeding experiences: idealism meets realism. *BMJ Open* 2(e000504): 1–14. doi:10.1136/bmjopen-2011-000504

- Holmes W, Phillips J, Thorpe L** 1997, Initiation rate and duration of breast-feeding in the Melbourne Aboriginal community. *Aust N Z J Public Health* 21(5): 500–503.
- Holmes W, Thorpe L, Phillips J** 1997, Influences on infant-feeding beliefs and practices in an urban Aboriginal community. *Aust N Z J Public Health* 21(5): 504–510.
- Homer CSE, Foureur MJ, Allende T, Pekin F, Caplice S, Catling-Paull C** 2012, 'It's more than just having a baby' women's experiences of a maternity service for Australian Aboriginal and Torres Strait Islander families. *Midwifery* 28(4): e509–e515.
- Labbok M, Krasovek K** 1990, Toward consistency in breastfeeding definitions. *Stud Fam Plann* 21(2): 226–230.
- Mackerras D** 2006, Breastfeeding in Indigenous Australians. *Nutrition & Dietetics* 63(1): 5–8.
- NACCHO/RACGP** 2012, *National guide to a preventive health assessment for Aboriginal and Torres Strait Islander people*. 2nd edn. RACGP, South Melbourne.
- Noble-Carr D, Bell C** 2012, Exposed: younger mothers and breastfeeding. *Breastfeed Rev* 20(3): 27–38.
- Palys T** 2008, Purposive sampling. In *The Sage Encyclopedia of Qualitative Research Methods*. URL: <http://www.sage-reference.com.ezproxy.library.uq.edu.au/view/research/n349.xml> Accessed 27/09/13.
- Perrine CG, Scanlon KS, Li R, Odom E, Grummer-Strawn LM** 2012, Baby-friendly hospital practices and meeting exclusive breastfeeding intention. *Pediatrics* 130(1): 54–60. doi:10.1542/peds.20113633
- QSR International Pty Ltd** 2010, NVivo qualitative data analysis software; Version 9.
- Schmied V, Barclay L** 1999, Connection and pleasure, disruption and distress: women's experience of breastfeeding. *J Hum Lact* 15(4): 325–334.
- Schmied V, Beake S, Sheehan A, McCourt C, Dykes F** 2011, Women's preceptions and experiences of breastfeeding support: a meta-synthesis of qualitative research. *Birth* 38(1): 1–12. doi:10.1111/j.1523-536X.2010.00446.x
- Schubert L** 2013, The mother, her boobs, Kachie and the backlash. *The Crikey Health Blog*. URL: <http://blogs.crikey.com.au/croakey/2013/01/24/on-breastfeeding-flash-mobs-david-koch-and-public-health-engagement-with-social-media/> Accessed 26/03/13.
- Sheehan A, Schmied V, Barclay L** 2009, Women's experiences of infant feeding support in the first 6 weeks post-birth. *Matern Child Nutr* 5(2): 138–150.

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