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Breast-feeding support in Ireland: a qualitative study of health-care professionals' and women's views

Barbara Whelan[1,*] and John M Kearney[2]
[1]School of Health and Related Research, University of Sheffield, Regent Court, 30 Regent Street, Sheffield S1 4DA, UK: [2]School of Biological Sciences, Dublin Institute of Technology, Dublin, Republic of Ireland

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Abstract

Objective: To examine women's experience of professional support for breast-feeding and health-care professionals' experience of providing support.

Design: We conducted semi-structured qualitative interviews among women with experience of breast-feeding and health-care professionals with infant feeding roles. Interviews with women were designed to explore their experience of support for breast-feeding antenatally, in hospital and postnatally. Interviews with health-care professionals were designed to explore their views on their role and experience in providing breast-feeding support. Interview transcripts were analysed using content analysis and aspects of Grounded Theory. Overarching themes and categories within the two sets were identified.

Setting: Urban and suburban areas of North Dublin, Ireland.

Subjects: Twenty-two women all of whom had experience of breast-feeding and fifty-eight health-care professionals.

Results: Two overarching themes emerged and in each of these a number of categories were developed: theme 1, facilitators to breast-feeding support, within which being facilitated to breast-feed, having the right person at the right time, being discerning and breast-feeding support groups were discussed; and theme 2, barriers to breast-feeding support, within which time, conflicting information, medicalisation of breast-feeding and the role of health-care professionals in providing support for breast-feeding were discussed.

Conclusions: Breast-feeding is being placed within a medical model of care in Ireland which is dependent on health-care professionals. There is a need for training around breast-feeding for all health-care professionals; however, they are limited in their support due to external barriers such as lack of time. Alternative support such as peer support workers should be provided.

Keywords
Breast-feeding
Professional support
Mothers' experience
Ireland

Despite recommendations from the WHO that infants be breast-fed for the first 6 months of life with the introduction of complementary food thereafter and continued breast-feeding for 2 years or longer[1], the rate of breast-feeding initiation in Ireland remains one of the lowest in Europe with only 55 % of women initiating breast-feeding at birth[2]. Breast-feeding is a learned behaviour and women often depend on health-care professionals for support. This is particularly the case in countries where there is not a culture of breast-feeding, such as in Ireland[3]. Current maternity services in Ireland are free to all women under the Maternity and Infant Scheme which entitles every woman to care from a general practitioner (GP) and hospital obstetrician. Midwives provide antenatal, labour and postnatal care. Once a woman is discharged from hospital, postnatal care is provided by the GP and public health nursing service.

Research has shown that women face different issues when breast-feeding such as not being adequately prepared for breast-feeding[4,5], feeling embarrassed about breast-feeding in public[6–8], perceiving insufficient milk supply[9,10] and receiving conflicting advice that subsequently undermines their confidence[11,12]. In addition, breast-feeding has been described as a 'problematic social act' whereby women try and find a balance between the act of breast-feeding and the needs, expectations and comfort of others[13]. Maternal psychological aspects such as self-efficacy[14] and intention to breast-feed[15] can also impact on breast-feeding initiation and/or duration.

Women sometimes complain about a lack of support for breast-feeding in the hospital and community[16]. Breast-feeding is a learned skill and women often depend on the skilled support of health-care professionals in the early postnatal period[17]. Health-care professionals are

*Corresponding author: Email b.whelan@sheffield.ac.uk

sometimes not the best placed to give breast-feeding support. They may lack the knowledge and confidence to do so and not have a positive attitude towards breast-feeding[18,19]. Breast-feeding is sometimes considered to be something that health-care professionals 'believe in' or not, and having this belief then leads to acquiring knowledge and supporting it[20]. Women seek consistent advice and support[21] that is practical and individualised to their needs[11,22,23]. Support, however, can be uncaring, routine, distant, standardised or rushed[24]. Labbok[25] has described the fractured messages and support that can be given for breast-feeding because of the different health-care professionals and disciplines involved. Recent research in Ireland has shown that first-time mothers depend on health-care professionals for information and many would have liked more information than they were given[3,26]. There has been no published research to date that has examined health-care professionals' and women's views of breast-feeding support in Ireland.

The purpose of the present study was to examine women's experience of professional support for breast-feeding and health-care professionals' experience of providing support in order to understand this dynamic of support and to identify how such support could be improved. Interviewing these two groups of stakeholders allowed us to explore the issue of professional support for breast-feeding from both the receivers' and the givers' viewpoints, providing us with a clearer understanding of the issue.

Methods

Sample/population

The present study was conducted in North Dublin, which has a population of 349 411 with 36 % of the population in social classes 1 and 2 (professional, managerial and technical positions) and 47 % in social classes 3, 4, 5 and 6 (non-manual, skilled manual, semi-skilled and unskilled positions)[27]. This distribution is the same as that of the general population in Ireland[27]. The study population comprised: (i) health-care professionals working in urban and suburban areas of North Dublin; and (ii) women with recent experience of breast-feeding who lived in North Dublin. The women who participated had not necessarily been treated by the health-care professionals who were interviewed. Purposive sampling was used to recruit both groups.

1. The contact details of GP, public health nurses and practice nurses were sought from the Irish College of General Practitioners, Directors of Public Health Nursing and the Irish Practice Nurses Association, respectively. A lactation consultant in the maternity hospital informed midwives, obstetricians and paediatricians about the study and also introduced the researcher to individual health-care professionals. An information letter was given/sent to a purposive sample based as far as possible on their potential to add insight into the developing categories during analysis. Initial uptake by health-care professionals who were willing to participate was low due to the time needed to do an interview; however, sampling and data collection continued until saturation was reached and categories were developed with sufficient depth. Inclusion criteria for health-care professionals were that they worked with women and their babies in the antenatal/postnatal period.
2. Women were initially recruited through public health nurses in North Dublin. They gave information sheets about the study to women who had any experience of breast-feeding in the previous year. The women could then either contact the researcher directly or give the public health nurse permission to pass on her contact details to the researcher. Initially, there was some evidence of gatekeeper bias whereby public health nurses facilitated access to women who they felt were 'good breast-feeders'. In order to overcome this the researcher emphasised the importance of interviewing women with a range of breast-feeding experience and also attended breast-feeding support groups to recruit mothers who may have been interested in participating in the study, so women were also recruited in this way. Inclusion criteria for women included being aged 18 years or over, had given birth to a healthy term baby in the past year, had initiated breast-feeding and had continued to exclusively breast-feed, mix feed (both formula and breast milk) or give formula.

Informed consent was obtained prior to participation in an interview. Ethical approval for the study was obtained from Dublin Institute of Technology Research Ethics Committee (Reference 16/08 and 20/09) and The Rotunda Hospital Research Ethics Committee.

Data collection

We conducted semi-structured qualitative interviews between May 2008 and December 2009. All interviews were recorded except in the case of four interviews with health-care professionals as they preferred not to have the interview recorded. In these cases notes were taken during and immediately after the interview. A topic guide was used for all interviews. In the case of health-care professionals questions were asked about their views on infant feeding, their experience of providing support to women who were breast-feeding and training they have received on the subject. In the case of women questions were asked generally about their experience of breast-feeding and then specifically about their experience of receiving information and support for breast-feeding in each of three key stages: antenatally, in the maternity hospital and postnatally. All interviews with health-care professionals, except for one, took place in a room in the

participant's workplace. In the case of one interview, the participant preferred to be interviewed by telephone. All interviews with women, except for two, were conducted in the women's homes. Two interviews were conducted in a parent and toddler play-group meeting.

Data analysis

All interviews were recorded, transcribed and imported into the NVivo 8 qualitative data analysis software package. The health-care professionals' responses and mothers' responses were considered separately. For each set, themes and categories were identified using content analysis and aspects of Grounded Theory: keeping a journal, writing memos, and conducting interviews and analysis in an iterative manner. The data were first analysed line by line in a process referred to as 'open coding'[28]. Coding then moved to more focused 'axial coding' whereby categories were developed based on relationships and connections between initial codes. This process was aided by keeping a research journal, writing memos and using the model function in NVivo; and in keeping with Grounded Theory methods, it was conducted in a cyclical manner and not sequentially. Through the process of initial coding, writing memos and modelling, coding became less disjointed and more focused, leading to the development of categories and themes. Categories were grouped under themes, with the themes labelling the data in a more interpretive way. Data collection and analysis continued until no new categories appeared in the interviews and all were developed with some depth and variation. Overarching themes and categories within the two sets were then identified and these are presented below.

Results

Twenty-two women were interviewed. Eleven women were exclusively breast-feeding (infant receives only breast milk) at the time of the interview. Four women were complementary feeding (breast milk and any other food or liquid, including formula, given at 6 months of age or beyond). The remaining seven women had breast-fed (breast milk and any food or formula) for 3–7·5 months and had stopped by the time of the interview. Thirteen of the women were primiparous and nine were multiparous. The majority of women (*n* 20) had tertiary level of education and two had secondary level. All were aged 25 years or older, with the majority between 30 and 34 years (*n* 13). Fifty-eight health-care professionals were interviewed, the majority of whom were female (*n* 55) and included GP (*n* 8), public health nurses (*n* 15), midwives (*n* 19), practice nurses (*n* 4), obstetricians (*n* 6) and paediatricians (*n* 6). The majority of participants were Irish (*n* 49) and between 30 and 50 years of age. Interviewees ranged from having only a few months of clinical experience to having over 30 years, with the majority (*n* 31) having 10–29 years' experience.

Two overarching themes were identified with regard to breast-feeding support: facilitators to breast-feeding support and barriers to breast-feeding support. In each of these a number of categories were developed. Quotations for the women are presented below with a pseudonym, age of their baby at time of interview and how they were feeding their baby, in parentheses.

Theme 1: Facilitators to breast-feeding support

Women reflected on their personal experience of breast-feeding and what facilitated them in doing it. Health-care professionals also discussed aspects of their job that facilitated them in supporting women with breast-feeding.

Being facilitated to breast-feed

Women appreciated when health-care professionals encouraged them to breast-feed and were able to give them advice and practical help with latching the baby on, particularly in the early days:

> 'The midwives in the delivery suite were great, they put her on straight away and they were really good about getting skin-to-skin contact.' (Sarah, 10 weeks and still exclusively breast-feeding)

They also liked when health-care professionals were 'down to earth' and could meet them 'where they were at' with breast-feeding, not imposing their own views on women, nor being prescriptive with their advice. Some women felt that health-care professionals could facilitate them better if they had had personal experience of breast-feeding; however, others felt that this was not important. This contrast was also seen among health-care professionals with some of those who had breast-fed feeling more assured in their knowledge about breast-feeding, particularly the practical aspects:

> 'I think a person that has breast-fed and has been successful in breast-feeding certainly has a lot more insight into it and I think the practical issues of you know positioning and you know that things settle down after a couple of weeks.' (Practice nurse 1)

However, the health-care professionals who had received training around breast-feeding were less likely to think it was a problem if they did not have personal experience of breast-feeding.

Having the right person at the right time

Many women described instances of having the right person at the right time to help them through a difficulty they had with breast-feeding:

> 'When I hear people saying it didn't work out for me that's where I feel, I feel like alarm bells in my head saying that is because there wasn't the right help

given, it wasn't in place for her. I was so lucky to have had the right people at the right time who could advise me from the start.' (Annie, 5 weeks and still partially breast-feeding)

This person was usually a health-care professional, in particular a midwife or public health nurse, and women singled them out for providing consistent help and support, giving them the skills and confidence to breast-feed. Sometimes as a result of meeting this person, women who were on the verge of discontinuing breast-feeding were supported to continue:

'The public health nurse mentioned that there was a breast-feeding nurse in the area and I rang her and she came that afternoon and from then on my experience completely changed. I mean I had been thinking about giving up because I was so, I felt so bad at it and I didn't know how much milk he was getting and at the same time I was racked with guilt, thinking why can't I do it.' (Stacey, 7½ months and breast-fed exclusively for 6 months)

Health-care professionals had different levels of 'commitment' or 'ownership' towards breast-feeding and this manifested itself in some seeking out training in breast-feeding, keeping up-to-date with the latest research and supporting women as best they could. Such commitment was expressed more by maternity staff and public health nurses than by any of the other professions interviewed, which is in line with women's comments above; however, it was sometimes compromised by busy schedules and heavy workloads:

'You need a lot of commitment in breast-feeding which is a bit difficult in the very busy hours.' (Midwife 1)

Being discerning

Health-care professionals expressed different levels of confidence in providing breast-feeding support with public health nurses and midwives generally expressing more confidence than doctors, describing themselves as 'confident' and 'happy in their knowledge'. Confidence positively correlated with having personal experience of breast-feeding or having received training around breast-feeding:

'They probably do trust us but I don't think we have any more knowledge [about breast-feeding] in general than most people.' (GP 4)

'I probably feel a lot more confident now in any case about it having done it myself but still I'm sure there's lots more I could learn.' (Practice nurse 2)

As a result of this, women discussed how they picked up subtle messages from their health-care provider which helped them decide whether they supported breast-feeding. These messages were, for example, being told she would have to give up breast-feeding at some stage and so it may as well be sooner than later, that breast-feeding for 2 months was enough, not being able to advise on breast-feeding issues such as cracked nipples and not being encouraged to breast-feed generally. Women demonstrated discernment in seeking out alternative support when they received inaccurate advice from health-care professionals, particularly their GP:

'My GP is not very pro-breast-feeding, give the bottle, give the bottle. So I didn't have a lot of contact with him at all.' (Jenny, 9 months and still partially breast-feeding)

'I never got the vibe from my GP … I just don't think, not that she's not supportive of either way, I just think that she would be quite indifferent of whichever way as long as he's feeding and putting on weight and whatever he's eating she doesn't mind.' (Sam, 8 months and still partially breast-feeding)

Breast-feeding support groups

The importance of attending a breast-feeding support group was discussed by nearly all of the women interviewed. Many women discussed the informal, social aspect of the support group. Breast-feeding support groups were usually run by public health nurses and the social aspect of the group was also endorsed by them in interviews:

'It was a great incentive to get up and get out in the early stages, you know, I went up to that group every Thursday religiously, hail, rain and literally snow. Yes, I went out in the snow because I felt it was very important to get out.' (Rebecca, 4 months and stopped partially breast-feeding at 3 months)

Contrasting views were given around weighing babies at the group, with public health nurses generally preferring not to as they feared it was a further endorsement of the medicalisation of breast-feeding, but with many mothers appreciating this aspect as it meant they did not need to go to the health clinic at another time. Both women and public health nurses preferred when the group met at a community venue rather than a health clinic as it meant there was less of a clinical emphasis on breast-feeding and the environment was more natural and informal.

Theme 2: Barriers to breast-feeding support

Barriers to breast-feeding support were described by both women and health-care professionals. Often the barriers described by health-care professionals were also described by women, allowing for greater understanding of the issues.

Time

Health-care professionals discussed not having enough time to adequately support women with breast-feeding.

This was especially the case for midwives, many of whom described a hectic work environment. Some interviewees discussed how giving breast-feeding support could be time consuming, particularly in order to give quality care to mothers. Some also felt that the issue of insufficient time was sometimes the determining factor in whether a woman succeeded with breast-feeding. There was a sense of disjointed care in the hospital environment, with the level of support being given dependent on the particular day and the amount of time available to the health-care professional:

> 'I know the women need the help and you know sometimes if you're frantically busy you can spend so much time and then you say look I'm really sorry but I have to go but I promise I'll come back and because of ward workload, you may not end up getting back for three or four hours, which is frustrating.' (Midwife 13)

In contrast to the frustration described by some health-care professionals in not having enough time to give support, community-based midwives described the ease of having time to give to women and being able to support them as much as they wanted:

> 'At home up in the community it is so different, when I go up to the houses I can be there as long as I like with that mother. It's fantastic.' (Community midwife 1)

Many women were disappointed that the hospital environment was so busy and hectic. They described midwives as not being able to give any dedicated time to women and so as soon as they helped latch the baby on they were gone, leaving the mother to her own devices. Women perceived that it was time consuming for midwives to support breast-feeding mothers, resulting in them being impartial in their support of breast-feeding:

> 'It's literally the question when the baby's born, you know are you bottle or breast and you know if you say bottle they'll get you the bottle, if you say breast they'll say do you need a hand to latch on but I think if you say unsure, I don't know that they'll have the time to physically give you the support.' (Holly, 8 months and still partially breast-feeding)

Women tended to really appreciate when health-care professionals had the time to support them in a practical way but more often than not this did not happen:

> 'Stop giving us all the things, we have the info, we just need the help.' (Hannah, 2 months and still exclusively breast-feeding)

Conflicting information

Many women discussed their frustration with getting conflicting advice about breast-feeding. They received conflicting advice about how often to feed the baby: three hourly, four hourly or on demand; and whether to feed from one breast or both. Women got conflicting advice in both the hospital and community. One woman's GP told her not to breast-feed while on antibiotics for mastitis, but her pharmacist and public health nurse told her the opposite. Another woman's public health nurse told her to give her baby a bottle of formula in addition to breast milk, but later another told her that she would not have recommended this.

Many health-care professionals discussed the issue of conflicting advice and the importance of everyone 'singing from the same hymn sheet'. Three reasons were given for why conflicting advice is given: (i) health-care professionals not having enough training and consequently lacking the skills and knowledge to give correct advice; (ii) health-care professionals being at odds in their approach to breast-feeding, with some taking a medicalised view and others a more holistic approach (in particular, doctors recommending top-ups of formula while midwives and public health nurses felt that this was unnecessary and harmful to breast-feeding); and (iii) women interpreting information they received in different ways and being less inclined to trust their own instinct on what is right.

Suggestions were made as to how to limit conflicting advice with one being to standardise information on breast-feeding. However, some health-care professionals felt that too many rules and regulations about breast-feeding could make it regimented and not suited to individual mothers and babies.

Medicalisation of breast-feeding

One source of conflicting advice was health-care professionals considering breast-feeding differently, with some regarding it as a natural life event and others criticising it for becoming too medicalised:

> 'I think maybe sometimes we talk too much about it because it's a very natural thing. I think that's a big problem. I think it's gone that way. That it's gone into something that's very sort of maybe technical.' (Midwife 4)

Some considered this divergence in the approach to breast-feeding being a consequence of maternity care being obstetric led rather than midwife led:

> 'I think one of the biggest barriers for those women in receiving support is that the model of midwifery care that we offer in this country, because really it's obstetric-led care.' (Midwife 8)

Interestingly, some GP did not think that breast-feeding was a medical issue and so consequently did not feel that it was of concern to them unless it was associated with a clinical condition such as mastitis. Other health-care professionals questioned whether something as natural as breast-feeding should be even discussed in terms of

science and medicine and whether this made it sound more complicated than it is:

> 'You know for a very natural thing you wonder why there's so much science involved. There shouldn't really be an awful lot of science involved in something that's so natural.' (GP 8)

While health-care professionals debated whether breast-feeding should be in the medical domain, many women placed it within this sphere. Women appreciated health-care professionals having expertise in breast-feeding by being an accredited lactation consultant. Some favoured their help over a midwife's because of their specialism in breast-feeding:

> 'It would have been nice to see the lactation consultant when I was in the hospital. Because although the midwives, of course they're very experienced, let's say the lactation consultant, that's all she does.' (Brigid, 3 months and still exclusively breast-feeding)

Role of health-care professionals in providing support for breast-feeding

All health-care professionals discussed their role, if any, in the promotion and support of breast-feeding. Different groups of professionals viewed their roles differently. Midwives and public health nurses felt that they played an important role and tended to want to give women practical advice and support. It was important also that they could promote breast-feeding in a balanced way, being able to discuss formula feeding if needed. There was disparity between doctors with some describing how they promote and support breast-feeding and others admitting to not putting much thought into it:

> 'I've never brought it up actually as an antenatal thing. Unless the patient brings it up herself, otherwise no I wouldn't really. There's no reason, I just never think about it.' (GP 8)

Some GP, in particular, did not feel that they are the best placed to promote and support breast-feeding as they felt their knowledge was not sufficient:

> 'It would be nice if you could give some solid advice you know, 'cause they probably do trust us but I don't think we have any more knowledge in general than most people.' (GP 4)

Many women wished that health-care professionals would show more of an interest in breast-feeding by not just asking them if they were going to breast-feed or give formula, but also by promoting and supporting breast-feeding. Women did not just want support from midwives and public health nurses but also from other professional groups:

> 'It would be good if the GP 'cause you go there every so often when you're pregnant, if they would, they should promote it [breast-feeding] I think or at least talk to you about options you have.' (Sam, 8 months and still partially breast-feeding)

Discussion

The present study involved qualitative interviews with women who had some experience of breast-feeding and health-care professionals with infant feeding roles. Many of the women who were interviewed in the study had breast-fed for more than 3 months and were primarily older and more educated, characteristics that are associated with breast-feeding. All interviewees were self-selected and so may have had an interest in the topic, possibly resulting in a positive bias in attitudes to breast-feeding. In addition, unfortunately we were unable to match the women who were interviewed as having received care with the health-care professionals who were interviewed and so cannot directly correlate the findings from both groups to each other. However, despite these limitations the study contributes important knowledge to areas of public health, nutrition and lactation.

Two overarching themes were identified between the interviews with both women who had experience of breast-feeding and health-care professionals. These were facilitators and barriers to breast-feeding support. These two themes are very much interlinked, with the facilitators to breast-feeding, which are presented in the findings, being mirrored in the barriers identified. For example, the issues that arose in the concept 'being facilitated to breast-feed' were reflected in 'the role of health-care professionals in providing support for breast-feeding', whereby women liked when health-care professionals showed an interest in how breast-feeding was going but some health-care professionals questioned whether they had any role in promoting and supporting breast-feeding. This pattern was repeated with the other concepts such as women 'being discerning' in accepting the advice that they received from health-care professionals compared with health-care providers giving conflicting advice when breast-feeding issues arose. And again with women describing 'having the right person at the right time' and the importance of this in continuing breast-feeding while health-care providers described not having enough time to adequately support women with breast-feeding.

The findings in our research are reflected in the results of other studies that have considered health-care professionals' views on breast-feeding support and those of women receiving the support. Dillaway and Douma[29] found that while some health professionals felt it would be best to have 'breast-feeding experts', women felt that all health professionals should have some knowledge of breast-feeding and be able to give support[29]. In addition, as with our study, women have described the need for health-care professionals to have basic skills to support

breast-feeding and also being able to communicate with them and understand their feelings[20]. While health-care workers are sometimes afraid of putting too much pressure on women to breast-feed[30], women have been found to want encouragement and information about breast-feeding from their care providers in the antenatal period[31]. Nelson[24] conducted a meta-synthesis of qualitative breast-feeding studies and she found that mothers looked to health-care professionals for information, technical and emotional support. The availability and time that a health professional could offer a woman were considered the most important characteristic; however, unfortunately our study found that this could often be lacking.

Our results show that the current model of care around breast-feeding for women in Ireland, which is dependent on health-care professionals encouraging and supporting women, is not ideal and alternatives to the current model need to be provided. The study found that women have placed breast-feeding in the medical world and consequently discussed the importance of having access to specialist care such as lactation consultants. This has been described before by Leahy-Warren *et al.*[16], who found that Irish women depended on specialist breast-feeding support. While this is a worldwide phenomenon and is somewhat inevitable due to the medicalisation of childbirth[32], our study found failings in placing breast-feeding within a medical model. Both health-care professionals and women described the hospital environment as being busy and hectic. Mothers and midwives described the lack of time available for breast-feeding support. Midwives were sometimes taken up with clinical tasks and could not dedicate time to sitting with a woman while she breast-fed. A lack of support from health-care professionals for breast-feeding is a common criticism among women in Ireland; however, when appropriate support is provided it is valued[3]. In addition, issues around conflicting information were described by both health-care professionals and mothers. Different professional groups in hospitals can have their own objectives, procedures and routines[33], and so while doctors and nurses work side by side they can have parallel agendas and separate aims for their patient. This reflection on hospitals is insightful to the way in which support around breast-feeding is currently delivered and it points to the fragmented care which was described by women and health-care providers. There can be discrepancies between what health-care professionals think is their role in promoting and supporting breast-feeding and what their clients think, with health-care professionals playing down the importance of their role[29,34]. Women described how it was a matter of luck to have the right person at the right time to support them through a particular issue with breast-feeding.

Our research reveals a tension between women's perceived need for breast-feeding support and the danger of making breast-feeding overly medical or technical. Given the constraints of the current medical model of breast-feeding, alternative forms of support for women need to be considered. This has already been suggested by Dykes[35], who has challenged the suitability of the hospital as a place in which women begin breast-feeding. A review of maternity services in the Dublin area[36] called for midwifery-led, community models of care being made available to women. This is supported by findings from a Cochrane review[37] advocating that most women should be offered midwife-led models of care. The review also found that women who give birth in midwife-led care are more likely to initiate breast-feeding. In Ireland there are currently only two midwifery-led units and an evaluation of these has led to recommendations that more be established across Ireland[38]. Other alternative forms of support could include breast-feeding peer supporters being employed to help women in maternity wards. This approach has been found to be successful on postnatal wards in Boston whereby peer counsellors could manage time-consuming cases such as social support, while lactation consultants would deal with more high-risk, medically complicated cases[39]. Peer support can offer an alternative which is worth considering when professional support is not available[40].

One form of support that was commented on by both mothers and health-care professionals as being beneficial was attendance at a breast-feeding support group. Public health nurses and breast-feeding women both recognised the importance of having a social support network. Public health nurses recognised the need to let women support each other while also being there if help was needed, and women acknowledged this as being really beneficial to their breast-feeding experience. A review from the UK on the effect of breast-feeding peer support on breast-feeding continuation found that the effectiveness of such support is often context specific and seems to be less beneficial when there are routine services already established to support breast-feeding[41]. In addition, research in Australia showed that women who attended first-time parent groups tended to discontinue breast-feeding if the majority of the other women in the group had stopped breast-feeding by the time they joined the group[42]. However, breast-feeding support that is provided in both the antenatal and postnatal period and which involves education and support from well-trained health-care professionals and peers can positively influence breast-feeding duration outcomes[43]. Further research is needed to explore whether support groups facilitate women to breast-feed in Ireland. The public health nurses and mothers who were interviewed also described the need for an adequate venue for the support group, preferably not in the health centre. In addition, they mentioned how babies were often weighed at the support group and while most mothers felt that this was important, some public health nurses and women felt that it took from the support aspect of the group and kept breast-feeding within a

medical domain. Mahon-Daly and Andrews[44] described a similar phenomenon with the primary reason for women attending a clinic being to weigh their babies and this was found to be as important as the peer support and pastoral care role of the clinic.

Conclusion

In conclusion, our study shows that breast-feeding is being placed within a medical model of care in Ireland and is currently dependent on health-care professionals. Our research has several policy implications: in order for breast-feeding to be sustained women need more encouragement, advice and support and health-care professionals need to be adequately trained to give this. Our research identified a clear need for training around breast-feeding for all health-care professionals, specific to their professional requirements for knowledge and skills in supporting breast-feeding. However, our research also notes that they are limited in the extent that they can support breast-feeding due to external barriers such as lack of time. Alternative or perhaps additional support in the form of peer support workers should be provided.

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