

Who supports breastfeeding?

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ABSTRACT

'Breastfeeding is best for baby' is the view supported by many health organisations including Australia's National Health and Medical Research Council (NHMRC) and the World Health Organization (WHO). This literature review of both quantitative and qualitative studies was conducted to determine who supports women to breastfeed successfully in the current environment. Results indicated that fathers, other family members and friends can have a significant impact in supporting breastfeeding if they are positive about breastfeeding and have the skills to support breastfeeding. Health professionals are more effective in their support if their attitude to breastfeeding is positive and they have appropriate knowledge and skills to help the breastfeeding mother, something that is often lacking in their training. Peer counsellors and breastfeeding support groups are very effective but only if women access them. Employers and the community know about the benefits of breastfeeding; however, they do not provide much support for breastfeeding. For breastfeeding to be better supported, family and friends need to be more aware of the importance of breastfeeding and how to help mothers; health professionals need more effective training in supporting breastfeeding; peer counsellors and breastfeeding support groups need to be more accessible to breastfeeding women; and employers and the community need to be more breastfeeding friendly.

Keywords: breastfeeding support, community, employers, family, friend, health professionals, peers
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INTRODUCTION

'Breastfeeding is best for the baby' is the view supported by many health organisations including Australia's National Health and Medical Research Council (NHMRC) and the World Health Organization (WHO) who both recommend that babies be exclusively breastfed to six months. In addition, the NHMRC recommend continued breastfeeding for at least 12 months and the WHO recommend continued breastfeeding for at least two years, while complementary foods are introduced (NHMRC 2003, WHO 2001). Although 133 million babies are born each year, only about one third of infants aged 0–5 months are exclusively breastfed (UNICEF 2006). In Australia, while over 80% of babies are fully breastfed at birth, only 18.4% of babies are still being fully breastfed at six months (Donath & Amir 2005).

One factor that may help extend breastfeeding duration is better support for the breastfeeding mother. For example, a recent review on support for breastfeeding mothers that focused on randomized or quasi-randomised controlled studies of interventions involving professional and trained lay people indicated that additional professional or lay support increases breastfeeding rates (Britton et al 2007).

This paper presents a review of the literature that goes beyond the randomized and quasi-randomised controlled studies by considering both qualitative and quantitative studies of

breastfeeding support. Its focus also extends beyond professional and trained lay support to include all key people in mothers' lives - fathers, family, friends, peer counsellors, health professionals, employers and the immediate community.

METHOD

A literature review using the databases Medline, CINAHL and PsychINFO was conducted to identify English language research articles published in peer reviewed journals since 1996. Keywords used were breastfeeding, support, father, spouse, partner, grandmother, sister, family, friend, doctor, nurse, midwife, midwives, professional, provider, physician, paediatrician, obstetrician, general practitioner, lactation consultant, health visitor, peer, counsellor, volunteer, employer, community and public. In addition, peer reviewed articles the authors already had on this topic were also included.

Both quantitative and qualitative research was included to provide a more comprehensive review of not just what works (or does not work) but some understanding of why this might have happened. Publications receiving funding from manufacturers of artificial baby milk were not included.

Results of the review are presented according to the key support groups: fathers; other family members and friends; lactation consultants; doctors; midwives, nurses and other health

professionals; peer counsellors; breastfeeding support groups; employers; and the community.

RESULTS AND DISCUSSION

Of the 152 articles included in this literature review, 59 reported intervention studies and 93 reported descriptive studies that focused on the impact of key people in relation to breastfeeding mothers. Studies were conducted in 24 countries; 7 were developing countries (Bangladesh, Czech Republic, Guatemala, Jamaica, Jordan, Thailand, Uganda) and 17 were developed countries (Argentina, Australia, Canada, Caribbean, Finland, France, Italy, Hong Kong, New Zealand, Northern Ireland, South Africa, Sweden, Scotland, Slovenia, Taiwan, UK, USA). A critique of the methodologies used in each of the articles included in this review was beyond the scope of the study and hence this is recognized as a limitation of this review.

Fathers

There is consensus that the father of the baby is one of the most influential persons to the mother regarding breastfeeding (Dennis et al 2002; Dykes et al 2003; Ekstrom, Widstrom & Nissen 2003; Humenick, Hill & Wilhelm 1997; Humphreys, Thompson & Miner 1998; Ingram & Johnson 2004; Ingram, Johnson & Greenwood 2002; Li et al 2004; Pisacane et al 2005; Scott et al 2001; Scott, Shaker & Reid 2004; Spear 2006a; Tarkka, Paunonen & Laippala 1998; Whelan & Lupton 1998; Wiemann, DuBois & Berekson 1998). This influence is particularly so when the mother is living with the father (Hoyer & Pokorn 1998) and when the partner is the main source of income (Chatman et al 2004).

While this is encouraging if the support is positive towards breastfeeding it can also be a barrier if the father does not support breastfeeding (Arora et al 2000) or is ambivalent about how the baby is fed (Scott et al 2001). For example, in a US study with 86 teenage mothers where only 24% breastfed, 61% of partners had no opinion on feeding method (Harner & McCarter-Spaulding 2004).

The proximity and frequency of contact with the mother may influence the impact other people have on the mother. For example, a long-term relationship with a partner is likely to be more influential on the mother's opinions than a temporary relationship with a health professional (Hauck & Irurita 2003). An Australian study of interviews with 10 women found that support and encouragement from their partner was crucial in keeping them breastfeeding (Hauck, Langton & Coyle 2002). Of interest is a study conducted in a Caribbean village where the absence of the father was associated with early weaning (Quinlan, Quinlan & Flinn 2003).

The lack of fathers' breastfeeding knowledge was found to hinder the support that was provided by fathers (Lavender, McFadden & Baker 2006; Matthey & Barnett 1999; Shepherd, Power & Carter 2000). Furthermore in a UK study, fathers indicated that if they received more practical help, especially with breastfeeding, then they would be better able to cope (Hunter 2004). This finding has been supported by several intervention studies. Ingram and Johnson (2004) tested an intervention with

UK fathers consisting of a 30-minute home visit providing information about the benefits, management and support of breastfeeding plus a demonstration of positioning and attachment of the baby at the breast. This intervention increased breastfeeding rates at eight weeks. Similarly, in Italy, a 40-minute training session with fathers about the benefits and management of breastfeeding was associated with increased rates of full breastfeeding at six months (Pisacane et al 2005). In the US, fathers who participated in a corporate Fathering Program had partners who, on average, breastfed their infants for eight months (Cohen, Lange & Slusser 2002). The proportion of women in this study still breastfeeding at six months was 69%, well above the national average of 21.7% (Cohen, Lange & Slusser 2002). Wolfberg and colleagues (2004) in the US also found that that breastfeeding initiation was significantly increased when expectant fathers attended a two-hour antenatal class on infant care and breastfeeding compared to a class only covering infant care.

Given their importance in supporting women to breastfeed, fathers should be encouraged to become educated about breastfeeding. This strategy needs to include providing fathers with practical skills on how best to support their partner in breastfeeding their baby.

Other family members and friends

In addition to the father, other family members and friends can be central in providing support and advice about breastfeeding, particularly if they have frequent and on-going contact with the mother (Abel et al 2001; Chezem, Friesen & Clark 2001; Haneuse et al 2000; Hauck & Irurita 2003; Scott & Mostyn 2003; Spear 2006a; Stamp & Casanova 2006; Whelan & Lupton 1998; Witters-Green 2003; Yimyam 2003) and do not contradict the father's attitude to breastfeeding (Bentley et al 1999). Women whose family members had a positive opinion about breastfeeding or who had previously breastfed were more likely to breastfeed their infants and to breastfeed longer (Benson 1996; Bentley et al 1999; Cernadas et al 2003; Evans et al 2004; Fallon et al 2005; Humenick, Hill & Spiegelberg 1997; Humphreys, Thompson & Miner 1998; Ingram & Johnson 2004; Ingram, Johnson & Greenwood 2002; Rose et al 2004; Scott et al 2006). Mothers often rely on family members and others for infant-feeding guidance rather than ask for assistance from health professionals when facing difficulties. For example, they expressed concern that health professionals may not understand them when they could not comply with infant-feeding recommendations (Barton 2001; Heinig et al 2006).

In contrast, a Scottish study found that a lack of empathy and approval from a woman's mother may be sufficient to undermine her early attempts to breastfeed, especially for less committed women (Scott & Mostyn 2003). Many women in both Scotland and Canada experienced continual pressure to give their baby a bottle by, often well meaning, family members; particularly when the family member had been unable to breastfeed or were embarrassed about breastfeeding (Lavender, McFadden & Baker 2006; Martens 2002). This pressure could include gifts of formula in case the mother experienced breastfeeding difficulties,

or pressure to bottle-feed as soon as the mother experienced breastfeeding problems (Scott & Mostyn 2003). However, some family members believed they were being supportive of breastfeeding by 'keeping out of her way' and tended to 'leave her in peace' whilst she breastfed even though the mother did not necessarily want this (Lavender, McFadden & Baker 2006).

Cultural factors influence the breastfeeding support offered by family members and friends including how the mothers respond to this. A study of Hong Kong women reported that it was common for Asian women to make their infant feeding decisions based on the wishes of significant others such as the mother, mother-in-law, and husband. Mothers in this study often faced immense pressure from family members to discontinue breastfeeding or to supplement with artificial baby milk (Tarrant, Dodgson & Choi 2004). Similarly, in the predominantly bottle-feeding culture of the UK, Bailey and colleagues (2004) found that expertise and confidence with bottle-feeding were widespread among family and friends. Given that the many influences on the mothers' decision-making are interconnected and reliant upon each other, if one aspect of breastfeeding becomes difficult, other reasons are often brought into play by the mothers and the difficulties with breastfeeding that are anticipated antenatally by these mothers are borne out (Bailey, Pain & Aarvold 2004). Women's perceptions of disapproval of breastfeeding in public and ridicule by friends also impacts on their choice of infant feeding method (Bentley et al 1999; Guttman & Zimmerman 2000; Lavender, McFadden & Baker 2006).

However, a cultural pattern that is supportive of breastfeeding may compensate for the absence of lactation experience. For example in rural Thailand, breastfeeding on demand, strong family support, and traditional practices that encourage close contact between mother and her newborn have enabled mothers to breastfeed even when they have no previous experience (Amatayakul et al 1999).

While the recent trend in countries such as Australia, the UK and USA towards early postnatal discharge and selective postnatal visiting by midwives may be acceptable to women, the care provided after discharge to breastfeed successfully needs to include practical, informational and psychological support (Beake, McCourt & Bick 2005). Indeed Beake and colleagues (2005) suggest that much of this care could be given by family members and friends provided they are supportive of breastfeeding.

Since family members and friends often have frequent and on-going interaction with the mother, providing them with practical information about how they could support a mother with breastfeeding should be encouraged (Ingram, Johnson & Greenwood 2002; Tarrant, Dodgson & Choi 2004). This information could be provided in a similar manner as that for fathers; however it may be somewhat challenging in predominantly bottle-feeding cultures where the support for the breastfeeding mother is often non-existent or minimal.

Lactation consultants

Several studies have shown that lactation consultants are able to help mothers who have difficulties with breastfeeding and in

doing so may contribute to a longer duration of breastfeeding (Bonuck et al 2005; Fetherston 1995; Gonzalez et al 2003; Haas et al 2006; Humphreys, Thompson & Miner 1998; Lawlor-Smith, McIntyre & Bruce 1997; McKeever et al 2002; Memmott & Bonuck 2006). Fallon and colleagues (2005) and Lee (1997) have also demonstrated this association with telephone-based support. Indeed, lactation consultants give more positive encouragement than other health professionals (Humenick, Hill & Spiegelberg 1998; Humphreys, Thompson & Miner 1998; McKeever et al 2002) and are recommended to mothers with breastfeeding problems by other health professionals (Register et al 2000).

Early discharge accompanied by in-home support from an International Board Certified Lactation Consultant (IBCLC) resulted in better exclusive breastfeeding rates for mothers of term newborns compared to the breastfeeding support offered in hospitals during standard length of hospitalization (McKeever et al 2002). An economic analysis of this Canadian study also showed that the cost of home lactation support was comparable to the hospital-based standard care (Stevens et al 2006).

Since lactation consultants have a positive effect on duration of breastfeeding, mothers should have easier access to these health professionals and be encouraged to use them. Given that there are currently less than 18,000 IBCLCs world wide (International Board of Lactation Consultant Examiners 2008), there is a real need to increase this number as well as to promote this profession to the community.

Doctors

Several studies have shown that doctors lacked knowledge about breastfeeding and how to support breastfeeding mothers. However these same studies also indicated that many doctors acknowledge that this is a gap in their formal training and that they rely on allied health professionals to provide this expertise (Arthur, Saenz & Replogle 2003; Bunik, Gao & Moore 2006; Burt et al 2006; DiGirolamo, Grummer-Strawn & Fein 2003; Smale et al 2006; Taveras et al 2004).

Nevertheless, mothers often breastfeed and breastfeed for longer when a pediatrician recommends that they breastfeed (Schneidrova et al 2003). In a US study, mothers of very-low-birth-weight babies who initially chose artificial baby milk, chose to breastfeed after the physician talked with them about the health benefits of breastfeeding their infant (Miracle, Meier & Bennett 2004). Increased breastfeeding due to breastfeeding support was also the case in an Australian study of Japanese immigrant mothers who breastfed for longer periods because their doctor was supportive of breastfeeding (Utaka et al 2005). Similarly, doctors' support of breastfeeding was positively associated with the initiation of breastfeeding in Chinese mothers in Australia (Li et al 2004). On the other hand, mothers who discontinued exclusive breastfeeding were more likely to report that a health care provider recommended supplementation with artificial baby milk (Taveras et al 2004). In this same US study, health care providers also reported that limited time with the mother and a lack of confidence in resolving breastfeeding problems were barriers to them promoting breastfeeding (Taveras et al 2004). In

another US study, lack of confidence in physician knowledge and support of breastfeeding were identified by breastfeeding mothers as major barriers to increasing breastfeeding rates (Witters-Green 2003). Furthermore Sheehan and colleagues (2001) found that risk factors for breastfeeding cessation in Canada included one or more maternal visits to a family physician; unmet need for care or help with breastfeeding; and receiving advice, information, or support about artificial feeding.

Educating doctors who have contact with breastfeeding women has a positive effect on breastfeeding duration as shown when physicians in a French study received a 5-hour training program on breastfeeding (Labarere et al 2005). Furthermore when US pediatric residents were enrolled in a field trip model of breastfeeding instruction they exhibited significant increases in attitude and experience towards breastfeeding and self-reported high levels of satisfaction compared to controls (Bunik, Gao & Moore 2006). This field trip model of breastfeeding instruction included a visit to a La Leche League home meeting, a lactation consultant clinic, hospital-based lactation rounds, and a children's hospital-based referral clinic. Hillenbrand and Larsen (2002) also showed that an education intervention increased clinical behaviours of US pediatric residents.

Given that doctors can have a significant impact on breastfeeding choice and duration, educating doctors about breastfeeding and the importance of support for the breastfeeding women is likely to improve breastfeeding rates.

Midwives, nurses and other health professionals

Health professionals, particularly midwives and nurses, can influence a woman's decision to initiate or continue breastfeeding. Women hold their opinions and knowledge in high regard and often defer to them for breastfeeding assistance (Miracle, Meier & Bennett 2004; Svedulf et al 1998).

The quality of breastfeeding knowledge and advice of the health professional can affect their level of support for the breastfeeding mother. Several surveys have shown that nurses involved in breastfeeding support had incorrect information and negative attitudes toward breastfeeding or did not have sufficient information to be able to help mothers (Freed et al 1996; Register et al 2000; Spear 2006b). Although US pediatric nurse practitioners appeared to have a more supportive attitude and better information than pediatric physicians, they reported themselves to be less effective in providing breastfeeding assistance than did their pediatric physician colleagues (Hellings & Howe 2004). Midwives who are often expected to be breastfeeding experts also reported being ill-prepared to support breastfeeding women (Smale et al 2006; Register et al 2000). Likewise, UK pediatric staff reported that they received no training in breastfeeding during or after nursing school (Pantazi, Jaeger & Lawson 1998).

Some studies found that not only were there concerns about poor attitudes towards breastfeeding from the staff but there were also concerns about staff patient ratios and inadequate breastfeeding knowledge and experience (Gagnon et al 2005; Hughes 1998; Moran et al 2004; Smale et al 2006). In an Australian hospital setting, the more skilled or experienced staff tended to

work in the birth suite while less skilled and experienced staff were allocated to the postnatal ward. In addition, the staff patient ratio was often higher in places where the need was great so that mothers were less likely to get help when they most needed it (Forster et al 2006).

Many women in countries such as Australia and the UK expect their period in hospital after giving birth to be a time of rest with support for breastfeeding. However, in a UK study mothers indicated that in practice the environment was not conducive to rest and the support they wanted was difficult to obtain (Beake, McCourt & Bick 2005). Conflicting advice was also a common complaint from mothers in the postpartum period and this has a detrimental effect on mothers who choose to breastfeed. Inconsistent advice was mostly associated with inaccurate information and an authoritarian way of communication which could worsen the effect of inconsistencies in approach and information provided (Miller et al 1997; Simmons 2002; Tarrant, Dedgeson & Fei 2002). In addition, from a timing perspective, offering breastfeeding support postnatally was not always sufficient to increase breastfeeding duration (Sheehan et al 2006).

Women preferred to be shown skills rather than be told how to do them. In post-natal interviews Scottish women described how the apprenticeship style learning of practical skills was valued, particularly time patiently spent watching them feed their baby (Hoddinott & Pill 2000). In the UK, those women who continued to breastfeed were more likely to have received good advice, especially with regard to positioning the baby at the breast; had greater continuity of midwifery input; had sufficient quality time with a midwife; and had the opportunity to solve problems with a community midwife's help (Whelan & Lupton 1998).

Health professionals who enabled positive breastfeeding experiences for women in the immediate postnatal period resulted in these women continuing to breastfeed (Benson 1996; Graffy & Taylor 2005; Hailes & Wellard 2000). On the other hand, women reported having negative breastfeeding experiences when they perceived midwives to be too busy, to not have enough time to help, or to be insensitive to the mothers' needs (Benson 1996; Berridge et al 2005; Cox & Turnball 2000; Gagnon et al 2005; Graffy & Taylor 2005; Hailes & Wellard 2000; Hauck, Langton & Coyle 2002; Hong et al 2003). Cloherty, Alexander and Holloway (2004) raise the issue that health professionals wanted to protect the mothers from tiredness or distress, although this, at times, conflicted with their role in promoting breastfeeding. In this UK study, health professionals reported that they were sometimes reluctant to promote breastfeeding because they were concerned about making mothers who chose artificial feeding feel guilty or making mothers who cannot breastfeed feel like failures. In addition they sometimes suggested supplementation because they perceived mothers to be tired (Cloherty, Alexander & Holloway 2004).

Nurses' supportive behavior was best predicted by their breastfeeding knowledge and attitudes (Bernaix 2000) and their own personal experience with breastfeeding (Patton et al 1996). Indeed, breastfeeding education has been shown to help midwives and nurses in improving their breastfeeding knowledge,

breastfeeding management advice and attitudes to breastfeeding (Downie, Rakic & Juliff 2002; Ekström, Widström & Nissen 2006; Mitra et al 2003; Moran et al 2000; Pugh, Milligan & Brown 2001; Vittoz 2004). However, Cantrill, Creedy and Cooke (2003a, 2004) found that there were deficits in key areas of breastfeeding knowledge and practice in Australia, and that on-the-job experience was the most common source accessed, with continuing education the most valued (Cantrill, Creedy & Cooke 2003b).

Midwives, nurses and other health professionals working with mothers need adequate training in the promotion and management of breastfeeding. In addition, these health professionals need to be better resourced so they can provide appropriate breastfeeding support.

Peer counsellors

Several studies have shown that women who had contact with a peer counsellor (also known as a breastfeeding counsellor) were very satisfied with their support, were more likely to initiate breastfeeding and tended to breastfeed longer (Adams et al 2001; Ahmed et al 2006; Anderson et al 2005; Arlotti et al 1998; Battersby & Sabin 2002; Berg 2003; Chapman et al 2004; Dearden et al 2002; Dennis et al 2002; Haider et al 2002; Hoddinott, Lee & Pill 2006; McInnes & Stone 2001; Pugh et al 2002; Schafer et al 1998; Shaw 1999, Sheehan & Kaczorowski 1999; Vari, Camburn & Henly 2000). Indeed, Martens (2002) found that postpartum peer counselling in Canada had better breastfeeding rates and maternal satisfaction than prenatal instruction by a community health nurse. Mothers consistently reported that peer counsellors were well prepared and effective in assisting them with breastfeeding (Smale et al 2006).

In a rural Ugandan study, women were trained as peer counsellors and were accepted by the mothers since they came from within their community. The husbands also welcomed the idea of their peer counsellor helping their wives with breastfeeding problems (Nankunda et al 2006).

A Scottish study showed that many women found the peer counsellors were often their only means of support apart from, and in some cases, in place of, a health professional (Scott & Mostyn 2003). Many women reported being able to talk more openly about their breastfeeding experiences without being hurried, and at a time that was convenient for them. Some women even became friends with their peer counsellor (Scott & Mostyn 2003).

By contrast, two randomised controlled studies of peer counsellors did not show any improvement in breastfeeding rates (Graffy et al 2004; Muirhead et al 2006). In a UK study, women in an intervention group who had access to peer counsellors did not breastfeed any longer, on average, than women in the control group. It was found that 38% of these women had not asked for help from the peer counsellors so, in effect, received no 'intervention' (Graffy et al 2004). Accordingly, Hay (2004) suggests that this support needs to be more proactive. However, in a Scottish study where peer counsellors contacted the mothers, breastfeeding rates did not change significantly although the

absence of this support in the first few days postpartum following discharge may have reduced the effect (Muirhead et al 2006).

Given that peer counsellors are both acceptable to mothers and effective in providing breastfeeding support where it is provided proactively and throughout the postnatal period, peer counsellors should be made more available.

Breastfeeding support groups

Like peer counsellors, breastfeeding support groups such as the Australian Breastfeeding Association and La Leche League provide good support for breastfeeding women that enables them to overcome breastfeeding difficulties and continue breastfeeding for longer (Alexander et al 2003; Brook 2006; Hoddinott, Chalmers & Pill 2006; Ingram, Rosser & Jackson 2004). Reassurance, feeding frequency, and breastfeeding technique are the most common reasons Australian mothers contact these groups (Grieve & Howarth 2000; Grieve et al 1997). Breastfeeding support groups are popular because they normalise breastfeeding in a social environment. They provide flexibility, a sense of control, and a diversity of visual images and experiences, which assists women to make feeding-related decisions for themselves. They offer a safe place to rehearse and perform breastfeeding in front of others, in a culture where breastfeeding is seldom seen in public (Hoddinott, Chalmers & Pill 2006). Mothers often find it easier to talk to other mothers about breastfeeding than they do with a health professional (Alexander et al 2003). More recently, internet breastfeeding support groups have been set up and found to be effective for some mothers (Gribble 2001).

Given that this resource is effective, women should be encouraged to participate in breastfeeding support groups. Indeed, breastfeeding support could be further enhanced with the formation of partnerships between health professionals, peer counsellors and breastfeeding support groups. This strategy could include sharing the workload, providing an informal tier of support to mothers, and the provision of support and advice stemming from personal experience (Raine 2003).

Employers

With over 50% of women with children aged 0–4 years in the Australian workforce (Australian Bureau of Statistics 2006), there is concern about the impact work has on breastfeeding. Many women find it difficult to combine breastfeeding with work often resulting in them weaning early or not even initiating breastfeeding (Kaewsarn & Moyle 2000; Khassawneh et al 2006; Libbus & Bullock 2002; McIntyre, Hiller & Turnbull 2001a; Scott et al 2006; Visness & Kennedy 1997). Studies in Taiwan and South Africa suggest that breastfeeding women need encouragement and support from family as well as their work colleagues and their employer when combining breastfeeding with work (Chen, Wu & Chie 2006; Netshandama 2002).

Breastfeeding support amongst employers is still relatively low. Several studies have shown that employers do not place a high priority on providing breastfeeding support, despite knowing of the benefits of breastfeeding for mothers and children (Brown, Poag & Kasprzycki 2001; Libbus & Bullock 2002). Dodgson,

Chee and Yap (2004) have found a similar lack of support in hospital workplaces that provide maternity services where health professionals promote breastfeeding. Without employer support and job flexibility, breastfeeding is hindered (Witters-Green 2003). Positive support toward breastfeeding in the workplace is more likely to occur where employers have had experience working with women who have breastfed or have knowledge of other businesses who have employed breastfeeding women (Bridges, Frank & Curtin 1997).

Employers need to be encouraged to develop and implement breastfeeding policies that support breastfeeding when breastfeeding mothers return to work (Eldridge & Croker 2005; McIntyre et al 2002). Health professionals could assist employers with this transition of workplaces becoming more breastfeeding friendly by providing breastfeeding education and support in their workplaces (McIntyre et al 2002).

The community

Although the community may acknowledge breastfeeding as the best source of nutrition for babies, it is generally not supportive of breastfeeding in public. Breastfeeding in public may cause embarrassment to members of the community and, in many cases, also the mother (Boyd & McIntyre 2004; Lavender, McFadden & Baker 2006; McIntyre, Hiller & Turnbull 2001a, 2001b; Sittlington et al 2007; Stopka et al 2002; Vogel & Mitchell 1998). This concern about breastfeeding in public is even more pronounced in predominantly bottle-feeding cultures such as found in Scotland (Scott & Mostyn 2003) and Northern Ireland (Sittlington et al 2006) where many believe that breastfeeding in public should be prohibited. Indeed, some mothers have stopped breastfeeding because of their concerns about breastfeeding in public (Scott & Mostyn 2003). Several studies have indicated that managing breastfeeding in public is dependent on a range of factors including confidence with breastfeeding, the ability to be discreet, previous experience, the age of the breastfeeding child, the audience, feelings of the partner, breastfeeding location and perceptions of societal expectations (Hauck 2004; Scott & Mostyn 2003; Sheehan, Schmied & Cooke 2003; Smith 2003).

Given that mothers nowadays spend more time outside the home and thus need to breastfeed while out of the home, breastfeeding in public is an essential part of breastfeeding successfully. However, studies in Australia and Scotland indicate that breastfeeding in public is a major barrier to breastfeeding (Boyd & McIntyre 2004; Scott & Mostyn 2003). It is imperative that breastfeeding in public be supported and promoted as an important factor to successful breastfeeding. Legislation is in place in many countries that protects breastfeeding in public (Australian Breastfeeding Association 1998; Infact Canada nd; UNICEF UK 2002; United States Breastfeeding Committee 2003). However, this needs to be promoted better so that breastfeeding mothers are aware of their rights to breastfeed in public (Boyd & McIntyre 2004).

CONCLUSION

This review has identified those key people who have supported breastfeeding mothers: fathers; other family members and friends;

lactation consultants; doctors; midwives, nurses and other health professionals; peer counsellors; breastfeeding support groups; employers; and the community. The variation in the level of support provided by these key people indicates that many mothers do not receive adequate and appropriate support to breastfeeding successfully.

Recommendations to improve this support involve providing information to these support people that is both practical and timely in relation to the promotion and management of breastfeeding. Fathers, family members and friends who have on-going contact can be more supportive if they had more practical information about the management of breastfeeding. Indeed, this also applies to most health professionals since very little is covered in their basic training. In addition, employers and the community need to be more breastfeeding friendly to ensure that mothers can breastfeed successfully.

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Statement of Mutual Support from the Australian Breastfeeding Association for the International Board of Lactation Consultant Examiners

The Australian Breastfeeding Association (ABA) (formerly the Nursing Mothers' Association of Australia) has been involved from the inception of the International Board of Lactation Consultant Examiners (IBLCE) because it recognised that some of the problems mothers experienced were beyond the scope of practice of the ABA counsellor. This credential was seen as providing a career option and professional recognition for those ABA counsellors who wanted to specialise in clinical lactation, ensuring their ongoing education as they built evidence-based practice.

Similarly, the IBLCE recognises the value of the ABA counsellors in providing the mother-to-mother support essential to widespread breastfeeding success in a contemporary setting. The IBLCE recognises that mother-to-mother support is the foundation on which rests the community-based public health programs in educating the public about the value of breastfeeding, advocating for breastfeeding babies, helping mothers and their families understand the normal course of breastfeeding and thereby empowering women to breastfeed.

The IBLCE recognises that the role of ABA counsellors is different from that of the IBCLC. The ABA counsellor provides ongoing support and information that is necessary to improve lactation outcomes. IBLCEs provide another layer of support and information, working cooperatively as members of the health care team by offering skilled crisis intervention and non-medical problem solving which the ABA counsellor may not wish to provide. The roles of the two designations are not duplicative but rather integrative and complementary, and mutual referrals provide optimum benefit to the mother-baby dyad.