

Mothers' experiences of breastfeeding support and breastfeeding specialists' views on breastfeeding promotion in Finland – a qualitative interview study

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Abstract

Promoting and supporting breastfeeding influences positively the health and well-being of both babies and mothers. However, many factors, such as maternal health, family and community support, cultural norms, societal aspects, educational level, and even marketing, affect breastfeeding. The aim of the present study was to describe mothers' experiences and wishes for breastfeeding support and specialists' views on breastfeeding promotion. Semi-structured interviews were undertaken individually with breastfeeding mothers ($n = 14$) and breastfeeding specialists ($n = 9$). The data were analyzed using inductive content analysis and reported using the COREQ guidelines. Mothers were content with practical, individual, and peer support for breastfeeding. Most mothers experienced insufficient support from family services and social networks. Breastfeeding specialists suggested that the breastfeeding service system should be strengthened, and support should be given both prenatally and on special occasions. They described the importance of interaction skills and breastfeeding-counselling education.

Keywords

breastfeeding benefits, breastfeeding counselling, breastfeeding practices, health promotion, qualitative methodology

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Background

Breastfeeding has multiple benefits that promote the health of the population. It offers a child optimal nutrition, including an ideal amount of energy and antibodies to support growth and development, reduces gastrointestinal and respiratory infections, prevents obesity in children, and improves children's cognitive development. Breastfeeding may protect mothers against breast and ovarian cancers, and obesity and type 2 diabetes occur less among breastfeeding mothers.^{1,2} Breastfeeding also has a positive effect on the attachment between mother and child, and it has been recognized as supporting maternal mental health and preventing postpartum depression.^{3,4} From a wider perspective, breastfeeding supports sustainable development by promoting goals of zero hunger, good health and well-being, reduced inequalities, responsible consumption and production, and climate action. An equal and accessible breastfeeding service system and peer support from associations promote health and well-being and prevent illnesses and social problems by improving the nutrition level of children and decreasing child mortality and non-communicable diseases.^{5,6} It is recommended to breastfeed exclusively until 6 months of age and partially until 2 years of age or more, and the early initiation of breastfeeding should happen within the first hour of birth.⁷

By reducing child morbidity and mortality, breastfeeding affects the economic situation of societies and the education level of the population. The public economic costs of not breastfeeding are estimated to rise to billions of dollars by country.^{7,8} Despite the unambiguous and convincing recommendations, two-thirds of babies worldwide are not exclusively breastfed.⁷ To promote breastfeeding, the World Health Organization (WHO) recommends adopting the recommendations of the baby-friendly initiative and the international code of marketing breast milk substitutes nationally.⁹ According to the Ottawa Charter for Health Promotion,¹⁰ breastfeeding promotion requires equal possibilities, support from the environment, a sense of safety and social inclusion, and up-to-date breastfeeding knowledge.

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Breastfeeding is highly dependent on socioeconomic and sociodemographic factors. A low socioeconomic position^{11–15} and the national education level¹¹ impact breastfeeding. The significance of the income level is contradictory in high-income countries. The highest- and lowest-paid mothers breastfeed more than mothers with middle income.^{11,12} Aside from socioeconomic factors, a strong connection has also been found between breastfeeding mothers and their sociodemographic background. Older mothers with a greater number of children are connected to successful breastfeeding during the baby's first year.¹⁴ Young mothers may breastfeed less frequently and for a shorter time than older mothers.^{15,16} Peer support and support from the spouse are less consequential among young mothers. Instead, they need and receive support more from close female relatives.¹⁷ There is insufficient knowledge about the impact of immigration on breastfeeding.^{11,18}

Despite the social position, all mothers are entitled to have sufficient breastfeeding support and knowledge to promote health and reduce social inequality.¹¹ Received breastfeeding counselling, adopted breastfeeding knowledge, and a way of delivery are connected to successful breastfeeding during the baby's first 6 months of age.¹⁴ Health education and breastfeeding counselling should be more efficient and arranged in different contexts for both parents and as group activities.^{13,19–21} Mothers' previous breastfeeding experiences are important to process. Young and less educated mothers need reception and support frequently and individually in maternity and child health clinics (MCHC). Mothers benefit from equal family services and education,^{12,15,22} which should also be directed to young mothers' relatives and friends.¹⁷

Breastfeeding should be promoted in a positive way in society. By reinforcing a low threshold for services and funding lactation counsellors and milk banks, it is possible to create supportive environments for breastfeeding mothers. In addition, breastfeeding positivity in the media and positive role models normalize and promote breastfeeding.²² Clinical practices may impact successful breastfeeding. Continuity of care supports health promotion for mothers and children, the initiation of breastfeeding, and exclusive breastfeeding. Continuity endorses the mother's mental health and sense of self-efficacy in early interaction and breastfeeding and reduces the symptoms of postpartum depression. To ensure the continuity of care, cooperation between organizations is needed.^{23–26}

The aim of the present study was to describe mothers' experiences and wishes for breastfeeding support and specialists' views on breastfeeding promotion. The knowledge acquired through this study can enhance the ability of nursing professionals and breastfeeding specialists to support mothers and families and improve overall breastfeeding practices.

The focus was on the following questions:

1. How do mothers describe the breastfeeding support they received?
2. What kind of breastfeeding support would mothers have hoped for?
3. What kind of perceptions do breastfeeding specialists have about breastfeeding promotion?

Methods

Study design and participants

A descriptive qualitative approach was considered appropriate to capture the participants' experiences and views of phenomenon.²⁷ Study methods are reported according to the consolidated criteria for reporting qualitative research (COREQ).²⁸ Two groups of participants were recruited for the study. The first group included mothers who had given birth less than 2 years ago and still breastfed their children, and whose highest level of education was either lower secondary school (grades 1–9, age range 7–15 years), upper secondary school (age range 16–18 years), or vocational school (age range 16–18 years). Mothers were recruited using a social media channel of the Finnish Association for Breastfeeding Support (FABS; which was a collaborator in this study). In total, 21 mothers received an informed consent form, a data protection form, and the interview guide via email; of them, 14 consented to participate in the study. The mothers' place of residence varied across Finland; they were aged 24–40 years, had 1–3 children, and by civil status, were all in a relationship.

The second group included breastfeeding specialists (henceforth 'specialists') who have further education as breastfeeding counsellors, trainers for breastfeeding counsellors, or International Board-Certified Lactation Consultants. They were recruited via two social media discussion forums targeted at breastfeeding instructors or counsellors. Nine specialists participated in the study and they received an informed consent form, a data protection form, and the interview guide via email. The specialists worked in healthcare and social welfare as nurses, midwives and senior nursing officers, social service workers, and association specialists.

Data collection

Interview guides for mothers and specialists were constructed based on the literature, guided by research questions, and developed in cooperation with the FABS. The individual, semi-structured interviews were conducted separately for both groups using MS Teams or telephone. All interviews were conducted by the first author, whose professional background is a public health nurse working in MCHCs and as a breastfeeding counsellor supporting and promoting breastfeeding. Mothers were interviewed in May and June 2021 and specialists during September and October 2021. The average length of interviews was 25 min and 52 min, respectively. The interviews were audio-recorded and transcribed verbatim into Finnish. Relevant quotes were translated into English by the first and last authors.

Data analysis

The data were analyzed manually by the first author using inductive content analysis,²⁹ separately for both groups of participants. After reading the transcribed texts several times, the unit of analysis was selected. The data were coded, and the codes were compared with similarities and differences throughout the text. The codes were formed into subcategories and then

Table 1. Example of categorization process of mothers' experiences of received support for breastfeeding.

Main category	Categories	Subcategories
Received support for breastfeeding	Diversity of breastfeeding support	Adequacy of breastfeeding support
	Updated breastfeeding information	Continuity of breastfeeding support Quality of breastfeeding information Personnel's breastfeeding education

into categories. Finally, the data were abstracted into main categories (Table 1). The categories were then compared to the original text to portray the data.²⁶ To ensure the rigor of the analysis, the research team reviewed the analysis several times during the process, and the final analysis was validated by all the authors.

Ethical considerations

Ethical factors were thoroughly discussed within the research group as the topic can be considered sensitive. Because breastfeeding is a public health priority worldwide, and specifically the breastfeeding rates are extremely low in the WHO Europe region,³⁰ the need to understand the reasons behind the low rates is high, providing justification for this study. Reaching voluntary mothers from the social media channel of the FABS was considered a suitable method for obtaining the voice of mothers, who have recent experiences of breastfeeding. The research permission for the study was received from the FABS, and the participants provided informed and signed consent.

Finnish regulations do not require formal authorization from an ethical committee as the study was not considered as violating physical integrity, the participants were adults, and they were not expected to experience strong stimulus, mental harm, or a security threat.³¹ Mothers participating in the study were fully aware that they were eligible for the study by fulfilling the criterion of a specifically defined education level and represented a group that could share their perceptions and increase understanding about breastfeeding support for this group of mothers. However, the participating mothers cannot be categorized as belonging to a risk group for breastfeeding because other sociodemographic or socioeconomic factors were not asked of them.

Personal information was maintained according to the General Data Protection Regulations.³² The transcribed interviews were pseudonymized to ensure that identification of the interviewees was not possible. Only the first author had access to the identifying code list.

Results

Context and categorization

Mothers received breastfeeding support from a variety of family services in social and healthcare. As the social and healthcare system in Finland is divided into three levels – (1) primary social and healthcare, (2) special healthcare, and (3) third-sector services – family services in this study mean all

these levels. Primary social and healthcare is provided in MCHCs and family work services, special healthcare is offered by obstetric units and children's special healthcare, and third-sector services are typically provided by family associations, congregations, or private services. Pre- and postnatal family education groups are organized by MCHCs. In addition, social networks provide informal support for mothers.

According to the results, mothers' descriptions of received support formed three categories: (1) diverse breastfeeding support; (2) breastfeeding atmosphere; and (3) breastfeeding knowledge that was up to date. Mothers' hopes for breastfeeding support formed four categories: (1) quality of breastfeeding support; (2) up-to-date breastfeeding knowledge; (3) quality of breastfeeding service system; and (4) breastfeeding atmosphere. The specialists' perceptions about breastfeeding promotion yielded five categories: (1) the national guidance of breastfeeding; (2) the breastfeeding service system; (3) the breastfeeding counselling skills; (4) the means of breastfeeding counselling; and (5) the different phases of life.

Mothers' experiences of breastfeeding support

Mothers had experienced **diverse support for breastfeeding** regarding sufficiency, quality, usefulness, content, continuity, and breastfeeding peer support.

Mothers expressed varying perceptions of sufficiency within family services. Although some had experienced the support adequate, others found it insufficient. Notably, breastfeeding clinics within obstetric units emerged as a reliable source of sufficient support, garnering contentment among mothers. Peer support and practical and personalized assistance were also well received. Moreover, the input from breastfeeding counsellors played a pivotal role in reinforcing mothers' viewpoints and choices. Mothers valued the easy access to counselling services provided by associations and the supportive community found on social media platforms.

We got into the breastfeeding clinic once again. I wanted to ensure everything was okay, like the latching and weight gain, and there was a lovely person working in the ward who took care of us in the hospital. (Mother 2)

Nevertheless, breastfeeding support failed to meet the needs of most mothers adequately. Described as minimal, the support did not meet maternal expectations and left many mothers uncertain about how to seek additional assistance. In particular, prenatal support and opportunities for discussion within MCHCs, family education groups, and obstetric units were notably lacking. Several mothers experienced receiving more

support while expecting their first child. Moreover, mothers experienced challenges in accessing specialized support, such as guidance for breastfeeding after gestational diabetes or maintaining a breastfeeding diet. Breastfeeding counselling, especially in hands-on techniques, proved insufficient in addressing mothers' concerns effectively. In terms of familial support, only a minority of mothers reported receiving any assistance from close relatives.

I have had quite minor support; at the child health clinic, nobody has asked about breastfeeding or how it is going, not even once. (Mother 4)

The quality of breastfeeding support varied widely, ranging from comprehensive to poor. Support from MCHCs was often one-sided and passive, lacking sufficient dialogue, peer support, or written material. Some mothers reported conflicting instructions between MCHCs and obstetric units. Conversely, specialized healthcare provided good and extensive support. Similarly, support from associations was characterized as reliable, useful, and up to date, with mothers feeling heard and their concerns addressed.

Mothers found breastfeeding support useful when they received practical counselling on checking the baby's latch, monitoring weight, or accessing breastfeeding aids from obstetric units. Hospital support was deemed unhelpful if personnel had been too busy. Mothers saw support from spouses, mothers-in-law, or friends as meaningful and peers were valuable in providing answers regarding breastfeeding when needed. Mothers felt supported in their breastfeeding journey when they received personalized counselling, felt listened to, had their needs met, and had their choices accepted.

When I had breast infections, my mom came here and brought food, and sometimes, she cooked the accessories; it must be because of that, I experienced it all so easy. (Mother 3)

Mothers described the content of breastfeeding support as too minor. Some mothers had received unnecessary or wrong advice about finishing breastfeeding at night or dieting during breastfeeding and had not received help with the baby's latching. Some mothers mentioned that sufficient instructions for using breastfeeding aids were lacking. However, mothers also had received useful support like information on where to seek support or about the spouse's role from private healthcare and associations. Peer support with practical and experiential advice had strengthened their views and opinions.

Mothers perceived the continuity of breastfeeding support from family services as important but could not always rely on its availability. Continuity was not implemented adequately during summer holidays because of the busyness of personnel or their insufficient orientation to patient records.

My son did not have a public health nurse of his own at the child health clinic when he was born at the beginning of July. There were many nurses when we had to follow the weight gain frequently. They took care of the matter but nothing more. (Mother 9)

The breastfeeding atmosphere affected the support mothers experienced. Mothers faced both positive and negative breastfeeding attitudes. Some mothers described positive experiences with MCHCs, special healthcare, and in associations, while some mothers encountered pressure and understatement regarding breastfeeding. Instances included unnecessary advice to use formula milk instead of breastfeeding or to discontinue breast-milk from a bottle, as well as inappropriate and breastfeeding confidence-reducing comments from clinic doctors, social networks, or through the obstetric unit's patient records.

The public health nurse said I should not intensify breastfeeding when wondering why the weight gain had become steady. She wondered out loud why I breastfeed a 6-month-old baby and why the baby does not get any solid food. (Mother 12)

Mothers described that personal encouragement had been important, especially if it came from a close female relative or friend, for example, aiming to support breastfeeding two different aged children at the same time.

The breastfeeding knowledge that was up to date enabled successful breastfeeding. Mothers emphasized the quality of breastfeeding knowledge and the personnel's education. Knowledge from MCHCs had not always been up to date or correct. Mothers had to question some of the knowledge and share it with the personnel of family services. Mothers were mainly satisfied with the breastfeeding knowledge among personnel in special healthcare and agreed that all personnel in family services would benefit from regular breastfeeding education. Associations and private family education groups provided mothers with breastfeeding knowledge easily, quickly, and in a timely fashion.

Our child health clinic, they are probably not that up to date. The birth rate in our municipality is very low, there are not many infant families, and the knowledge is old-fashioned. (Mother 12)

Mothers' hopes for breastfeeding support

The quality of breastfeeding support included individual, practical, and active breastfeeding support and support for parenthood. Mothers hoped for individual support in which their own choices were noticed, and they needed more face-to-face conversations. Mothers requested more practical counselling about breastfeeding safety signs, such as the baby's sufficient weight gain or excretion; plain weight monitoring was not enough. They described that first-born families in particular benefit from practical advice. Active breastfeeding support should be offered to families homogenously, and confidential conversations about breastfeeding should be included in family services' receptions. In addition, mothers hoped for support for parenthood and discussion about parenthood and the family's everyday life.

I would have needed more individual support from the child health clinic. I have given them constructive feedback about many things, and breastfeeding and breastfeeding support is one of them. (Mother 2)

Mothers needed more **up-to-date knowledge about breastfeeding** and its benefits from MCHCs and family education groups. They described the quality of breastfeeding knowledge as competent counselling, prenatally and postnatally. Mothers also hoped for information about breastfeeding problems and up-to-date breastfeeding knowledge on organizations' web-pages. Personnel of MCHCs and obstetric units should be educated well and regularly.

It would be important to underline the benefits and different options that are really beneficial. And not just the antibodies because it also develops the baby's brain and the bond between mother and child and more. The advantages are so extensive that many people may not even think about them. (Mother 3)

Mothers described **the quality of the breastfeeding service system**. Mothers hoped that breastfeeding services would be easily accessible and work locally and remotely. Mothers needed more continuing follow-up and help with breastfeeding problems in family services. They requested information about peer support in family education groups and MCHCs prenatally.

A place where you can go concretely to talk with a specialist, that kind of place we do not have. It would be marvelous to find that kind of accessible channel where you can ask for advice and help if you feel like it. (Mother 2)

A **breastfeeding atmosphere** was important for mothers. They hoped for an unhurried breastfeeding atmosphere and more positive, or at least neutral, attitudes in family services, their social network, and society. Mothers wanted to be faced with an unhurried atmosphere. Formula milk and bottles should not be recommended when a mother has breastfeeding problems.

It would be so important that there is enough time to go into that and put effort into that because the milk does not necessarily rise to the breasts at the hospital. The rising of the milk is not possible until you are relaxed. (Mother 6)

Breastfeeding specialists' perceptions of breastfeeding promotion

The specialists indicated that **the national guidance in breastfeeding promotion** should be strengthened. Specialists suggested that recommendations in family services and health promotion programs should contain up-to-date and evidence-based knowledge. Written material should be accessible to all families and languages, and the material produced by associations should be utilized. According to specialists, to promote breastfeeding nationally and affect society's attitudes, it is necessary to bring breastfeeding and its benefits to the general discussion as a normal part of family life. When breastfeeding attitudes change among risk groups, a baby-friendly atmosphere will increase in society. Breastfeeding counsellors

should be aware of their attitudes and experiences and should trust the potential of breastfeeding mothers.

It is also affected by those things you have learned and most of all the attitudes, so I would say that is the biggest thing. And how important it is to experience. (Specialist 4)

Specialists emphasized that in a positive breastfeeding atmosphere, the baby's needs are seen as a center of action. The health and economic benefits of breastfeeding as well as personnel's education should be embedded in organizations' strategies and structures. Breastfeeding-friendly communication and practices in organizations and between co-operators are strengthened via education.

And, of course, the general positive breastfeeding atmosphere should be a norm among the services of baby families. (Specialist 7)

According to specialists, **the breastfeeding service system** should be strengthened to enable the support of all families equally. The service system needs to be scaled for basic and special breastfeeding support services. The regional compilation of statistics helps develop a service system. A strong service system and structures would also ensure support for changes. Most specialists believed that the prenatal breastfeeding counselling process in maternity clinics should be developed to include preparing for breastfeeding and counselling that is free of charge, well-timed, and easily accessible. At-risk groups, such as young mothers and mothers with gestational diabetes, in turn, need special clinical pathways when basic services are inadequate.

Specialists called for sufficient resources for the breastfeeding service system that enable basic and special breastfeeding counselling equally and homogeneously for all families. Resources are needed to ensure long enough receptions for time to communicate. Further, resources are needed also for making accessible materials for young and less educated mothers. Resources in MCHCs should be shared equally and targeted to the preventive health promotive work.

We try to offer this free service in maternal and child health clinics, too. The special healthcare services cost €9, and even that can be too much for someone. It is easier to access primary healthcare. We also want to offer well-timed services and answer needs so that families who are at risk get support to finish breastfeeding earlier. (Specialist 6)

Specialists emphasized cooperation in all family services. More resources are needed for cooperation and integrating information systems. Breastfeeding counselling should be given through the cooperation of family services, for example, shared home visits by public health nurses and social workers. A renewed healthcare and social welfare system would also increase cooperation.

Specialists described the meaning of **breastfeeding counselling skills** to include comprehension to separate experience and evidence-based knowledge and, further, multidisciplinary knowledge about health, health risks, and sickness. The

WHO's 20 h of breastfeeding counselling education is a background of counselling skills giving abilities to start guiding. It contains basic knowledge about the progress of normal breastfeeding and the sensitive period of becoming a parent, common challenges in breastfeeding, prenatal counselling, and the meaning of good communication skills.

You must understand the situation of an infant family and the psychology of family and social meanings because it is special right after delivery. (Specialist 7)

The approach of breastfeeding counselling education is baby-friendly and practical, as specialists described. Peer support mothers of associations need education to recognize the breastfeeding risk groups. Trainees' own breastfeeding experiences should be processed during counselling education. The regularity of breastfeeding counselling education and its updating need to be monitored between all operators in family services.

Specialists further stated that most breastfeeding counselling is communication between a mother and a counsellor. With good communication skills, counsellors can guide families sensitively to create a confidential and supportive atmosphere. Counsellors also need practical and technical skills achieved through work experience. Breastfeeding counselling is more than checking latching; the mother's feelings and breastfeeding situation are monitored, the status is documented, and families are guided to a specialist if needed.

Most breastfeeding counselling involves facing and listening to the family; there are a lot of things that can be solved by hearing the parent's worries. (Specialist 2)

Practicality is part of **the means of breastfeeding counselling**. Specialists assessed that baby and family friendly programs should be put into practice in family services. Practical counselling is needed about milking, and how to combine breastfeeding and leisure time, or breastfeeding being an economical choice. Instead of written material, low educated mothers in particular need practical counselling. Specialists described that individuality in the structures of family services and associations helps families breastfeed the way they hope. It is important to recognize families who want to breastfeed, ask for their needs, and request feedback.

You can, like, ask what the family wants because counselling is not effective if you do not start from the basis of the family. (Specialist 2)

Specialists emphasized ensuring support for non-smoking prenatal and postnatal periods is important. Mothers need information and open individual and practical advice on smoking because it is a sensitive topic among breastfeeding mothers.

We forget that the non-smoking person is so young at that point when the baby is born. If we do not ensure the non-smoking support, the mother will certainly start smoking again sooner or later. The support is needed for much longer after delivery.

The carbon monoxide measurements would be beneficial as interventions. (Specialist 8)

Specialists mentioned that breastfeeding promotion strengthens families' resources through various means. Breastfeeding counselling contains family-oriented support for parenthood and discussion of the baby's needs and parents' roles. Fathers, single mothers, and young mothers in particular need parenting support from family services. To support parenthood, it is important to strengthen the early interaction and the bond between a child and the parent. Further, it is important to process previous breastfeeding experiences prenatally. Families need encouragement and a feeling of being coherent and valuable.

It would be helpful to support the bond between parent and child and by putting joy, happiness, love, and experiences into words. (Specialist 3)

Specialists described that breastfeeding promotion among risk groups requires **support for different phases of life**. Socioeconomic factors, the use of social services, the increasing number of mental problems, and their meaning in families' lives should be considered in family services. Because of their backgrounds, families have different individual possibilities and options in life, and breastfeeding counselling should be planned according to families' situations. In addition, cultural factors may affect breastfeeding promotion as specialists described; counselling should be adjusted to the characteristic features of the culture in question. Multilingual written and online material should be produced, sufficient time preserved in family services, and peers with diverse backgrounds are needed to support mothers. The delivery of information is sensitive and targeted to a whole ethnic community, especially to the female relatives of mothers. Professionally skilled and safe interpreting services are required.

Breastfeeding promotion among risk groups requires sufficient support services for families in everyday lives to identify the primary cause of challenges. Specialists described that to support a mother in focusing on a baby, breastfeeding support networks are scanned and help is organized at home. Specialists emphasized ensuring the continuity of care especially for young and less educated mothers and shared that young, single, and less educated mothers and mothers with more than one child would benefit from peer support and group activities with topics such as breastfeeding or parenting counselling. Group activities should be arranged as multilingually as possible.

If we want to support breastfeeding among certain families who may have problems, we should affect the primary causes to ensure the family becomes stronger in accepting new information or to invest in something that is important to them. The basics of life should be in order: you should have food, a place to sleep, and no insurmountable problems. (Specialist 8)

Discussion

This study describes the support for breastfeeding mothers from the view of mothers and breastfeeding specialists. According to the key findings, mothers had experienced diverse support and attitudes toward breastfeeding, and the breastfeeding knowledge of some professionals needed updating. Mothers hoped for active, homogeneous, and continuing support for breastfeeding and parenthood, and breastfeeding services that are easy to access. Breastfeeding specialists described the importance of content and skills for breastfeeding counselling, the personnel's need for breastfeeding education, and the strengthening of the breastfeeding service system to promote breastfeeding in general and among mothers in risk groups.

Mothers experienced both helpful and insufficient support for breastfeeding. Even though breastfeeding counselling is a basic task of healthcare and social welfare according to the WHO baby-friendly hospital initiative,^{8,26} mothers' experiences in this study varied largely from caring and supportive relationships to low-quality care. The place of breastfeeding promotion turned out to be a significant factor: the atmosphere in obstetric units had been too busy and counselling too contradictory compared to MCHCs. Furthermore, breastfeeding knowledge was not always up to date in family services. Families should be given information about breastfeeding recommendations, successful breastfeeding, and maintaining milk production prenatally^{8,26} because it might help families cope with big changes caused by the birth of a baby and the start of breastfeeding. Mothers in this study hoped for more high-quality knowledge from MCHCs, family training, and organizations' websites. It is noteworthy to remember that higher-educated parents have better possibilities in searching for breastfeeding knowledge and adapting to it. The mothers' higher level of education also supports breastfeeding confidence.^{10,14} Less educated mothers may not have access to breastfeeding knowledge that is up to date.^{13–15}

Mothers further hoped that personnel in family services would receive regular breastfeeding counselling education. High-quality and updated breastfeeding education maintains the breastfeeding knowledge of personnel.² Quality and knowledge may vary regionally in healthcare and social welfare units. In bigger cities, breastfeeding education may be offered more frequently, and services may be more versatile. In smaller municipalities, the birth rate is lower, and the breastfeeding knowledge of personnel may need updating. It is not ideal that the mothers in this study had to question the inaccurate information they received and continue searching for supporting information from private services and associations.

The lack of continuity of care and the negative attitudes of personnel had influenced mothers' experiences. As individual support or prenatal group activities have been proven to strengthen families' positive breastfeeding attitudes,² they could be one way to improve the situation. Continuity of care, promoted by cooperation between organizations, in turn, has a strong impact on the experienced support: carefully implemented, continuing care can affect breastfeeding success.²³ Breastfeeding support should specifically be given to first-born families, families with unsuccessful previous

breastfeeding experiences, and families in weaker social positions because of the increased risk of finishing breastfeeding earlier than recommended.² Encouraging and genuine support has been reported to strengthen the feeling of capability and breastfeeding confidence of mothers.²⁵

The specialists confirmed the mothers' experiences. They described that the breastfeeding support system does not function adequately. Even though sometimes it is difficult to access the services and mothers may have to wait for an appointment, support should still be received in a timely manner. Personnel's busyness and lack of competence may affect the support families receive and their interaction skills and attitudes may be seen as influencing the quality of counselling. It is not always possible to offer continuing care for a whole family, but follow-up and support should be more efficient, equal, frequent, and sustained, especially among risk groups.^{12,15,19} In addition, several preventive and support services and group activities have been reduced because of economic reasons and changes in the healthcare and social welfare system.

Specialists further described that decreasing social inequality and accessibility of breastfeeding knowledge can be achieved by strengthening health literacy skills since childhood. Personnel do not always have enough skills to recognize or meet families that are in a more vulnerable position socially. All mothers, regardless of their background, are entitled to receive breastfeeding information.¹⁰ However, personnel may not possess enough information about special occasions in breastfeeding, so it is important to cooperate multi-professionally.

Specialists mentioned the development of the breastfeeding service system. Legislation and recommendations guide breastfeeding promotion. Risk groups should be offered regular prenatal follow-ups, accessible services, and group activities to organize peer support.¹² Young mothers are sometimes left out of the family service system because they do not need specialist-orientated counselling but rather individual and health-promoting counselling.^{12,16} To promote immigrant mothers' breastfeeding, high-quality interpreter services and enough time at reception are needed. Means of family services and peer support should be considered from the view of different starting points in health literacy skills.¹⁰ Resources of the service system should be shared equally to promote health instead of healing illnesses.

Families in a more vulnerable social position live in diverse situations in which support and counselling should be acknowledged. As specialists noted, multi-professional cooperation can offer families support for breastfeeding and managing everyday life. It is important to monitor families' social networks and offer support for the determinants of challenges. Mothers would benefit from the versatile services of a breastfeeding counsellor, nutrition therapist, or midwife.⁵ Support is needed to strengthen the parents' relationship because the meaning of the spouse is important for families to manage and for breastfeeding to succeed.¹⁵ Practical support is needed for issues such as mental health problems, lack of social networks, or multiple children in the family. Peer support services endorse families' mental health, roles of parenthood, and breastfeeding and decrease stress.^{5,23,25}

Strengths and limitations

The qualitative approach was deemed appropriate for this study as the experiences of mothers and specialists would have been difficult to obtain through other methodological approaches. The results are rich and provide a window into the phenomenon of breastfeeding from two central viewpoints: mothers and professionals. The findings are transferable into similar environments or service systems.

The reflexivity was increased by the different roles of the first author; maternal and professional backgrounds complemented each other in understanding the complex phenomenon. At the same time, however, it may have affected the assumptions and interpretations, although the objectivity was upheld to the greatest extent possible. The benefits of the phone interviews were the ease of access and the ease of talking about intimate subjects. The disadvantage of the phone interviews, in turn, was the absence of non-verbal interaction.

Conclusion

This study presents mothers' experiences of breastfeeding support and breastfeeding specialists' views on breastfeeding promotion in Finland. Several factors affected the experienced support that should be sufficient, continuing, and of high quality and contain peer and parenting support. Mothers hoped for individual, practical, and accessible breastfeeding support. The breastfeeding atmosphere should be unhurried and encouraging and the breastfeeding knowledge updated. Breastfeeding specialists viewed that the breastfeeding service system's guidance, structures, and resources need to be developed. Family services would benefit from strengthening their cooperation and breastfeeding education for personnel. This study may help address more comprehensive support for breastfeeding mothers in social and healthcare and may contribute breastfeeding promotion in social and healthcare organizations.


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