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Breastfeeding among Vietnamese women in Ho Chi Minh City: Attitudes and confidence

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Abstract

Breastfeeding has several advantages for both mother and child. A woman's attitude to breastfeeding is a good predictor for infant feeding method and her confidence in breastfeeding has an impact on her breastfeeding duration. **Aim:** The aim of the study was to assess the attitude to and confidence in breastfeeding among Vietnamese women in Ho Chi Minh City. The aim was also to investigate if the type of family, nuclear and extended, influences the Vietnamese women's attitude to and confidence in breastfeeding. **Method:** A descriptive and comparative cross-section study with quantitative method was used. The Self-Care Theory and The Cultural Care Diversity and Universality Theory were used as theoretical framework of this study. A questionnaire which consisted of demographic information, attitude to and confidence in breastfeeding, was distributed to 110 voluntarily participating women in Ho Chi Minh City, Vietnam. **Results:** The results showed that the women had an attitude in favour of breastfeeding and rated their confidence between "sometimes confident" and "often confident". No significant differences of total score, between nuclear and extended family, in attitude to and confidence in breastfeeding were shown. **Conclusion:** The attitude to and confidence in breastfeeding among the women in Ho Chi Minh City were rather good but improvements can be made. When healthcare professionals counsel Vietnamese women, in Sweden and Vietnam, about breastfeeding, this result can be used as guidance, in order to give relevant and cultural congruent advice.

Key words: Breast feeding, Attitude, Confidence, Family Characteristics, Vietnam

Sammanfattning

Amning har flera fördelar för både mor och barn. En kvinnas attityd till amning är en bra predikator för hur hon kommer att mata sitt barn och hennes självförtroende i sin amning kan användas för att uppskatta hur länge hon kommer att amma. **Syfte:** Syftet med denna studie var att undersöka attityden till och självförtroendet i amning hos vietnamesiska kvinnor, i Ho Chi Minh City. Vidare var syftet att undersöka om typen av familj, kärnfamilj jämfört med utökad familj, påverkade vietnamesiska kvinnors attityd till och självförtroende i amning. **Metod:** Denna deskriptiva och jämförande studie genomfördes med en kvantitativ metod. Orens teori om egenvård och Leiningers teori om kulturrelaterad omsorg användes som teoretiskt ramverk i denna studie. En enkät som bestod av demografiska information, attityd till och självförtroende i amning gavs ut bland 110 frivilligt deltagande kvinnor i Ho Chi Minh City, Vietnam. **Resultat:** Resultaten visade att kvinnorna hade en positiv attityd till amning och uppskattade sitt självförtroendet mellan ”ibland säker” och ”oftast säker”. Ingen signifikant skillnad i totalpoäng, mellan kärnfamilj och utökad familj, i attityd och självförtroende till amning hittades. **Slutsats:** Attityden och självförtroendet till amning bland kvinnor i Ho Chi Minh City var relativt bra men förbättringar kan åstadkommas. När sjukvårdspersonal ger råd om amning till vietnamesiska kvinnor, i Sverige och Vietnam, kan detta resultat användas som riktlinje i syfte att ge relevanta och kulturellt förankrade råd.

Nyckelord: Amning, Attityd, Självförtroende, Familjekarakteristika, Vietnam

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1. Background

Breast milk contains a unique composition of nutrition especially made for the human infant. The amount of protein changes after the child's needs, among other things it contains cholesterol and taurine that is important for the infant. Breast milk also holds a lot of antibodies against gastrointestinal and respiratory diseases (Lawrence & Lawrence, 2005; Weström, 2005). It is shown that children who have been exclusively breastfed, when the infant only receives breast milk and no additional food or drink, including water, for at least 4 months have a lower risk of develop allergy such as asthma and eczema (Almroth, Dinh Quang, Thi Thuy Hoa & Williams, 2008). Breastfeeding also has psychological benefits for the woman and the infant and help the woman to recover after the partum (Lawrence & Lawrence, 2005; Weström, 2005). The profits of breastfeeding do not only last for as long as breastfeeding is continued. For both the mother and the child there are many long-term benefits. Lower rates of overweight and type-2 diabetes have been shown among breastfed children. Women who have breastfed have been shown to have a decreased risk of cancer in breast and ovaries (WHO, 2008).

1.1. WHO recommendations

The World Health Organization, WHO, recommends that all infants shall breastfeed exclusively for six months and together with The United Nations Children's Fund, UNICEF, WHO has launched Baby-friendly hospitals which are obliged to promote breastfeeding and work with "Ten steps to successful breastfeeding" (WHO, 2009). "Ten steps to successful breastfeeding" includes recommendations to healthcare givers, information to the pregnant woman and support to the post partum woman. All steps support breastfeeding as the superior infant feeding method (WHO, 1998).

WHO (1981) reclaims that governments all over the world have the responsibility to protect families from formula advertising by the International Code of Marketing of Breast milk Substitutes. Moreover, the governments shall see to that the women have the access to skilled support for initiating and sustaining exclusive breastfeeding for six months and healthcare professionals should be able to give effective feeding counselling (WHO, 1981).

The weanling dilemma

Kramer and Kakuma (2004) have conducted a review to assess the effects on child health, growth, development, and on maternal health, of exclusive breastfeeding for six months compared to exclusive breastfeeding for three to four months with mixed breastfeeding. In developing countries it is common that the growth in children falters after three months of age. According to the authors, WHO has earlier overestimated the energy requirements for infants and it was therefore recommended to breastfeed the first three to four months and after that give weaning foods, such as porridge and other easily digested foods. Weaning foods in developing countries are often inadequate in its energy and nutritional contents. These factors have led to the so called “weanling-dilemma” concerning how long women should breastfeed exclusively. The result of the review showed that there are several advantages with exclusive breastfeeding for six months compared to three or four months of exclusive breastfeeding. Advantages such as less gastrointestinal infections, quicker maternal weight loss after birth were found and that it did not impair the growth in the infant. The result also pointed out that exclusive breastfeeding for six months is recommended in both developing and developed country settings. Exclusive breastfeeding can be lifesaving in developing countries when providing the child a protection against deceases (Kramer & Kakuma, 2004).

1.2. Attitude

A literature review by Losch, Dungy, Russell and Dusdieker (1995) showed that a person’s intentions are closely associated to her actual behaviour and that this is possible to apply on infant feeding practices. A positive attitude to breastfeeding was shown to be associated with breastfeeding as infant feeding method. Losch et al. (1995) considered attitude as a better predictor for infant feeding method than demographic factors because attitude is a factor that is possible for healthcare professionals to affect. By using a predictor that is possible to affect, interventions can be made. The results of the study also showed that attitudes from persons in a woman’s social network and from healthcare professionals had an influence on the woman’s choice of infant feeding method. The support from healthcare professionals has been described by Sjögren (2005) to have an influence on the woman’s attitude and that the support she gets from her family affects how she chose to feed her child. The support could also make a woman, who had planned to bottle feed her infant, change her mind.

Furthermore, Sjögren (2005) described that the attitude to breastfeeding in the woman's culture had an influence on her choice of infant feeding method.

For measuring maternal attitudes in infant feeding methods, Iowa Infant Feeding Attitude Scale (IIFAS) has been developed by de la Mora, Rusell, Dungy, Losch and Dusdieker (1999). The IIFAS contains statements concerning breastfeeding and formula, where the women rate how much they agree or disagree. The IIFAS has been valued in a systematic review by Chambers (2007) that assessed different scales concerning women's knowledge, attitude, confidence and satisfaction towards breastfeeding. The IIFAS was shown to be a good instrument for predicting infant feeding method and breastfeeding duration. The study by Sittlington, Stewart-Knox, Wright, Bradbury and Scott (2007) also showed that the IIFAS has good reliability and validity. The study was conducted in Northern Ireland with the aim to investigate the breastfeeding attitude among pregnant women and how the attitude relates to the breastfeeding rate. The result showed that a higher score on the IIFAS indicated that the woman had intentions to breastfeed and that she was more likely use breastfeeding as infant feeding method when her baby was born.

The IIFAS was also used in a study by Shaker, Scott and Reid (2004) conducted in Scotland with the purpose to compare the infant feeding attitudes among parents who give breastfeeding and parents who give bottle feeding. The results showed that the mothers who breastfed had higher scores on the IIFAS and a better knowledge according to the health benefits and the nutritional superiority of breastfeeding, compared to mothers who bottle fed their infants.

1.3. Confidence and self-efficacy

A woman who feels confident in her ability to breastfeed, to produce breast milk and who are motivated to breastfeed are more likely to have a longer duration of breastfeeding. When a woman worries about her ability to breastfeed she can more easily lose her confidence and stop breastfeeding (Sjögren, 2005). The perceived ability influences the thoughts and actions of the individual and is therefore shown to be a predictor for her health behaviour, writes Dennis (1999) in her article about self-efficacy. Dennis found that a high level of self-efficacy in breastfeeding leads to choosing, performing and maintaining breastfeeding as infant feeding method.

The Breastfeeding Self-efficacy Scale (BSES) has been developed by Dennis and Faux (1999) in Canada, with the objective to receive a predictor for breastfeeding initiation and duration. The results from assessing the scale showed that participants who rates their self-efficacy higher, more often exclusively breastfeed. A later study by Dennis (2003), also conducted in Canada, showed that the rates on the BSES have no correlation with demographic factors such as maternal age, education and income. In the BSES the woman answers questions about whether she chooses to breastfeed, how much effort she will provide in this task, how her thought pattern looks and how she will respond to difficulties. The answers to these questions show her confidence and thereby can her breastfeeding duration be predicted (Dennis, 1999). According to Dennis and Faux (1999) the scale helps healthcare professional to identify mothers in risk of early discontinuing of breastfeeding and the healthcare professionals are thereby able to perform interventions.

The predictive validity of the BSES has been further tested in a methodological study carried out in Australia by Creedy et al. (2003). This study supported the results of earlier studies that have indicated that BSES is a good predictor of infant feeding method. Creedy et al. (2003) suggested that a higher score on the BSES would be 140 and higher, and a lower score 130 and lower, but declared that more evaluation are needed.

A study, conducted in Australia by Blyth et al. (2004) with the aim to investigate the influence of antenatal variables on breastfeeding outcome, used the BSES for exploring the confidence of the mothers in breastfeeding. The results indicated that most of the mothers felt confident in breastfeeding. Further the results revealed that the BSES score, also here, had a significant relation with breastfeeding duration and level.

In Thailand, a study conducted by Bergström and Zyto (2009), also used the BSES for measuring mother's confidence in breastfeeding. The aim of the study was to investigate the attitude and confidence of breastfeeding mothers and showed that the Thai mothers had a good confidence in breastfeeding and a positive attitude to it.

A study conducted in Sweden by Ekström, Widström and Nissen, (2003) had the objective to describe breastfeeding support and confidence in relation to breastfeeding duration. The results showed that one week after childbirth, first time mothers rated their confidence lower than mothers who had given birth before. The authors also showed a relation between the mother's confidence and her social support. An influence on breastfeeding from grandmothers were shown, which brought Ekström et al. (2003) to the conclusion that

healthcare professionals should include grandmothers who are positive to breastfeeding when supporting mothers.

1.4. Vietnam

Vietnam is a developing country, located in south-east Asia, with borders to China, Laos and Cambodia. The country has 86.2 millions citizens and 4.3 millions of them live in Ho Chi Minh City, situated in the south of the country. The most common religious view is Buddhism and others views are Christians, Hoa hao and Cao dai (Nationalencyklopedin [NE], 2008b). In 2005, 75 % of the population lived in rural areas and 25 % in urban. Education program in Vietnam is highly developed even though the country has suffered from economic difficulties after the war. Read and write ability is 90.3 % of the population (Shia, 2008).

Vietnam is a political one-party state, with the communist party as the only legal party. During the last decades Vietnam received many economical achievements due to economic reforms. The economy of the country has changed from a socialist planned economy to a market economy (Utrikespolitiska institutet [UI], 2006). The economic reforms made in the country have unfortunately not improved the healthcare. The government has lowered their subventions on medicines and the people have to pay for almost their entire healthcare by themselves. Only a small part of the population has healthcare insurance. The government hospitals are old with a low standard and differ much from the much more expensive private hospitals (UI, 2006). Vaccinations for measles, polio, hepatitis, pertussis, diphtheria and tetanus for children are free (Meeting, Ms Thu, 2009).

The changing of the economic situation in the country has benefited the children. According to UNICEF (2009), Vietnam is near to achieve the Millennium Development Goals in children's health and education. The children are better educated and the mortality among children under the age of five has decreased. Despite the decrease the rate is still much higher in Vietnam compared to Western countries. The mortality among rate of children under five years old is 23/1000 in Vietnam compared to 4/1000 in Sweden (WHO, 2006a; 2006b).

Breastfeeding practices in Vietnam

Only 19 % of the infants are exclusively breastfed at the age of four months and the number drops down to 12 % among six months old infants in Vietnam (UNICEF, 2009). This could

be compared to Sweden, where 60 % of the women exclusively breastfeed their infants for 4 months and 15 % exclusively breastfed for 6 months according to Socialstyrelsen (2006). Malnutrition rates among children are high in Vietnam, 25 % of the children less than five years old are malnourished and one of the reasons to this is the low rate of exclusive breastfeeding according to UNICEF (2007, 2009). According to UNICEF (2004) the causes for the low rate of exclusive breastfeeding are the women's lack of support and education in the issue together with the fact that many women have to work long days. The early introduction of complementary food and the common use of formula are also a part of the problem (UNICEF, 2007).

An earlier study by Almroth et al. (2008), conducted in Vietnam, had the aim to investigate community views of exclusive breastfeeding. This study showed that only 30 % of the infants in Vietnam were exclusively breastfed at the age of 4 months. The most common additional food the babies are given are water with or without sugar and milk. The reasons for non-exclusive breastfeeding as infant feeding method were lack of knowledge of the advantages of exclusive breastfeeding.

Three studies investigated infant feeding practices among Vietnamese women in rural Vietnam by interviewing 463 women (Duong, Binns & Lee, 2004, 2005; Duong, Lee & Binns, 2005). The study by Duong, Binns and Lee (2004) showed that most of the women felt self-confident and comfortable with breastfeeding. However, the study conducted by Duong, Lee et al. (2005) found that if the woman is discomfort to breastfeed in public places, she is less likely to exclusively breastfeed. It was shown that if the parents lived independently and not in an extended family, they were more likely to give their infant solid food. Duong et al. (2004) found that the influence from grandmothers and fathers were important to consider when giving breastfeeding counselling. The three articles all showed that despite a high level of breastfeeding initiation, many infants get complementary food and liquids early. The authors stated that the main problem seemed to be the poor knowledge of the women and poor knowledge and lack of counselling skills of healthcare professionals.

A study by Li, Lan, Hoa and Ushijima (2002), conducted in Ho Chi Minh City, Vietnam, had the aim to investigate the prevalence of breastfeeding and the possible risk factors for discontinuing of exclusive breastfeeding. Maternal antenatal plan of non-exclusive breastfeeding together with access to formula in maternity wards were shown to influence the breastfeeding rate among mothers with infants of three months of age. In the study, 53 % of the women exclusively breastfed their baby after three months and a reason not to do so was

perceived insufficient milk supply and working hours. The result showed that the majority of the mothers had help from their families in taking care of the infant and in some cases, the grandmothers were the main caretaker. Furthermore, the study revealed that despite the fact that many hospitals were a part of the Baby-Friendly Hospital Initiative, not all used the policies they were obliged to.

Vietnam and the family

It is written, by Newman-Giger and Davidhizar (1999), that the Vietnamese society is much different from the Western individualistic society. According to this literature, the immediate family in Vietnam traditionally includes grandparents, children and sometimes the husband's brother and wives. In a Western society that would be called an extended family and a nuclear family includes only the parents and their child.

The study by Hien and Kam (2008) carried out in one of the poorest province in Vietnam, had the aim to investigate the nutritional status and characteristics influencing malnutrition in children under five years of age. Results from the study found that a protective factor against underweight among children was living in a family with many individuals. Children in extended families were also found to be well taken care of. In the study it was concluded that children who were exclusively breastfed less than 6 month were more likely to be underweight compared to children who were breastfed more than 6 months.

1.5. Breastfeeding practices among immigrated Vietnamese women

Earlier studies have reported that the rate of breastfeeding among Vietnamese women decreases when the women immigrate to a Western country (MacLachlan & Forster, 2006; Mistry, Freedman, Sweeney & Hollenbeck, 2008; Rossiter & Yam, 2000).

One of these studies was conducted in Australia and had the aim to explore cultural different attitudes and early breastfeeding practices in Vietnamese, Turkish and Australian women, all giving birth in Australia. The main results of this study showed that Vietnamese women were less likely than Australian women to exclusively breastfeed the first day postpartum, less likely to breastfeed at all and more likely to give their baby formula in the hospital (MacLachlan & Forster, 2006).

Babington and Patel (2008) conducted a study in Boston, U.S., with the aim to investigate the child-feeding practices of Vietnamese women immigrated to the U.S. Their results showed that due to convenience and work many of the women chose to bottle feed even though they believed it was better for the baby to be breastfed.

Rossiter and Yam (2000) investigated factors influencing immigrated Vietnamese women's choice of infant feeding practices in Australia and how healthcare professionals can promote breastfeeding. The results showed that the main factors for choosing breastfeeding are the benefits for the child and woman and the influence and support from others. The two main reasons to choose formula as infant feeding method were convenience and the fact that the women had the financial opportunity to choose formula. The women also suggested interventions that could promote breastfeeding among immigrated Vietnamese women such as bilingual nurses, a positive attitude from healthcare professionals, culturally-specific education programs and social support.

Attitudes of healthcare professionals, education and information both prepartum and postpartum were shown to affect infant feeding method, by Mistry et al. (2008) in their study conducted in the U.S. with the aim to explore and describe breastfeeding practices among immigrated Vietnamese women. The study also showed that the family's opinions affected the woman and therefore it was suggested to involve family and relatives when giving information to the mother.

1.6. Theoretical framework

Dorothea Orem's Self-care Theory and The Theory of Culture Care Diversity and Universality by Madeleine Leininger were provided as a theoretical framework of this study.

Dorothea Orem's Self-care Theory

Orem's Self-care theory concludes that every adult person has ability to keep and treat herself. This ability can be diminished if the patient has reduced self-care ability, if the need of care has increased, or both. The healthcare professionals' role is to support, partially or totally, during the time when the patient has a reduced ability to help herself. The task of the healthcare professionals is to identify the patient's needs of care and help the patient to help herself (NE, 2008a). Further is the task to promote existing capabilities and determine the

potential for continued development of self-care of the patient (Alligood & Marriner-Tomey, 2002; NE, 2008a). The newly become mother has an increased need of care due to a new life situation. The woman needs to strengthen her self-care to be able to “maintain and promote health” and to “contribute wellbeing”, according to the therapeutic self-care demands of Orem (Alligood & Marriner-Tomey, 2002). The woman will require more information and support to be able to help her self and her child (NE, 2008a).

The Theory of Culture Care Diversity and Universality by Madeleine Leininger

The Theory of Culture Care Diversity and Universality by Madeleine Leininger was also provided as a theoretical framework because of the focus on the patient both as an individual and as a part in a cultural context (Alligood & Marriner-Tomey, 2002). The theory can be adhibited in both Western and non-Western cultures and contains a holistic view that unifies cultural, social, physical, biological and psychological factors (Fawcett, 1993; Marriner-Tomey & Alligood, 2006). It allows finding what is diverse and what is alike between cultures, related to care. The purpose of the theory is to evolve new knowledge in healthcare and establish a culturally congruent care. (Marriner-Tomey & Alligood, 2006). To achieve this purpose, the advices and care that are given are to be based on the cultural beliefs of the patient to receive a good relation and compliance (Alligood & Marriner-Tomey, 2002).

Conclusion of theoretical framework

The two theories clarify the relevance of this study by bringing forward the problems with self-care and cultural diversity from healthcare profesionnal's point of view. The results of our study can be used to show in what areas the women require more information and therefore have decreased self-care ability as Orem's Self-care Theory explains it. Vietnamese and Swedish healthcare professionals can use the results of our study when advising Vietnamese newly become mothers. Leininger suggests that research about a culture should be based on information from the people living in the culture. By investigating the attitude to and confidence in breastfeeding among women in Vietnam, Swedish healthcare professionals will get the tools that are needed to give good nursing care to Vietnamese immigrants, that combines the cultural diversities and universalities of the two cultures.

1.7. Rationale of research

Healthcare professionals should gain knowledge about the woman's life situation in order to know how to individualise the information. This is pointed out by Ekström (2005), in her thesis with the aim to chart factors that affect breastfeeding. By doing this, healthcare professionals can focus on women in high risk of short duration of exclusively breastfeeding. The thesis also showed that women who rated the support they had in breastfeeding higher, also exclusively breastfed for a longer time.

In the ethical code of nursing, developed by the International Council of Nurses, ICN, (2007), it is written that every patient has the right to get professional and good nursing care, not dependent of the nationality, cultural background or religious beliefs of the patient. A comprehensive view of the patient's situation is important for the nurse to see, according to the Swedish Socialstyrelsen (2005), to be able to give good care.

Sweden is becoming more multicultural and Swedish healthcare professionals have to improve their knowledge concerning patients from different cultures in order to gain the goal of individualized, holistic and good care, suggested by Ekström (2005), ICN (2007) and Socialstyrelsen (2005). Because of the differences in the two societies of Sweden and Vietnam there is relevance for this study. By survey Vietnamese women's attitude to and confidence in breastfeeding, Swedish nurses can give proper information, in a cultural specific way, according to Leininger's Theory of Culture Care Diversity and Universality, and by doing so the women are given the support they need to help themselves and their child according to Orem's Self-care Theory. Investigating what scores Vietnamese women receive on the IIFAS and the BSES will reveal what attitude to and confidence in breastfeeding that they have. According to earlier literature, this will also be a predictor for their breastfeeding practices. Rates of the different statement in the IIFAS and the BSES will give valuable information about what areas the Vietnamese women need, or do not need, support. In the Vietnamese culture it is common to live in an extended family and therefore it is also relevant to investigate the influence of the type of family on attitude and confidence. The information about the attitude and confidence among Vietnamese mothers will help to obtain the goal of exclusive breastfeeding for 6 months.

1.8. Aim

The aim of the study was to assess the attitude to and confidence in breastfeeding among Vietnamese women in Ho Chi Minh City. The aim was also to investigate if the type of family, nuclear and extended, influences the Vietnamese women's attitude to and confidence in breastfeeding.

1.9. Questions of issue

- What attitude do Vietnamese women have to breastfeeding?
- What confidence do Vietnamese women have in breastfeeding?
- Is there a difference in attitude to and confidence in breastfeeding between women living in nuclear family compared to extended?

2. Methods

2.1. Design

A descriptive and comparative cross-section study with a quantitative method was used in this study.

2.2. Setting

The data collection took place at a children's health center at the department of Obstetric and gynecology, Branch 2, Hospital of University of Medicine and Pharmacy in Ho Chi Minh City, Vietnam.

2.3. Procedure

The project was carried out in the collaboration between Department of Public Health and Caring Sciences, Uppsala University, Sweden and the Faculty of Nursing and Medical Technology, University of Medicine and Pharmacy in Ho Chi Minh City, Vietnam.

Mr. Luong van Hoan, Lecturer at the Department of Nursing and Ms Trieu Thi Ngoe Thu, Head of the Department of Midwifery, contacted the head of the clinic for permission to carry out the study.

The questionnaire (Appendix 1b) was distributed to the participants at the children's health center at the Hospital of University of Medicine and Pharmacy in Ho Chi Minh City during eight days in April 2009, with help from the Vietnamese teachers from the Department of Midwifery, Faculty of Nursing and Medical Technology, University of Medicine and Pharmacy, Ho Chi Minh City. The participants were informed about the study and their rights for participation, verbally and by using the information letter (Appendix 2a and b). While waiting in the waiting room of the children's health center, the women filled out the questionnaire which took approximately 20 minutes. The questionnaire was handed back to the authors by the end of the women's visit at the center.

2.4. Sample

A purposive convenient sample was used for selecting the participants. One hundred and ten women, who visit the children's health center of the the Hospital of University of Medicine and Pharmacy, or worked in the same hospital, voluntarily participated in the study.

The inclusion criteria were;

- Women with at least one child in the age between 0 up to 24 months old.
- Women in the age of 18 and older.

2.5. Instrument

The questionnaire consists of totally 59 questions divided in three parts; demographic variables, Iowa Infant Feeding Attitude Scale (IIFAS) and Breastfeeding Self-efficacy Scale (BSES) (Appendix 1a). The IIFAS and the BSES are both tested for validity and reliability in earlier studies (Chambers, 2007; Dennis & Faux, 1999). Permission to use the IIFAS is given by the constructors, de la Mora et al. (1999). The constructors of the BSES have encouraged further use of the scale (Dennis & Faux, 1999). The three-part questionnaire has been used in a similar study which was conducted in Bangkok, Thailand 2008 (Bergström & Zyto, 2009).

The questionnaire has been translated into Vietnamese language by Mr. Luong van Hoan, Lecturer at the Department of Nursing, Faculty of Nursing and Medical Technology, University of Medicine and Pharmacy, Ho Chi Minh City, Vietnam (Appendix 1b). Ms Thi Tra My An, Lecturer at the same department, has done a double check of the Vietnamese language. Ms Trieu Thi Ngoe Thu, Head of the Department of Midwifery has also double-checked the translation with focus on having a context easily understood by the women. Together with Ms Thu the translation of the questions where misunderstandings and difficulties could occur, was changed.

The questionnaires first part was developed by Pranee Lundberg, Associate Professor at the Department of Public Health and Caring Sciences, Uppsala University. The first part is containing nine multiple-choice questions concerning the participants' background; religious views, age, marital status, education level, occupation, type of family, total numbers of pregnancies and children, difficulties of delivering, type of delivery, numbers of people in the household and infant feeding method.

The second part is the IIFAS which contains 17 questions about the participant's attitude to breast and formula feeding. Every question has a five-point scale, rated from one to five, where one is "strongly agree", two is "agree", three is "neutral", four is "disagree" and five is "strongly disagree". Approximately half of the questions are formulated in favour to breastfeeding and half in favour to formula. The rates of the questions in favour of breastfeeding have been reversed (i.e. 1=5, 2 =4, 4=2, and 5=1) before the analysis started. A higher score reflects a more positive attitude towards breastfeeding. A low score reflects a preference to formula (Dennis, 2003; de la Mora et al., 1999).

The third part is the BSES that concerns the participants' breastfeeding confidence; 18 questions about intrapersonal thoughts and 15 questions concerning technique. These questions are also to be rated in a five-point scale, and when converted into meaning, one is "not at all confident", two is "rarely confident", three is "sometimes confident", four is "often confident" and five is "always confident". These scores are also calculated together to a total confidence score. A higher score indicates a stronger confidence in breastfeeding (Dennis & Faux, 1999).

2.6. Analysis of data

The data analysis were conducted with descriptive and comparative statistics in Microsoft Excel and The Statistical Package for the Social Sciences (SPSS).

The demographic variables were shown in tables and in charts. A mean value with standard deviations was calculated for each parametric variable and the non-parametric variables were shown by percentages.

The aim of the IIFAS was to answer what attitude the mothers had to breastfeeding while the BSES had the aim to investigate the mothers' confidence in breastfeeding. Mean scores for each of the two scales were calculated together with a mean score for each question. The mean score for each of the two parts of the BSES, Intrapersonal thoughts and technique, were also calculated. These mean scores are shown in tables.

To answer the question if there is a difference in attitude to and confidence in breastfeeding between women living in nuclear family compared to an extended family, the sample was divided into two groups after type of family, nuclear (NF) and extended (EF). A nuclear family contains of only the parents and their children and if there is additional relatives, for example grandparents, living in the family it is defined as an extended family. The demographics and mean scores of the IIFAS and the BSES, for each group was calculated and shown in the same approach as for the total sample. To compare the two groups, NF and EF, the non-parametric variables were compared by using the Chi-square test. The parametric variables were compared by mean scores using an independent T-test. The results of the tests were shown in tables.

2.7. Ethical considerations

Permission to carry out the study were given by the head of the children's health center. An information letter was constructed by Ms Trieu Thi Ngoe Thu, Head of the Department of Midwifery and Ms Pham Thi Van Nhu, teacher at the same department, who informed the participants' of the aim of the study (Appendix 2a, 2b). The letter was used together with oral information from Ms Pham Thi Van Nhu to give information to the participants before the questionnaire distributed. The participants were free to interrupt their participation at any time they wanted. The data was coded and analysed confidentially. The ethical consideration was taken by using the World Medical Association's, WMA, Declaration of Helsinki (2004) and The Code of Ethics for Nurses (ICN, 2007).

3. Results

The total number of participants completed this study was 110. 102 (93 %) of the women were recruited and asked to take part in the study when they were visiting the children's health center of the Hospital of University of Medicine and Pharmacy in Ho Chi Minh City. 8 (7 %) of the women were employees working at the same department. Eleven women who were asked to participate in the study declined. The causes of the falling off were the women's lack of time and/or misunderstandings due to language. The total sample of women was divided into two groups according to their type of family, 42 (38 %) women were living in a nuclear family, NF, and 68 (62 %) women were living in an extended family, EF. See table 1a and 1b.

3.1. Demographic characteristics

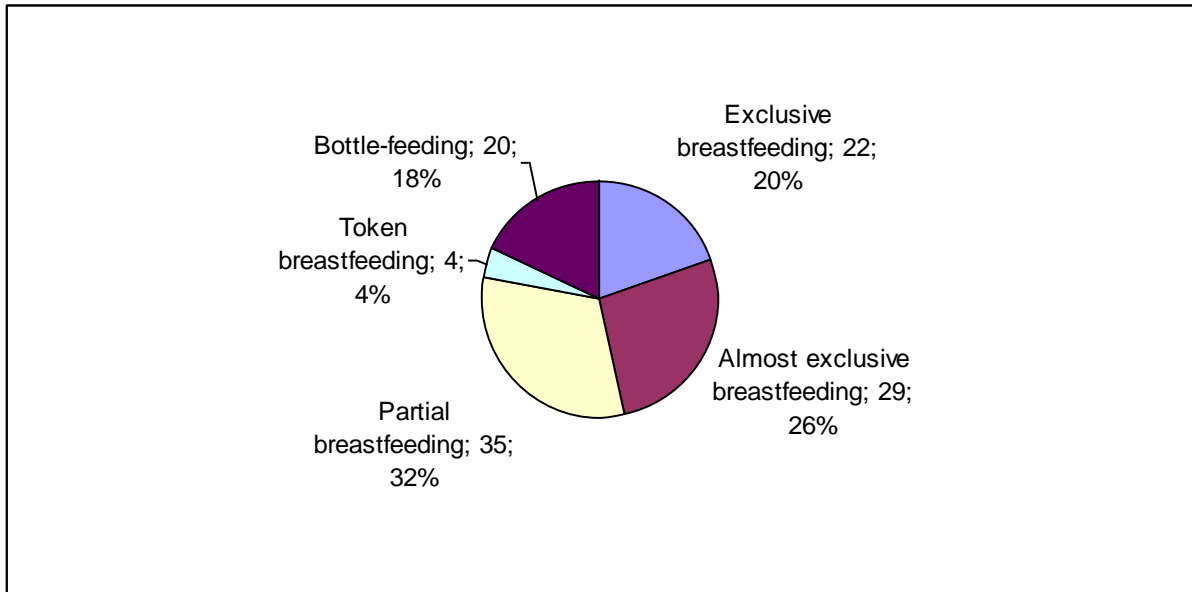
The age of the participants were between 19 and 44 years with a mean age of 30.4 years (SD 4.9). The women in NF were older with a mean age of 32.0 years (SD 5.5), compared to the women in EF who had a mean age of 29.5 years (SD 4.3). The two groups differed significantly ($p= 0.01$). See table 1a.

The women in NF had fewer people living in their household, mean of 3.5 persons (SD 0.5), compared to the women in EF, mean of 6.0 persons (SD 2.3). The difference were shown to be significant ($p= 0.00$). See table 1b.

The most common infant feeding method was partial breastfeeding (32%), followed by almost exclusively (i.e. 2/3) breastfeeding (26%). 20 % of the women exclusively breastfed their infant and 18 % used bottle feeding as infant feeding method. See figure 1.

All demographics included religious views, marital status, education level, occupation, living location, number of pregnancies and children and information concerning delivery are shown in table 1a and 1b.

Figure 1. Choice of infant feeding method in total.



Definitions;

Exclusive breastfeeding- only breast milk and no additional food or drink, including water,

Almost exclusive breastfeeding- 2/3 of the infant feeding contains of breast milk,

Partial breastfeeding- breastfeeding and other infant feeding,

Token breastfeeding- breastfeeding for comforting,

Bottle-feeding- no breastfeeding.

Table 1a. Demographics of the Vietnamese women.

	Total		Nuclear family (NF)		Extended family(EF)		Significance (p-value)
	<i>N (%)</i>	<i>Mean score (SD)</i>	<i>n (%)</i>	<i>Mean score (SD)</i>	<i>n (%)</i>	<i>Mean score (SD)</i>	
Religion	109 (99)		42 (100)		67 (98)		N.S.
Buddhist	61 (55)		20 (48)		41 (61)		
Christian	21 (19)		9 (21)		12 (18)		
Ancestors	26 (24)		13 (31)		13 (19)		
Other	1 (1)		-		1 (2)		
Age	109 (99)	30.4 (4.9)	42	32.0 (5.5)	67 (98)	29.5 (4.3)	S. (p=0.01)
18-22	5 (5)		1 (2.4)		4 (5.9)		
23-27	24 (22)		10 (23.8)		14 (20.6)		
28-32	41 (37)		10 (23.8)		31 (45.6)		
33-37	30 (27)		12 (28.6)		18 (26.5)		
38-42	8 (7)		8 (19.0)		-		
43-	1 (1)		1 (2.4)		-		
Marital status	108 (98)		42 (100)		66 (97)		N.S.
Married	101 (91)		38 (90)		63 (95.5)		
Separated	1 (1)		-		1 (1.5)		
Divorced	1 (1)		-		1 (1.5)		
Widowed	-		-		-		
De facto married	5 (5)		4 (10)		1 (1.5)		
Education	110 (100)						N.S.
Primary school	3 (3)		-		3 (4)		
Secondary school	11 (10)		4 (10)		7 (10)		
High school	38 (35)		15 (35)		23 (34)		
Higher education	57 (51)		23 (55)		34 (50)		
Other	1 (1)		-		1 (2)		
Occupation	110 (100)		42 (100)		68 (100)		N.S.
Worker	4 (4)		3 (7)		1 (1.5)		
Government and private officer	43 (39)		15 (36)		28 (41)		
Technician	7 (6)		4 (10)		3 (4)		
Merchant	22 (20)		6 (14)		16 (24)		
Farmer	-		-		-		
Gardener	-		-		-		
Household duty	31 (28)		12 (29)		19 (28)		
Other	3 (3)		2 (4)		1 (1.5)		

p<0.05 = significant difference (S), and p>0.05 = non-significant difference (NS)

Table 1b. Demographics of the Vietnamese women.

	Total		Nuclear family (NF)		Extended family(EF)		Significance (p-value)
	<i>N (%)</i>	<i>Mean score (SD)</i>	<i>n (%)</i>	<i>Mean score (SD)</i>	<i>n (%)</i>	<i>Mean score (SD)</i>	
Type of family	110 (100)		42		68		N.S.
Nuclear family	42 (38)						
Extended family	68 (62)						
Living location	110 (100)		42		68		N.S.
Ho Chi Minh City	103 (94)		39 (93)		64 (94)		
Other province	7 (6)		3 (7)		4 (6)		
Total number of pregnancies		1.5 (0,7)		1.46 (0.55)		1.50 (0.72)	N.S.
1 preg	64 (58)						
2 preg	39 (35)						
3 preg	4 (4)						
4 preg	2 (2)						
Total number of children	110 (100)	1,4 (0,6)		1.4 (0.5)		1.4 (0.63)	N.S.
1 child	69 (62)						
2 children	38 (35)						
3 children	2 (2)						
4 children	1 (1)						
Difficulties delivering	103 (94)						N.S.
No difficulties	98 (89)		38 (90)		60 (88)		
Yes difficulties	5 (5)		2 (5)		3 (4)		
Mode of delivery	108 (98)		41 (98)		67 (99)		N.S.
Vaginal	65 (59)		27 (64)		38 (56)		
Caesarean section	43 (39)		14 (34)		29 (43)		
How many people live in your household		5,1 (2,2)		3.5 (0.5)		6.0 (2.3)	S. (p=0,00)
Infant feeding method	110 (100)		42 (100)		68 (100)		N.S.
Exclusive breastfeeding	22 (20)		7 (17)		15 (22)		
2/3 breastfeeding	29 (26)		15 (36)		14 (21)		
Partial breastfeeding	35 (32)		11 (26)		24 (35)		
Token breastfeeding	4 (4)		-		4 (6)		
Bottle-feeding	20 (18)		9 (21)		11 (16)		

p<0.05 = significant difference (S), and p>0.05 = non-significant difference (NS)

3.2. Vietnamese womens' attitudes to breastfeeding

The scores on the IIFAS are ranged between one and five where a higher score indicates an attitude to infant feeding method in favour of breastfeeding. A lower score indicates an attitude in favour of formula as infant feeding method. The calculated mean score on the IIFAS scale for the total sample was 3.45 (SD 1.56) which showed that the women had an attitude more in favour of breastfeeding then to formula as infant feeding method. The mean

score of the NF were 3.46 (SD 1.58) and for the EF the mean score were 3.45 (1.55). No difference between NF and EF, in total mean score of the IIFAS, were found. See table 2.

The three statements rated with the highest scores in favour of breastfeeding by the women in total, were; “Breast milk is the ideal food for babies”, “Breastfeeding increases mother-infant bonding” and “Breast milk is more easily digested than formula”. The women of EF had the same top three statements but the women of NF rated the statement “Breast milk is cheaper than formula” higher than “Breast milk is more easily digested than formula”. See table 2.

“The benefits of breast milk last only as long as the baby is breastfed”, “Formula feeding is the better choice if a mother plans to go out to work” and “Formula fed babies are more likely to be over fed than breast fed babies”, were the three statements with the lowest scores. These statements, that indicate an attitude in favour of formula, were the same in total as in the NF and the EF. See table 2.

There were no significant differences between women living in NF and EF in any statements concerning attitude to breastfeeding showed by the scores of the IIFAS. See table 2.

Table 2. Attitudes to breastfeeding among the Vietnamese women.

Attitudes to breastfeeding , measured by Iowa Infant Feeding Attitude scale (IIFAS)				
	Total (n=110) Mean (SD)	Nuclear family (NF) (n=42) Mean (SD)	Extended family (EF) (n=68) Mean (SD)	Significans (P-value)
Total	3.45 (1.56)	3.46 (1.58)	3.45 (1.55)	N.S.
Highest scores (indicates an attitude in favour of breastfeeding)				
Breast milk is the ideal food for babies. *	4.74 (0.77)	4.68 (0.97)	4.78 (0.61)	N.S.
Breastfeeding increases mother-infant bonding. *	4.73 (0.81)	4.85 (0.65)	4.66 (0.88)	N.S.
Breast milk is more easily digested than formula. *	4.65 (0.93)	4.48 (1.22)	4.76 (0.65)	N.S.
Breast milk is cheaper than formula.*	4.56 (1.00)	4.55 (1.03)	4.57 (0.98)	N.S.
Lowest scores (indicates an attitude in favour of formula)				
The benefits of breast milk last only as long as the baby is breastfed.	1.50 (0.84)	1.53 (0.84)	1.49 (0.85)	N.S.
Formula feeding is the better choice if a mother plans to go out to work.	2.13 (1.17)	2.20 (1.25)	2.09 (1.12)	N.S.
Formula fed babies are more likely to be over fed than breast fed babies.	2.22 (1.33)	2.05 (1.25)	2.33 (1.37)	N.S.

p<0.05 = significant difference (S), and p>0.05 = non-significant difference (NS)

* The statements are in favour of formula and have been calculated in reversed order before analysing.

3.3. Vietnamese womens' confidence in breastfeeding

The scores of the BSES are ranged between one and five where a higher score indicates a stronger confidence. It is divided into two parts 'Intrapersonal thoughts' and 'Technique'. Including the total BSES, the mean score of the women was 3.83 (SD 1.40) which evince that the Vietnamese women rated their self-efficacy between “sometimes confident” and “often confident”. The mean total score of the BSES, calculated by the mean score of the total group, were found to be 126.4. The mean score of the women in NF was 3.83 (SD 1.42) and the mean score of the women in EF was 3.82 (SD 1.38). No significant difference was found between the groups. See table 3.

The mean score of the questions concerning 'Intrapersonal thoughts' was 3.89 (SD 1.36) for all the women. The women in NF had a mean score of 3.97 (SD 1.33) in this part and the women in EF rated their intrapersonal thoughts to a mean of 3.84 (SD 1.38). The women

seemed to have a lower confidence in technique than in intrapersonal thoughts, according to the mean scores of the two parts. The mean score of technique was 3.75 (SD 1.43) for all the women, 3.67 (SD 1.50) for the women in NF and 3.80 (SD 1.39) for the women in EF. No differences between the groups, concerning the mean scores of the part of Intrapersonal thoughts or the Technique part were found. See table 3.

Intrapersonal thoughts

The highest scores, indicating a strong confidence, in the part of BSES concerning Intrapersonal thoughts, were found in the statements “Keep wanting to breastfeed.”, “Be satisfied with my breastfeeding experience.” and “Manage the breastfeeding situation to my satisfaction.”. Among the women living in EF, the third statement was rated lower than the statement “Stay motivated to breastfeed my baby”. A significant difference ($p=0.02$) between the two groups, NF and EF, was found concerning the statement “Manage the breastfeeding situation to my satisfaction”. Women in NF had a higher confidence in this issue, mean score 4.69 (SD 0.77), than women in EF, mean score 4.18 (SD 1.31). See table 3.

“Focus on getting through one feed at a time”, “Breastfeed my baby without using formula as a supplement” and “Accept the fact that breastfeeding may temporarily limit my freedom”, were the statements in the part of the Intrapersonal thoughts, that the women had the lowest confidence in. The women in NF rated a fourth statement “Monitor breast milk by keeping track of my baby’s urine and bowel movements”, lower than the statement “Accept the fact that breastfeeding may temporarily limit my freedom”. See table 3.

Technique

“Hold my baby comfortably during breastfeeding”, “Recognize the signs of a good latch” and “Position my baby correctly at my breast” were the three statements concerning technique, that the total sample expressed the highest confidence in. The women in EF also rated the statement “Ensure that my baby is properly latched on for the whole feeding”, high.

The lowest scores of technique were the same in total as for the two groups, NF and EF. These low scores were found in the statements “Comfortably breastfeed in public places”, “Manage to breastfeed even if my baby is crying” and “Depend on my family to support my

decision to breastfeed". No significant differences were found between the two groups in any statements concerning technique. See table 3.

Table 3. Vietnamese women's confidence in breastfeeding

Confidence in breastfeeding , measured by Breastfeeding Self-Efficacy Scale (BSES)				
	Total (n=110) Mean (SD)	Nuclear family (NF) (n=42) Mean (SD)	Extended family (EF) (n=68) Mean (SD)	Significance (P-value)
Total	3.83 (1.40)	3.83 (1.42)	3.82 (1.38)	N.S.
Intrapersonal thoughts	3.89 (1.36)	3.97 (1.33)	3.84 (1.38)	N.S.
Highest scores				
Keep wanting to breastfeed.	4.62 (0.97)	4.83 (0.69)	4.49 (1.09)	N.S.
Be satisfied with my breastfeeding experience.	4.40 (1.13)	4.64 (0.84)	4.25 (1.26)	N.S.
Manage the breastfeeding situation to my satisfaction.	4.37 (1.16)	4.69 (0.77)	4.18 (1.31)	S. (0.02)
Stay motivated to breastfeed my baby.	4.23 (1.19)	4.23 (1.21)	4.24 (1.17)	N.S.
Lowest scores				
Focus on getting through one feed at a time.	2.91 (1.39)	2.925 (1.29)	2.90 (1.45)	N.S.
Breastfeed my baby without using formula as a supplement.	2.97 (1.20)	3.10 (1.21)	2.89 (1.20)	N.S.
Accept the fact that breastfeeding may temporarily limit my freedom.	3.41 (1.49)	3.40 (1.46)	3.41 (1.50)	N.S.
Monitor breast milk by keeping track of my baby's urine and bowel movements.	3.46 (1.37)	3.29 (1.45)	3.57 (1.31)	N.S.
Technique	3.75 (1.43)	3.67 (1.50)	3.80 (1.39)	N.S.
Highest scores				
Hold my baby comfortably during breastfeeding.	4.40 (0.88)	4.46 (0.80)	4.37 (0.92)	N.S.
Recognize the signs of a good latch.	4.35 (1.12)	4.29 (1.16)	4.38 (1.09)	N.S.
Position my baby correctly at my breast.	4.31 (0.94)	4.43 (0.90)	4.24 (0.96)	N.S.
Ensure that my baby is properly latched on for the whole feeding.	4.28 (1.14)	4.36 (1.13)	4.24 (1.14)	N.S.
Lowest scores				
Comfortably breastfeed in public places.	2.65 (1.49)	2.33 (1.44)	2.85 (1.49)	N.S.
Manage to breastfeed even if my baby is crying.	2.68 (1.56)	2.38 (1.53)	2.87 (1.54)	N.S.
Depend on my family to support my decision to breastfeed.	3.18 (1.63)	3.07 (1.66)	3.25 (1.61)	N.S.

p<0.05 = significant difference (S), and p>0.05 = non-significant difference (NS)

4. Discussion

The aim of this study was to investigate the attitude to and confidence in breastfeeding among Vietnamese women. The aim was also to investigate if there was any difference in attitude to and confidence in breastfeeding between women living in a nuclear family compared to women living in an extended family. One hundred and ten women participated in this study, 38 % of them were living in a nuclear family and 62 % were living in an extended family. The women in the two groups of family types differed significantly according to age and number of people living in the household. The women who lived in an extended family were shown to be younger and lived together with a higher number of persons. The rate of women using exclusively breastfeeding as infant feeding method was low in this study, at 20 %. The results showed that the women had an attitude more in favour of breastfeeding than of formula as infant feeding method. The confidence of the women was rated between “sometimes confident” and “often confident” on the BSES. No significant differences of total score, between nuclear and extended family, in attitude to and confidence in breastfeeding were shown.

4.1. Discussion of results

The results from this study can be used as basic data when healthcare professionals, both in Sweden and in Vietnam, meet Vietnamese newly become mothers. When a woman becomes a mother, her self-care demands are increased. If she does not have the knowledge on how to take care of her and her child in the best way, her self-care ability is decreased, according to the Self-care Theory of Orem (Alligood & Marriner-Tomey, 2002; NE, 2008a). It is the healthcare professionals' task to investigate if the woman has reduced self-care ability and if she has, she should be given advises that increases this. These results showed that Vietnamese women have an attitude in favour of breastfeeding and that their confidence is rather good. Healthcare professionals should consider these factors as strengths for the Vietnamese woman's self-care ability. To be able to give advises in a cultural specific way, pursuant to Leininger's Theory of Culture Care Diversity and Universality (Alligood & Marriner-Tomey, 2002; Marriner-Tomey & Alligood, 2006), Swedish healthcare professionals should think about both the cultural context that the woman is living in and the one she is born in. The results revealed that it was common for the Vietnamese women to live in an extended family, which shows one cultural difference between Sweden and Vietnam.

Choice of infant feeding method

The rate of exclusive breastfeeding among the women in this study were lower than the rate of “almost exclusive breastfeeding”. Results from earlier studies described approximately the same rate of exclusive breastfeeding in Vietnam as was found in this study (Almroth et al., 2008; Li et al, 2002; UNICEF, 2007, 2009). The rate of exclusive breastfeeding found in this study was a bit higher than the reported rate at in Sweden for six months but much lower than the rate for four months (Socialstyrelsen, 2006). The higher rate of “almost exclusive breastfeeding” shown in this study agrees with the results from Duong, Binns et al. (2005) who stated the early introduction of complementary food as the major problem of infant feeding among Vietnamese women. This also agrees with the study by Almroth et al. (2008) and the UNICEF (2007) who investigated when infants were given supplements. Furthermore, this problem was demonstrated in this study by the fact that the women rated “Breastfeed my baby without using formula as a supplement” neutral, which was one of the lowest rates on the BSES. Therefore, Swedish and Vietnamese healthcare professionals should be aware of the fact that many Vietnamese women use supplements. The common use of supplements should be considered when advising them in infant feeding method.

A majority of the Vietnamese women lived in an extended family in this study. The results did not reveal any differences according to the choice of infant feeding method between women in NF and women in EF, though several earlier studies have pointed out this influence (Duong, Binns et al., 2005; Mistry et al., 2008; Sjögren, 2005). Sjögren (2005) stated that the opinions of the family members could make mothers who had planned to bottle feed change their mind. In addition, the results of Duong et al. (2005) showed that women living in a nuclear family earlier introduced solid food to their infant than women living in an extended family. Mistry et al. (2008) also revealed that the opinions of the family members affect the choice of the infant feeding method.

In this study, the results did not show any influence of the family on choice of infant feeding method. However, regarding earlier studies, it is important that healthcare professionals should have the influence of family in mind when advising women, because the influence of the family is important to consider in every culture. It may be even more important in a culture where it is common to live in an extended family.

Attitude

The attitude in total in this study was shown to be in favour of breastfeeding. The women seemed to have a good knowledge about the benefits of breastfeeding. The strongest agreements of the IIFAS were shown in statements concerning these issues, “Breast milk is the ideal food for babies” and “Breast milk is more easily digested than formula”. In this study, the knowledge of the women seemed to be overall good even though many women used supplements, that does not agree with the results from Shaker et al. (2004) who showed that the knowledge among women who breastfed were better than the knowledge of the women who fed their children with supplements.

Overall, the literature and recommendations worldwide state breastfeeding as the superior infant feeding method but the optimal length of exclusive breastfeeding has been discussed. WHO has changed their recommendations of length of exclusive breastfeeding after the results in the review by Kramer and Kakuma (2004). The review concluded that the optimal duration of breastfeeding is six months and not three to four months that earlier recommendations said. We think that the different recommendations could have led to misunderstandings among infant feeding mothers. In this study vietnamese women were shown to have the correct knowledge about breastfeeding as the optimal infant feeding method, but no question assessed the duration of breastfeeding, which means that no conclusion on what recommendation the women acted after, can be made.

The statement “Breastfeeding increases mother-infant bonding”, was also rated with high agreements by the women in this study. According to several studies (Lawrence & Lawrence, 2005; Weström, 2005), the women seemed to have a correct knowledge regarding to the psychological benefits of breastfeeding, but the in the overall knowledge there were found notable gaps of knowledge. The gaps are illustrated by the answers to the statement “The benefits of breast milk last only as long as the baby is breastfed”, that was rated between “strongly agree” and “agree”. WHO (2008) has stated several examples of the long-term benefits of breastfeeding for both the child and the mother. Therefore, the results from this study are valuable information for the Vietnamese health care professionals as verification on the quality of counselling provided to the Vietnamese women. The results also give healthcare professionals, in both Sweden and Vietnam, a reminder that it is important to inform new become mothers not only about the direct benefits of breastfeeding but also about the long-term profits from this infant feeding method.

The women in NF rated “Breast milk is cheaper than formula.” with one of the strongest agreements on the IIFAS. Rossiter and Yam (2000) described that one reason for immigrated Vietnamese women to give their infant formula instead of breast milk were that they in their new country had the financial opportunity to choose this more expensive alternative. When Vietnam’s economy is developing, we believe that this concern need to be noticed because an improved economic situation among the people may decrease the exclusive breastfeeding rate further, if no intervention are made.

The results in this study showed that the women rated the statement ”Formula feeding is the better choice if a mother plans to go out to work”, close to “agree”. That work is an aspect influencing on the infant feeding method have been shown by Babington and Patel (2008) and UNICEF (2004). This means that the Vietnamese mothers think that formula feeding is a better choice if the mother plans to go out to work, and therefore the developing of the country and the women’s liberation may influence the breastfeeding rate in the same way as the economic development.

There were found no differences concerning attitude between the women of the two groups, NF and EF, in this study. Sjögren (2005) has described the support from fathers and other relatives given to the women which can affect her attitude. Losch et al. (1995) showed that attitudes of the mother’s social network influenced her choice of infant feeding method. We think that living in an extended family could have a supportive influence on the women and their children which can be used as a resource when counselling the women and other family members on infant feeding methods, as it has been shown in several studies (Duong, Binns et al., 2004, 2005; Duong, Lee et al., 2005; Hien & Kam, 2008; Mistry et al., 2008).

Confidence

The results of this study showed that the Vietnamese women had a confidence rated between “sometimes confident” and “often confident” on the BSES. The result of Blyth et al. (2004) declared that most of the Australian women felt confident in breastfeeding. Bergström and Zyto (2008) showed that Thai mothers also had a good confidence in breastfeeding. The earlier measures of the confidence in breastfeeding of Vietnamese women by Duong et al. (2004) indicated that most of them felt self confident. The rate of confidence among the women in this study is approximately the same as the rate of women in other countries (Bergström & Zyto, 2008; Blyth et al., 2004; Duong et al., 2004). The total BSES score of

this study, 126, were below the limit for a low value, 130, suggested by Creedy et al. (2003). This advocates that improvements of the confidence among Vietnamese women can be made by interventions of healthcare professionals and thereby it is possible that the rate of breastfeeding initiation and duration increases.

The statement which the women rated with the lowest confidence was “Comfortably breastfeed in public places”. The confidence was rated between “not confident” and “neutral”. Not being comfortable with breastfeeding in public places has been shown to have a negative influence on the choice of exclusive breastfeeding by Duong, Lee et al. (2005). The discomfort of breastfeeding in public places among the women in this study is considered to be depending on the cultural context of Vietnam. The opinion of the Vietnamese women differs much from Swedish women who are affected by the cultural context of Sweden. Healthcare professionals need to be concerned about this cultural difference when the two cultures meet, for example when a Vietnamese woman immigrates to Sweden.

The only difference between the women in the two groups, NF and EF, concerning confidence in this study was that the women in NF rated a higher confidence in the statement “Manage the breastfeeding situation to my satisfaction”, than the women in EF. There was a similar tendency of a higher confidence of women in NF, in many other statements. The results of this study are contradicted to the results of Ekström et al. (2003) who showed that social support, for example from grandmothers, improved the confidence of the women. According to Ekström et al. (2003), the women living in an extended family would be the one with higher rated confidence. We reckon that the tendency of a higher confidence among women in NF, might have to do with the traditions in Vietnamese culture and the economic situation, where few newly become parents have the opportunity to live independently. The women living in NF were also shown to be older. Therefore, the women who have the opportunity to live independently may also be more life experience, which could improve their confidence.

4.2. Implementation for healthcare professionals

This study revealed information about the Vietnamese women’s attitude to and confidence in breastfeeding. The authors believe that this information is useful for healthcare professionals, both in Sweden and Vietnam, while giving counselling to Vietnamese women about breastfeeding. Sjögren (2005) showed that healthcare professionals play a part in the

women's decision making of infant feeding method. According to the reclaims of WHO (1981), mothers have the right to get infant feeding counselling and the government are obliged to see to that they get it in a proper way. However, lack of knowledge and incorrect advices from health care professionals has been shown to be a reason for non-exclusive breastfeeding in studies by Almroth et al. (2008) and Sjögren (2005). The contents of the above mentioned literature give healthcare professionals both an opportunity and a responsibility to counsel women in an adequate way.

Vietnam

The Hospital of University of Medicine and Pharmacy in Ho Chi Minh City are not a part of the Baby-Friendly Hospital Initiative (BFHI). Taking part of the BFHI and adapting the “Ten steps to successful breastfeeding” is a constructive way for the healthcare professionals to work after, in order to follow the WHO (2009) recommendations of exclusive breastfeeding as the superior infant feeding method. The “Ten steps to successful breastfeeding” are also a way to help the healthcare professionals to give the women the tools she needs to take care of herself and her child which is according to the Orem's Self-care Theory (Alligood & Marriner-Tomey, 2002). Unfortunately, the study by Li et al. (2002), showed that hospitals in Ho Chi Minh City, despite commitment to the BFHI, did not always follow the recommendations concerning breastfeeding counselling. Therefore, if The Hospital of University of Medicine and Pharmacy takes a part in the BFHI, the implementation of the policies has to be followed up. In addition, taking part of the BFHI could lead to improvements in both the attitude to and confidence in breastfeeding of the women visiting the hospital.

Sweden

When giving counselling to immigrated women, healthcare professionals must consider the women as individuals and as a part of a cultural context, in order to show respect for their choice of infant feeding method. To be able to advice women from different cultural backgrounds, in breastfeeding, the Theory of Culture Care Diversity and Universality by Leininger (Alligood & Marriner-Tomey, 2002) describes that it is important for healthcare professionals to respect the consisting differences. Women who are born in one cultural context and living in another, are influenced by two cultures which can lead to confusion

when traditions contradict each other. The healthcare professionals should in those situations give information that helps the women to make a decision that is congruent with both cultures and the women's own beliefs.

In the study of Rossiter & Yam (2000), the Vietnamese immigrated women suggest cultural specific breastfeeding counselling by bilingual nurses. Influenced by Leininger's Theory of Culture Care Diversity and Universality (Allgood & Marriner-Tomey, 2002), we think that having respect for the cultural diversities is of the same importance as to reach over the barriers of language.

4.3. Method discussion

A quantitative method was used in this study. Very little knowledge consisted about the attitude to and confidence in breastfeeding in the population of women in Ho Chi Minh City and the quantitative method made it possible to investigate a big sample which made the results possible to generalize (Ejlertsson, 2003). Though, a limitation in the generalization is that this study was conducted in the biggest city of Vietnam and the results therefore demonstrate the opinions of urban women. In Vietnam, 75% of the people live in rural areas (Shia, 2008) and to be able to generalize the results for all Vietnamese women, it would be necessary to conduct a similar study in a rural area.

The two scales for measuring attitude and confidence are both controlled for reliability and validity by Chambers (2007) and Dennis and Faux (1999), which make the results in this study trustworthy. Both scales are also using a predictor that is possible for healthcare professionals to influence and therefore it is relevant to use these predictors (Dennis & Faux, 1999; Losch et al., 1995). The translation has been checked by two teachers and one of them had the focus of making the translation not only correct but also understandable in allusions for the Vietnamese women. The teacher who made this check is a midwife and she was therefore suitable for this task when she meets many women and has a good knowledge in the subject of infant feeding.

The women were recruited to participate in this study while visiting a children's health centre. The main reason for visiting the center was vaccinations for the children. On the health center, needed vaccinations for children are free. Visits at the clinic for other reasons than vaccinations, the women have to pay themselves. Due to this, it is possible that wealthier women are visiting the centre more often than poor women. The sample in this study could

therefore consist of more wealthy mothers than the whole population. A known problem with samples from waiting rooms are that people who visit a center often, has a higher probability to participate in the study and they may not share the same opinions as people who seldom visit (Ejlertsson, 2003). The low rate of the falling of, 11 women, are not considered to affect the results. The reasons for declining were lack of time and/or language misunderstandings.

Due to the language barrier, between the participants and us, a Vietnamese teacher helped when the women had difficulties concerning the questionnaire. Before handing out the questionnaire the content was discussed with the translator, us and the teacher. Even though this was discussed, the teacher who helped the women could have had an influence on the results.

The question in the demographic part regarding infant-feeding method do not specify for how many months it is concerning. The Vietnamese translator believed that the Vietnamese word for infant imply six months. Despite that we believe that misunderstanding could have occurred according to the duration and the reported infant feeding methods in our study is therefore not completely reliable.

There was often a misunderstanding in the question concerning type of family. The women often chose nuclear family even though, when we ask them, they said that their grandmother lived in their household. Due to this, we checked when the marital status, the number of children and the number of people living in household did not summarize to type of family. If it was obvious that a misunderstanding had occurred the answers were corrected and if it was possible the women were asked to clarify their answers.

Both the IIFAS and the BSES contain questions that may be perceived as sensitive. The two scales are both pro-breastfeeding and can therefore be found as offending to the women who bottle feed their infants. This was not noted as a problem but some women who declined participation explained it by the fact that they bottle fed their infant and for that reason thought that the questionnaire did not concern them.

To perform further research in this issue, the results from our study can be used for performing a qualitative study. A qualitative study is suitable for this objective because it can more deeply describe what thoughts, feelings and traditions that lay the base for the women's attitude to and confidence in breastfeeding. With that knowledge it would be possible to perform interventions with the goal to improve the rate of exclusive breastfeeding among Vietnamese women.

5. Conclusion

The conclusion from this study was that the urban Vietnamese women have an attitude in favour of breastfeeding and a confidence that is considered as rather good but there are improvements that can be made. These results can be useful for healthcare professionals, in Vietnam and Sweden, when counselling new become mothers in views of the Orem's Self-care Theory. The results can also be used, by Swedish healthcare professionals, as a valuable tool to advise Vietnamese women in a cultural congruent way, according to the Theory of Cultural Care Diversity and Universality by Leininger. In addition, the tool can help healthcare professionals in both countries to advice newly become mothers in a way that improves the rate of exclusive breastfeeding for six months. Further research should be carried out in order to find out the reasons why the attitude to and the confidence in breastfeeding not were higher among Vietnamese women.

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7. References

- Allgood, M.R. & Marriner-Tomey, A. (2002). *Nursing theory : utilization and application*. St. Louis, Mo. Mosby, cop.
- Almroth A., Arts M., Dinh Quang N., Thi Thuy Hoa, P. & Williams, C. (2008). Exclusive breastfeeding in Vietnam: an attainable goal. *Acta Paediatrica*, 97(8), 1066-9. Retrieved from PubMed database.
- Babington, L. & Patel, B. (2008). Understanding child feeding practices of Vietnamese mothers. *MCN. The American Journal of Maternal Child Nursing*, 33(6), 376-81. Retrieved from PubMed database.
- Bergström, E. & Zyto, M. (2009). *Attitudes to and confidence in breastfeeding and perceptions of insufficient breast milk among Thai mothers*. Thesis on C-level. Uppsala University, Uppsala. Department of public health and caring sciences.
- Blyth, R.J., Creedy, D.K., Dennis, C.L., Moyle, W., Pratt, J., De Vries, S.M. et al. (2004). Breastfeeding duration in an Australian population: the influence of modifiable antenatal factors. *Journal of Human Lactation*, 20(1), 30-8. Retrieved from PubMed database.
- Chambers, J. A. (2007). A systematic review of measures assessing mothers' knowledge, attitudes, confidence and satisfaction toward breastfeeding. *Breastfeeding Review: professional publication of the Nursing Mothers' Association of Australia*, 15(3), 17-25. Retrieved from PubMed database.
- Creedy, D., K., Dennis, C.-L., Blyth, R., Moyle, W., Pratt, J. & DeVries, S. M. (2003). Psychometric Characteristics of the Breastfeeding Self-Efficacy Scale: Data from an Australian Sample. *Research in Nursing and Health*, 26(2), 143-52. Retrieved from PubMed database.
- Dennis, C.-L. (1999). Theoretical underpinnings of breastfeeding confidence: A self-efficacy framework. *Journal of Human Lactation*, 15, 195-201. Retrieved from PubMed database.
- Dennis, C.-L. (2003). The Breastfeeding Self-Efficacy Scale: Psychometric Assessment of the Short Form. *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, 32(6), 734-44. Retrieved from PubMed database.

- Dennis, C.-L. & Faux S. (1999). Development and Psychometric Testing of the Breastfeeding Self-Efficacy Scale. *Research in Nursing and Health*, 22(5), 399-409. Retrieved from PubMed database.
- Duong, D.V., Binns, C.W. & Lee, A.H. (2004). Breast-feeding initiation and exclusive breast-feeding in rural Vietnam. *Public Health Nutrition*, 7(6), 795-799. Retrieved from PubMed database.
- Duong, D.V., Binns, C.W. & Lee, A.H. (2005). Introduction of complementary food to infants within the first six months postpartum in rural Vietnam. *Acta Paediatrica*, 94, 1714-1720. Retrieved from PubMed database.
- Duong, D.V., Lee, A.H. & Binns, C.W. (2005). Determinants of breast-feeding within the first 6 months post-partum in rural Vietnam. *Journal of Paediatrics and Child Health*, 41, 338-343. Retrieved from PubMed database.
- Ekström, A. (2005). *Breastfeeding and quality of care*. Thesis of doctoral degree. Karolinska Institutet, Stockholm. Department of Women and Child health.
- Ekström, A., Widström, A.M. & Nissen, E. (2003). Breastfeeding support from partners and grandmothers: perceptions of Swedish women. *Birth*, 30(4), 261-6. Retrieved from PubMed database.
- Ejlertsson, G. (2003). *Statistik för hälsovetenskaperna*. Lund: Studentlitteratur.
- Fawcett, J. (1993). *Analysis and Evaluation of Nursing Theories*. Philadelphia: F.A. Davis comp.
- Hien, N.N. & Kam, S. (2008). Nutritional status and the characteristics related to malnutrition in children under five years of age in Nghean, Vietnam. *Journal of Preventive Medicine and Public Health*, 41(4), 232-40. Retrieved from PubMed database.
- International Council of Nurses. (2007). *Code of Ethics for Nurses*. International Council of Nurses.
- Kramer, M.S. & Kakuma, R. (2002). Optimal duration of exclusive breastfeeding. *Cochrane Database of Systematic Reviews 1*. Art. No.: CD003517. doi.: 10.1002/14651858.CD003517.
- Lawrence, R. A. & Lawrence, R. M. (2005). *Breastfeeding: A Guide for the Medical Profession*. St Louis. Mosby.

- Li, L., Lan, D.T.P., Hoa, N-T. & Ushijma, H. (2002). Prevalence of breast-feeding and its correlates in Ho Chi Minh City, Vietnam. *Pediatrics International: official journal of the Japan Pediatric Society*, 44, 47-54. Retrieved from PubMed database.
- Losch, M., Dungy, C.I., Russell, D. & Dusdieker, L.B. (1995). Impact of attitudes on maternal decisions regarding infant feeding. *The Journal of Pediatrics*, 126(4), 507-14. Retrieved from PubMed database.
- MacLachlan, H.L. & Forster, D.A. (2006). Initial breastfeeding attitudes and practices of women born in Turkey, Vietnam and Australia. *International Breastfeeding Journal*, 1, 7. doi:: 10.1186/1746-4358-1-7
- Marriner-Tomey, A. & Alligood, M.R. (2006). *Nursing Theorists and Their Work*. St. Louis, Mo. Mosby, cop.
- Mistry, Y., Freedman, M., Sweeney, K. & Hollenbeck, C. (2008). Infant-Feeding Practices of Low-Income Vietnamese American Women. *Journal of Human Lactation*, 24, 406. doi:: 10.1177/0890334408318833.
- Mora, A. de la, Rusell, D. W., Dungy, C. I., Losch, M. & Dusdieker, L. (1999). The Iowa Infant Feeding Attitude Scale: Analysis of reliability and validity. *Journal of Applied Social Psychology*, 29, 2362–80.
- Nationalencyklopedin. (2008a). Dorothea E Orem. Stockholm: Nationalencyklopedin From <http://www.ne.se/artikel/777118>. Retrieved the 10th of Januray 2009.
- Nationalencyklopedin. (2008b). Vietnam. Stockholm: Nationalencyklopedin. From <http://www.ne.se/artikel/342676>. Retrieved the 10th of Januray 2009.
- Newman-Giger, J. & Davidhizar, R.E. (1999). *Transcultural nursing. Assessment & Intervention* (3rd ed.). St Louis. Mosby Inc.
- Rossiter, J.C. & Yam, B.M.C. (2000). Breastfeeding: How can it be enhanced? The perceptions of vietnamese women in Sydney, Australia. *Journal of Midwifery and Women's Health*, 45, 3, 271-276. Retrieved from PubMed database.
- Shaker, I., Scott, J.A.& Reid, M. (2004) Infant feeding attitudes of expectant parents: breastfeeding and formula feeding. *Journal of Advanced Nursing*, 45(3), 260-8. Retrieved from PubMed database.

Shia. (2008). *Vietnam*. Svenska Handikapporganisationers Internationella Biståndsförening. From <http://www.shia.se/index.php?l=sv&p=285>. Retrieved the 22th of April 2009.

Sittlington, J., Stewart-Knox, B., Wright, M., Bradbury, I. & Scott J.A. (2007). Infant-feeding attitudes of expectant mothers in Northern Ireland. *Health Education Research*, 22(4), 561-70. Retrieved from PubMed database.

Sjögren, B. (2005). *Psykosocial obstetrik*. Lund: Studentlitteratur.

Socialstyrelsen. (2005). *Kompetensbeskrivning för legitimerad sjuksköterska*. Stockholm: Socialstyrelsen.

Socialstyrelsen. (2006). *Amning av barn födda 2006*. Stockholm: Socialstyrelsen.

UNICEF. (2004). *Exclusive Breastfeeding – Safe, Sound and Sustainable, says UNICEF*. UNICEF. From http://www.unicef.org/vietnam/media_522.html, Retrieved the 13th of April 2009.

UNICEF. (2007). *Breastfeeding within one hour of birth can significantly reduce infant mortality in Viet Nam*. UNICEF. From http://www.unicef.org/vietnam/media_7147.html. Retrieved the 13th of April 2009.

UNICEF. (2009). *The children in Viet Nam*. UNICEF. From <http://www.unicef.org/vietnam/children.html>. Retrieved the 13th of April 2009.

Utrikespolitiska institutet. (2006). *Länder i fickformat: Asien nr 807. Vietnam*. Stockholm: Utrikespolitiska institutet.

Weström, L. (2005). *Obstetrik och gynekologi: klinik och vård*. Lund: Studentlitteratur.

World Health Organization. (1981). *International Code of Marketing of Breast-milk Substitutes*. Geneva: World Health Organization.

World Health Organization. (1998). *Evidence for the ten steps to successful breastfeeding*. Geneva, 1998. Geneva: World Health Organization.

World Health Organization. (2006a). *Mortality profile Sweden*. Geneva: World Health Organization. From http://www.who.int/whosis/mort/profiles/mort_euro_swe_sweden.pdf Retrieved the 11th of January 2009.

World Health Organization. (2006b). *Mortality profile Vietnam*. Geneva: World Health Organization. From http://www.who.int/whosis/mort/profiles/mort_wpro_vnm_vietnam.pdf Retrieved the 11th of January 2009.

World Health Organization. (2008). Fact file: 10 facts on breastfeeding. <http://www.who.int/features/factfiles/breastfeeding/en/> Retrieved the 6th of May, 2009.

World Health Organization. (2009). *Exclusive breastfeeding*. Geneva: World Health Organization. From http://www.who.int/nutrition/topics/exclusive_breastfeeding/en/ Retrieved the 11th of January 2009.

World Medical Association. (2004). *Declaration of Helsinki*. World Medical Association.

Appendix 1a. Questionnaire (English)

Attitude to and confidence in breastfeeding among Vietnamese mothers in Ho Chi Minh City

The questionnaire is divided into three parts: Background information, infant feeding attitude and breastfeeding confidence. Please mark (X) your answer for every question.

Background information

1. Religion Buddhist
 Christian
 Ancestors
 Other, _____
2. Age _____ years.
3. Marital status Married
 Separated
 Divorced
 Widowed
 De facto married
4. Education Primary school
 Secondary school
 Certificate
 Bachelor
 Other, _____
5. Occupation Worker
 Government officer
 Technician
 Merchant
 Farmer
 Gardener
 House duty at home
 Other, _____
6. a. Type of family Nuclear family (live with husband and children)
 Extended family (live with husband and children, and other relatives)
b. Where do you live? Ho Chi Minh City
 Other, _____
7. a. Total number of pregnancies _____ b. Total number of children _____
c. Have you had difficulty of delivery your baby?
 No
 Yes, please, specify _____
c. Type of delivery Vaginal
 Cesarean section
8. How many people live in your household? _____

9. Infant feeding method
- Exclusive breastfeeding
 - Almost exclusive breastfeeding
 - High partial breastfeeding
 - Partial breastfeeding
 - Token breastfeeding
 - Bottle-feeding

Iowa Infant Feeding Attitude Scale (IIFAS)

10. What is your opinion about infant feeding?

	Strong agreement			Strong disagreement	
1. The benefits of breast milk last only as long as the baby is breastfed.	1	2	3	4	5
2. Formula feeding is more convenient than breast feeding.	1	2	3	4	5
3. Breastfeeding increases mother-infant bonding.*	1	2	3	4	5
4. Breast milk is lacking in iron.	1	2	3	4	5
5. Formula fed babies are more likely to be over fed than breast fed babies.*	1	2	3	4	5
6. Formula feeding is the better choice if a mother plans to go out to work.	1	2	3	4	5
7. Mother who formula feed miss one of the great joys of motherhood.*	1	2	3	4	5
8. Women should not breastfeed in public places such as restaurants.	1	2	3	4	5
9. Breast fed babies are healthier than formula fed babies. *	1	2	3	4	5
10. Breastfed babies are more likely to be over fed than babies formula fed.	1	2	3	4	5
11. Fathers feel left out if a mother breastfeeds.	1	2	3	4	5
12. Breast milk is the ideal food for babies.*	1	2	3	4	5
13. Breast milk is more easily digested than formula.*	1	2	3	4	5
14. Formula is as healthy for an infant as breast.	1	2	3	4	5
15. Breast milk is more convenient than formula feeding.*	1	2	3	4	5
16. Breast milk is cheaper than formula.*	1	2	3	4	5
17. A mother who occasionally drinks shouldn't breastfeed.	1	2	3	4	5

Breastfeeding Self-Efficiency Scale (BSES)

11. What confidence do you have in your breastfeeding?

	Not at all confident			Always confident	
Intrapersonal Thoughts					
1. Continue to breastfeed my baby for every feeding.	1	2	3	4	5
2. Feed my baby with breast milk only.	1	2	3	4	5
3. Manage to keep up with my baby's breastfeeding demands.	1	2	3	4	5
4. Stay motivated to breastfeed my baby.	1	2	3	4	5

5. Breastfeed my baby without using formula as a supplement.	1	2	3	4	5
6. Keep feeling that I really want to breastfeed my baby for at least 6 weeks.	1	2	3	4	5
7. Refrain from bottle feeding for the first 4 weeks.	1	2	3	4	5
8. Maintain my milk supply by using the “supply and demand” rule.	1	2	3	4	5
9. Be satisfied with my breastfeeding experience.	1	2	3	4	5
10. Keep wanting to breastfeed.	1	2	3	4	5
11. Motivate myself to breastfeed successfully.	1	2	3	4	5
12. Successfully cope with breastfeeding like I have with other challenging tasks.	1	2	3	4	5
13. Focus on getting through one feed at a time.	1	2	3	4	5
14. Manage the breastfeeding situation to my satisfaction.	1	2	3	4	5
15. Determine that my baby is getting enough milk.	1	2	3	4	5
16. Monitor breast milk by keeping track of my baby’s urine and bowel movements.	1	2	3	4	5
17. Accept the fact that breastfeeding may temporarily limit my freedom.	1	2	3	4	5
18. Deal with the fact that breastfeeding can be time consuming	1	2	3	4	5
Technique					
19. Position my baby correctly at my breast.	1	2	3	4	5
20. Ensure that my baby is properly latched on for the whole feeding.	1	2	3	4	5
21. Hold my baby comfortably during breastfeeding	1	2	3	4	5
22. Recognize the signs of a good latch	1	2	3	4	5
23. Keep my baby awake at my breast during a feeding.	1	2	3	4	5
24. Feel if my baby is sucking properly at my breast.	1	2	3	4	5
25. Take my baby off the breast without pain to myself.	1	2	3	4	5
26. Recognize when my baby is finished breastfeeding.	1	2	3	4	5
27. Finish feeding my baby on one breast before switching to the other breast.	1	2	3	4	5
28. Comfortably breastfeed in public places.	1	2	3	4	5
29. Manage to breastfeed even if my baby is crying.	1	2	3	4	5
30. Feed my baby every 2-3 hours.	1	2	3	4	5
31. Comfortably breastfeed with my family members present.	1	2	3	4	5
32. Depend on my family to support my decision to breastfeed.	1	2	3	4	5
33. Count on my friends to support my decision to breastfeed.	1	2	3	4	5

Thank you for your answers!

Appendix 1b. Questionnaire (Vietnamese)

**Thài ñoã, niềm tin, và nhàn thòuc về việac cho con bù sỗa meì ôu
caùc Baø meì taiì vương thaønh thò-Vieät nam**

Baø caâu hoùì naøy ñoõic chia laøm 3 phaàn: Thoâng tin neàn, thài ñoã cho treù bù, sỗi tỗi tin khi cho treù bù.

Vui loøng ñaùng ðaáu **X** vào phaàn traù lôøi cuõa baìn cho meì caâu hoùì ðoõu ñaây.

Thoâng tin neàn

1. Toãn giaùo

- Phaät giaùo.
- Thieân Chuõa giaùo.
- Thòø OÃng Baø.
- Toãn giaùo khàuc, _____

2. Tuõai

_____ Tuõai.

3. Tình traìng hoãn nhàn

- Ñão laáp gia ñinh.
- Ly thaân.
- Ly ðo.
- Gòa bùi.
- Sỗng chung.

4. Trình ñoã hoìc vaán

- Tieâu hoìc.
- Trung hoìc cô sỗu.
- Trung hoìc phoả thoâng.
- Cao ñaúng, Ñaì Hoìc.
- Khaùc, _____

5. Ngheà nghiệp

- Công nhàn.
- Công chòuc nhaø ñoõuc, tỗ nhàn.
- Kyõ thuaät vieân.
- Buoãn baùn.
- Noâng ðaân.
- Laøm vồõn.
- Nội trợ.
- Khaùc, _____

6. a. Loãì gia ñinh

- Gia ñinh tieâu bieâu (Või choàng & con caùi).
- Gia ñinh nhieàu theá heã(Või choàng, con caùi & hoì haøng).

b. Baìn soáng ôu ñaây?

- Tp. Hoà Chí Minh.
- Khaùc, _____

7. a. Soá làn mang thai _____.

b. Soá con coøn soáng _____.

c. Baìn coù gặp kho khã ñi khi sanh khoàng ?

- d. Hình thức sanh
- Không.
 - Nếu có, xin ghi rõ _____
 - Thờ ờng.
 - Sanh mỏ.

8. Có bao nhiêu ngòøi sóng trong gia ñình? _____

9. Cách thờ ờc cho trẻ bu
- Bu sỏa mẽi hoặ ờn toặ ờn.
 - Cho bu sỏa mẽi 2/3 thờ ời gian.
 - Cho bu sỏa mẽi mỏt phầ ờn.
 - Cho bu qua loa, chieáu le.
 - Bu bình hoặ ờn toặ ờn.

Bảng ñánh giá thầi ñỏ cho trẻ ờn

10. Bả ờn có y kiế ờn gì về vieć cho trẻ ờn ?

Rất ñỏng y
ỏng y

Rất không

1. Lờ ời í ờch củ ờa vieć bu sỏa mẽi sẽ keò daøi mieĩn lạ ờ ñỏu trẻ ñỏðic cho bu.	1	2	3	4	5
2. Cho bu sỏa bình thì tieĩn lờ ời hờn cho bu sỏa mẽi.	1	2	3	4	5
3. Cho bu sỏa mẽi lạ ờm gia taẽng tình củ ờm giỏð ờ mẽi vặ ờ con.	1	2	3	4	5
4. Sỏa mẽi thì không ñuũ chấ ờt sắ ờt.	1	2	3	4	5
5. Trẻ bu sỏa bình có thể phầ ờn triẻ ờn toấ ờn hờn trẻ bu sỏa mẽi.	1	2	3	4	5
6. Sỏa hoặ ờn lạ ờ sỏi lờ ờa chỏ ờn toấ ờn hờn nếu bặ ờ mẽi có ke ờ hoặ ờ ñi lạ ờm.	1	2	3	4	5
7. Bặ ờ mẽi cho bu sỏa hoặ ờn sẽ ñỏnh má ờt ñieĩm vui lờ ờn củ ờa củ ờc ñỏði lạ ờm mẽi.	1	2	3	4	5
8. Bặ ờ Mẻi không ñeĩn cho bu sỏa mẽi ôu ñỏðng ñỏi công củ ờng ñỏ ôu ñỏặ ờ hặ ờng.	1	2	3	4	5

9. Treû buù söða meï thì khoeû mãnh hôn laø treû buù söða bình.	1	2	3	4	5
10. Treû buù söða meï thì cou theá buï baãm hôn treû buù söða hoäp.	1	2	3	4	5
11. Ngöôøi cha caùm thaáy bò boù queân neáu baø meï cho treû buù söða meï.	1	2	3	4	5
12. Söða meï laø thöüc aên lyù töôùng cho treû.	1	2	3	4	5
13. Söða meï thì deã tieäu hoùa hôn laø söða hoäp.	1	2	3	4	5
14. Söða hoäp cuõng boá döôõng cho treû nhö laø söða meï.	1	2	3	4	5
15. Söða meï thì tieän löiï hôn söða hoäp.	1	2	3	4	5
16. Söða meï thì reû hôn söða hoäp.	1	2	3	4	5
17. Ngöôøi meï thænh thoaùng uoáng röôiu bia thì khoâng neân cho con buù.	1	2	3	4	5

Bảng đánh giá hiệu quả của việc cho bú sữa mẹ

11. Bạn suy nghĩ gì về sự tự tin trong việc cho trẻ bú sữa mẹ của bạn?

Không tự tin

Luôn tự tin

Câu nói của nhân					
	1	2	3	4	5
1. Tiếp tục cho trẻ bú khi trẻ có nhu cầu.	1	2	3	4	5
2. Chăm sóc sữa mẹ để nuôi trẻ.	1	2	3	4	5
3. Cho trẻ bú mẹ theo nhu cầu của trẻ.	1	2	3	4	5
4. Nâng viên dạ dày mẹ cho trẻ bú.	1	2	3	4	5
5. Cho trẻ bú mẹ mà không cần dùng sữa hộp bổ sung.	1	2	3	4	5
6. Tôi cảm thấy rằng tôi thất vọng cho trẻ bú ít nhất là 6 tuần.	1	2	3	4	5
7. Hiện chế việc bú sữa bình trong 4 tuần đầu.	1	2	3	4	5
8. Duy trì nguồn sữa mẹ bằng cách cho bú mẹ theo yêu cầu.	1	2	3	4	5
9. Hài lòng với việc cho bú sữa mẹ.	1	2	3	4	5
10. Tôi luôn mong muốn cho con bú sữa mẹ.	1	2	3	4	5
11. Tôi nâng viên mình để việc cho con bú thành công.	1	2	3	4	5
12. Thành công khi cho con bú cũng giống như tôi nâng viên nhận những thử thách khác.	1	2	3	4	5
13. Tập trung cho trẻ bú một lần vào một thời điểm nhất định.	1	2	3	4	5
14. Tôi hài lòng với việc cho con bú sữa mẹ.	1	2	3	4	5
15. Chắc chắn rằng con tôi bú no.	1	2	3	4	5
16. Theo dõi lượng sữa mẹ bằng cách theo dõi lượng nước tiểu & số tiêu của trẻ.	1	2	3	4	5
17. Chấp nhận việc cho bú sữa mẹ có thể mất thời gian hiện chế tôi do của tôi.	1	2	3	4	5
18. Việc cho bú sữa mẹ có thể mất thời gian nhưng tôi vẫn cho con bú sữa mẹ.	1	2	3	4	5

Kỹ thuật					
19. Năët trêu tồ theá ñuùng khi cho bù.	1	2	3	4	5
20. Chaéc chaén raèng trêu ngaãm chaéc ñààu vuù trong luùc cho bù.	1	2	3	4	5
21. Giõõ trêu tồ theá thoáúi maùi trong luùc cho trêu bù.	1	2	3	4	5
22. Nhaän bieát ñöôïc daáu hieäu ngaãm chaéc ñààu vuù.	1	2	3	4	5
23. Giõõ cho trêu thòuc trong luùc cho bù.	1	2	3	4	5
24. Coù caùm giaùc khi trêu bù ñuùng.	1	2	3	4	5
25. Toái khoâng caùm thaáy ñâu khi trêu rôpì vuù.	1	2	3	4	5
26. Toái nhaän bieát ñöôïc khi naøo con toái bù no.	1	2	3	4	5
27. Cho trêu bù xong möät beân vuù, tröôùc khi cho bù vuù beân kia.	1	2	3	4	5
28. Cho trêu bù thoáúi maùi ôù nôi coâng coäng.	1	2	3	4	5
29. Coù theá cho bù caù khi ñöùa trêu ñang khoùc.	1	2	3	4	5
30. Cho trêu bù möái 2-3 giôø.	1	2	3	4	5
31. Cho bù thoáúi maùi khi coù maët ngöôøi thaân trong gia ñình.	1	2	3	4	5
32. Quyéát ñònh cho con bù cuùa toái phui thuôác vaøo söï ñoäng vieân cuùa gia ñình.	1	2	3	4	5
33. Baïn beø toái hoã tröi toái quyéát ñònh vieác cho trêu bù	1	2	3	4	5

Caùm ôn söï hôp taùc cuùa baïn

Appendix 2a. Translation of the Vietnamese information letter.

Hello everybody!

We are: - Frida Westin
 - Hanna Mogensen

Students from Uppsala University - Sweden.

We expect to receive your participation in answering the questionnaire about “Attitude, Belief, and Knowledge about breastfeeding of mothers in Vietnam urban area”, so that we can gain experience of breastfeeding of Vietnamese women, from which we can take better care of Vietnamese mothers in Sweden.

Looking forward to your corporation.

Sincerely thanks!

Appendix 2b. Information letter in Vietnamese.

Kính chào các chị!

Chúng tôi tên: - Frida Westin.

- Hanna Mogensen.

Là sinh viên của trường đại học Uppsala – Thụy Điển.

Chúng tôi rất mong được sự tham gia của quý chị trả lời bộ câu hỏi về” Thái độ, niềm tin, nhận thức về việc cho con bú sữa mẹ ở các Bà mẹ tại vùng thành thị - Việt Nam” Nhằm giúp chúng tôi có thêm kinh nghiệm về việc cho con bú sữa mẹ của phụ nữ ở Việt Nam.

Từ kết quả này chúng tôi có thể chăm sóc các bà mẹ Việt Nam tại Thụy Điển được tốt hơn.

Rất mong được sự tham gia của quý chị.

Thành thật cảm ơn!