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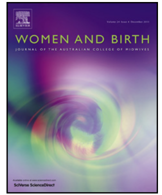

Original Research - Qualitative

“The right help at the right time”: Positive constructions of peer and professional support for breastfeeding

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Statement of significance

Problem or issue

Support during the early establishment phase of breastfeeding is important but women report that health professionals can undermine their confidence with breastfeeding.

What is already known

Breastfeeding support provided in fragmented hospital based models of care predominantly reflect authoritative expert advice-giving which women describe as conflicting and unsupportive. Women show a preference for support from a known midwife, or a peer supporter, or a combination of the two.

What this paper adds

Peer support counsellors and privately practicing midwives approached breastfeeding support in a similar way. They interacted with women as a ‘knowledgeable friend’ and normalised breastfeeding challenges which enhanced women’s confidence with breastfeeding.

1. Introduction

Breastfeeding offers significant health benefits to mothers, babies and families, and substantial economic benefits for the community.[1,2] According to the recent Lancet series on breastfeeding “breastmilk makes the world healthier, smarter and more equal”.[3] Supporting women to breastfeed is a vital public health strategy. Yet breastfeeding is one of the few health improvement behaviours that is more common in poor countries than rich ones.[3]

Women, from high income countries, report that the early weeks of breastfeeding are particularly difficult, requiring emotional and practical support from others. Midwives provide support during the early establishment of breastfeeding however many women report dissatisfaction with the support they receive from health professionals in these early weeks.[4,5] Some women indicate a preference for either peer support provided by a trained volunteer[5,6] or relationship based support provided by a known midwife[7] or a combination of the two.[8,9] Both peer support and midwifery continuity of care have been linked to improved breastfeeding exclusivity, and, extended duration of breastfeeding.[9,10]

In Australia, approximately 96% of infants start life breastfeeding. This percentage drops as the infant grows so that by 5 months of age only 15% of Australian infants are still breastfed exclusively.[11]

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Research has shown that the breastfeeding support style adopted by professionals in the first few weeks after birth impacts on women's experience of establishing breastfeeding. Observations of hospital and community based health professional support, during the first week after birth, revealed an authoritative style, of expert 'teaching' novice.[12] This style of support has been described by mothers as "bossy and judgmental" and includes prescriptive advice giving which undermines confidence.[4,5] Health professionals in hospital environments have been observed offering advice in a mechanistic way that interferes with the developing mother infant relationship and places blame for breastfeeding difficulties on an uncooperative newborn.[5,13,14]

Schmied et al.[15] describe authentic support as reflecting a trusting relationship characterised by rapport and connection between the care giver and the woman.[4] McLelland et al.[16] recently explored the views of Australian midwives about the support provided to breastfeeding women. They report that midwives perceived that a lack of continuity of midwifery care limited relationships with women.[16] Our research has previously shown that only a small percentage of hospital based midwives (9%) adopt a relationship based approach to breastfeeding support and very few provide continuity of care during early breastfeeding (Burns et al., 2013).

The aim of this study was to explore the similarities and differences in breastfeeding communication styles, and language and practices used, in the first month after birth, by privately practicing midwives (PPM), working in a continuity of care model, and, trained breastfeeding peer support counsellors (PSC) providing support at a national breastfeeding organisation's community-based drop-in lounge. Women who access PPM's predominantly do so to facilitate birthing in their own home environment with a known midwife. This option is unavailable in almost all public maternity units in Australia. Standard maternity care consists of a fragmentation of service delivery in pregnancy, birth and postnatal with little opportunity for continuity of care.[16] In this study peer support counsellors were accessed by women who had tried other mainstream health avenues for support without success.

2. Method

Discourse analysis was the most appropriate method[17] for an examination of the language and practices of Privately Practicing Midwives (PPM) and Peer Support Counsellors (PSC) when supporting breastfeeding women after birth. Discourse analysis has been used by many health disciplines to highlight the dominant discourses influencing the language and practices of health practitioners.[18,19] In this study, the method included observation and audio recording of communication exchanges between participants, including assessment of the context and surroundings, followed by an exploration of the discourses, recurring words, phrases, metaphors, ideas, beliefs and practices found during interactions between the study group.[20–22] Observation of interactions enabled the documentation of non-verbal communication and practices which would not have been apparent in an analysis of the recorded language only.

Data for this study were collected through both observation of interactions, and, through in-depth interviews with some women six weeks after the interaction. Ethics permission was granted from Western Sydney University Human Research Ethics Committee (Approval Number H9478) and permission to approach the PSC at the community based drop-in centre was granted through a centralised approval process at the Australian Breastfeeding Association (ABA).

2.1. Setting

There were two settings in the study—a 'drop-in' lounge and women's homes. The ABA community-based drop-in lounge was located in a community building, with parking and was accessible by public transport. It was furnished as a welcoming, comfortable, and relaxed home environment with access to tea and coffee and home-like baby change facilities. The drop-in lounge was established to offer women a central place for seeking face-to-face support for breastfeeding challenges. The other observational setting was women's homes where the PPM interactions occurred and the interviews with women at 6 weeks post birth. PSC and PPM models of care engaged with women at different ends of the maternity journey. PPM providing care from early pregnancy and PSC providing a service after breastfeeding difficulties had developed.

2.2. Participants and recruitment

Three groups of participants were recruited for this study; PPM, PSC and breastfeeding women. Midwives were provided with information about the study at their regular private group practice meeting time. The participant information statements and consent forms were provided and midwives were asked to email an expression of interest to participate. Interested midwives were contacted by the first author to arrange a convenient time for observation of interactions, and the midwives sought agreement, from the women in their care, for the researcher to attend the next visit, explain the study and invite the woman to participate.

Peer support counsellor's were approached at the drop in centre and an expression of interest sought. PSC's who identified that they were interested, in being in the study, were contacted to arrange a convenient time for observations. Breastfeeding women participants were then approached, by the researcher, at the time of support provision at the drop-in lounge. Participant information statements were provided to all potential participants and time allocated to facilitate decision making regarding participation, or not.

In total, there were 5 PPM participants with experience ranging from two years to 25 years, one of whom also had qualifications as a lactation consultant. Four PSC's participated, two of whom also had qualifications as a lactation consultant. One of the peer support interactions observed was a group session.

2.3. Data collection

In total, 22 women participated in the study, 16 individual interactions were observed and audio recorded, by Author 1, and 6 women participated as part of a group session. Interviews were collected with 14 women following discharge from the service, 7 from each group. The breastfeeding interactions ranged from 30 min to 1 h and 30 min. The 16 one-on-one interactions occurred in the lounge room of the woman's home or the lounge area of the drop-in centre. The one group session occurred in a community hall. Field notes were collected before, during and after the interactions. Women were interviewed, by Author 1, when their baby was around 6 weeks of age.

Two interviews were collected over the phone and the rest occurred in the woman's own home. The interviews lasted between 30 min and one hour. Interview questions were open ended and included: Can you tell me about your experience of breast feeding support from (PSC or PPM); Do you have any feedback that you would like to give to the service?

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