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Women's perspectives on the role and impact of Breastfeeding Support Groups in Ireland

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Abstract

Background: Breastfeeding Support Groups are deemed effective in promoting breastfeeding initiation and duration, but few studies have addressed the mothers' perspectives.

Research aim: To investigate the role and impact of Breastfeeding Support Groups on breastfeeding mothers in Ireland from the women's perspective. Specific objectives included the assessment over time of breastfeeding self-efficacy knowledge, use, and limitations of BSGs and whether they contributed towards women achieving their breastfeeding goals.

Methods: An online survey using an established, validated Breastfeeding Self-Efficacy tool and custom-designed questions was administered at two time points as part of a larger sequential explanatory mixed methods' design. Cultural Historical Activity Theory was used as the theoretical framework.

Results: Majority of respondents at Phase 1 (N=978) were multiparous, urban dwellers, and breastfeeding more than twelve months. Mothers first attend Breastfeeding Support Groups primarily to meet other breastfeeding mothers with many attending multiple types of group formats weekly. Qualities considered extremely important in breastfeeding supporters were: personal breastfeeding experience breastfeeding knowledge empathy understanding and listening skills There was no statistical difference in breastfeeding self-efficacy over time ($z=-1.296$, $p=.195$, $r=-0.06$).

Conclusions: Participants attend Breastfeeding Support Groups to 'meet other mothers' in a convenient and local location, and not necessarily for a problem. Breastfeeding Support Groups normalise breastfeeding through social support, with breastfeeding supporters providing knowledge, empathy, understanding listening, and personal breastfeeding experience. Breastfeeding self-efficacy was high and did not increase over time, suggesting mothers need to be highly efficacious in this cohort to breastfeed.

Keywords:

Breastfeeding support; cultural norms; maternal health; peer support; social support, Cultural Historical Activity Theory; breastfeeding self-efficacy

Introduction:

A significant body of scientific literature shows breastfeeding has significant positive long-term impacts on the health, nutrition and development of mother and child (Victora et al., 2016) resulting in short and long term health, economic and environmental benefits for society (Baker et al., 2023; Pérez-Escamilla et al., 2023; Rollins et al., 2016; Victora et al., 2016).

Globally, only 44% of infants under 6 months of age are exclusively breastfed (UNICEF & WHO, 2022; WHO, 2024) with few countries likely to meet the WHO targets of 70% exclusive breastfeeding by 2030 (Pérez-Escamilla et al., 2023). Countries are advised to

amplify their efforts to meet all target rates as a priority (UNICEF & WHO, 2022). The World Health Organization recommends breastfeeding support interventions should form part of any health strategy to improve breastfeeding rates (Trickey et al., 2018), acknowledging that community networks are crucial in supporting breastfeeding maintenance and overcoming difficulties (UNICEF & WHO, 2022). Community-based support is a key part of the Baby-friendly Hospital Initiative (BFHI) (WHO, 2018) and Harris et al. (2015) suggests that community-based peer support increase health literacy, reducing health inequalities for all income groups.

A Cochrane Systematic Review on support for healthy breastfeeding mothers and healthy full-term babies (McFadden et al., 2017) concluded all forms of additional breastfeeding support, both lay and professional, increases breastfeeding continuation. However, the review located few articles relating to peer support groups, recommending a need to obtain women's views and the effective aspects of peer support.

Peer supporters have been found to provide socio-emotional support and practical breastfeeding assistance both prenatally and postnatally (Kempenaar & Darwent, 2013). The Breastfeeding Lancet Series 2023 papers (Pérez-Escamilla et al., 2023) acknowledge that skilled support and practical assistance is needed before and after birth to enable mothers to breastfeed their children optimally for as long as they, or their babies, desire.

A systematic search of the literature for this study suggested there were five key factors that affected women's breastfeeding: levels of breastfeeding self-efficacy; parity (primiparous or prima/multiparous or multi); location; length of current breastfeeding; and maternal Age that guided the comparative factors used in this quantitative study.

There is a dearth of research on women's perspectives of BSGs with most focused on health professionals' views of single, time-limited interventions run by health professionals rather than peer support groups run by trained, accredited peer counsellors as evidenced by McFadden et al. (2017).

Breastfeeding self-efficacy was also identified as an important construct to measure in any breastfeeding research (Tuthill et al., 2016) with the breastfeeding self-efficacy scale (BSES-SF) instrument (Dennis, 2003) the most widely used by researchers (Tuthill et al., 2016).

Additionally, there was little discussion in the literature related to theory and breastfeeding support. This research uses Cultural Historical Activity Theory (CHAT) as the theoretical framework that focuses on practice in communities rather than on individual action (Engeström, 2009; Engeström, 1987, 1999). Breastfeeding is considered a public health responsibility (Brown, 2017) and a societal issue requiring a collective approach rather than being the responsibility of individual mothers (Baker et al., 2023; Pérez-Escamilla et al., 2023) The CHAT framework informed the design of the study and survey questions and is the first study, to our knowledge, that considers breastfeeding support from a CHAT perspective.

The aim of this study, therefore, was to investigate the role and impact of Breastfeeding Support Groups on breastfeeding mothers in Ireland from the women's perspective. The

following objectives were determined, to determine the knowledge and use of BSGs, to investigate the strengths and limitations of BSGs, to ascertain if breastfeeding support enables achievement of breastfeeding goals and increases breastfeeding self-efficacy.

This study comprised the quantitative aspect of a mixed-methods' study with the qualitative aspect of the study reported elsewhere (McCarthy Quinn et al., 2019b).

Design

An online survey, that included a previously validated instrument: the Breastfeeding Self-Efficacy Scale (BSES-SF) (Dennis, 2003) and custom-designed questions were developed. to determine a) knowledge and use of BSGs b) women's views on strengths and limitations of BSGs c) ascertain if BSGs enable achievement of own breastfeeding goals and increased breastfeeding self-efficacy. The survey design was informed by CHAT (Table 1).

There were 5 sections in the survey: 1) Facilitated generation of code to match follow-up survey 2) Breastfeeding status 3) Experiences of BSGs 4) Knowledge of BSGs 5) Use of BSGs 6) Breastfeeding Self-Efficacy tool and 7) Demographics.

An 'expert panel' (N=7) consisting of trained breastfeeding supporters and academic researchers were asked to review the initial questions and make comments and suggestions related to the survey content and ease of use.

Table 1: CHAT informing Study design and Survey questions (adapted from Mwanza 2001)

Activity	What sort of activity am I interested in?
Object (objective)	Why is the activity taking place?
Subjects	Who is involved in carrying out the activity
Tools	By what means are the subjects performing the activity?
Rules and regulations	Are there any cultural norms, rules or regulations governing the performance of the activity?
Division of Labour	Who are responsible for what, when carrying out activity, and how are those roles organized?
Community	What is the environment in which this activity is being carried out?
Outcomes	What is the desired outcome from carrying out this activity?
Source: (Mwanza, 2001)	

A Pilot survey was completed by participants online (n=219) to test the study processes during June 2015 (for Phase 1). Participants were breastfeeding supporters who would not be participating in the actual study as is advised by Bryman and Bell (2015). A sub-sample of nineteen participants were asked to repeat the pilot survey 48 hours' later (Phase 2) to assess for stability of response over time using test-retest procedures. From the sub-sample, data collected from 14 matched participants for the BSES-SF (Phase 1 and Phase 2) and indicated that the scale has a high level of internal consistency, as determined by a Cronbach alpha co-efficient α .96 comparing favourably to that reported by Dennis (2003) (Cronbach's alpha 0.94).

The online survey (BSGS survey) was administered at two time points (Phase 1 and 2) that were three months apart to assess if there had been a change in breastfeeding self-efficacy over time, as part of a larger sequential explanatory mixed methods' study (McCarthy Quinn et al., 2019a). The survey at Phase 1 and 2 were conducted first with the results informing the design of the qualitative interviews conducted subsequently: the interview data was published separately (McCarthy Quinn et al., 2019b) The online survey data from Phase 1 is reported in this paper along with the data on breastfeeding self-efficacy from Phases 1 and 2 to assess for change in self-efficacy over time.

Ethics:

Ethical approval was obtained from the School of Nursing and Midwifery Research Ethics Committee (SNMREC). Ethical guidelines for the conduct of internet-mediated research were followed throughout that include four principles: respect for the autonomy, privacy and dignity of individuals and communities; scientific integrity; social responsibility; and maximising benefits and minimising harm (British Psychological Society 2017).

Informed consent was obtained by clicking on a link at the end of the Participation Information Leaflet on the website indicating consent before proceeding to the survey. The study was guided by The Code of Ethics of the World Medical Association (Declaration of Helsinki) (World Medical Association, 1964, 2013, 2023) that includes: general principles of conduct for medical research; risks, burdens, and benefits; vulnerable groups and individuals; scientific requirements and research protocols; privacy and confidentiality; and informed consent.

Population/Sample:

The population of interest were breastfeeding mothers who were; currently breastfeeding or who had recently breastfed in the last 6 months, were aged over 18 years, sufficient English language fluency, and attended face-to-face BSGs or accessed online BSGs. All participants who identified as a 'mother' were included.

Based on numbers supplied by breastfeeding support groups and the health services, 215 face-to-face BSGs and a population of 8,000 mothers was assumed. By applying a '1 in 20' sampling fraction (Bryman & Bell, 2015), this resulted in a proposed sample of 400, confidence level of 95% for the quantitative aspect for Phase 1, and 200 for Phase 2. The actual level of participant achieved was considerable higher (Phase 1, N=938, Phase 2, N=412).

Recruitment

In Ireland, there are two main Breastfeeding Support Groups: La Leche League (La Leche League of Ireland, 2014) and Cuidiú (Cuidiú, 2014b) providing regular face-to-face meetings and have formal training/accreditation programmes (Cuidiú, 2014a; La Leche League, 2009) for their "Leaders" (uppercase L) and "breastfeeding counsellors" respectively. Friends of Breastfeeding (FOB), originally an online group, have also initiated face-to-face groups and they also now provide training (Friends of Breastfeeding, 2015).

Mothers were recruited through Cuidiú, La Leche League and Friends of Breastfeeding, along with general parenting websites. Participants were directed towards the study website www.breastfeedingresearch.ie, specifically designed and set up for the study, with the online Survey link open for four weeks for each phase. SurveyMonkey® (www.SurveyMonkey®.com) was used to collect survey data, providing a secure encryption-coded interface collection of data.

Method:

Data collection:

Participants were asked to identify their own 4-digit code in Phase 1 in July 2015 (N=978) and invited to participate in Phase 2 in October 2015 (N=412). This code facilitated linking the two questionnaires, preserving confidentiality. Survey data were exported from SurveyMonkey® into IBM SPSS Statistics 24.

The survey collected data relating to breastfeeding status, experiences and knowledge of BSGs, and demographic details and included a previously validated breastfeeding self-efficacy instrument (BSES-SF), widely used in breastfeeding research (Dennis, 2003) (**Error! Reference source not found.**). The Cronbach alpha co-efficient α in Phase 1 at 0.93 for this study were in line with (Dennis, 2003) at .94 indicating high reliability.

Data analysis

Descriptive statistics are presented for Phase 1 with Phase 2 data presented relating to the BSES-SF only to assess for change over time.

Inferential statistics, using chi-square, was used for comparative factors for Phase 1 data. Four comparative factors were used: Parity (primiparous or prima/multiparous or multi); Location (Urban/Rural); Length of current breastfeeding (<3mths, 3–6mths, 6–12mths, and >12mths) and Maternal Age. These factors were compared to variables relating to BSG attendance such as: reasons for attending; access to BSGs; knowledge of; and rates of breastfeeding self-efficacy.

Breastfeeding self-efficacy was assessed using the BSES-SF (Dennis, 2003) (Table 2):

Table 2: BSES-SF (Breastfeeding Self-Efficacy Short form) adapted from Dennis (2003)

BSES-SF – Breastfeeding Self-Efficacy Scale – Short Form	not at all confident	not very confident	sometimes confident	confident	very confident
I can always determine that my baby is getting enough milk	1	2	3	4	5
I can always successfully cope with breastfeeding like I have with other challenging tasks	1	2	3	4	5
I can always breastfeed my baby without using artificial milk as a supplement	1	2	3	4	5
I can always ensure that my baby is properly latched on for	1	2	3	4	5

the whole feeding					
I can always manage the breastfeeding situation to my satisfaction	1	2	3	4	5
I can always manage to breastfeed even if my baby is crying	1	2	3	4	5
I can always keep wanting to breastfeed	1	2	3	4	5
I can always comfortably breastfeed with my family members present	1	2	3	4	5
I can always be satisfied with my breastfeeding experience	1	2	3	4	5
I can always deal with the fact that breastfeeding can be time consuming	1	2	3	4	5
I can always finish feeding my baby on one breast before switching to the other breast	1	2	3	4	5
I can always continue to breastfeed my baby for every feeding	1	2	3	4	5
I can always manage to keep up with my baby's breastfeeding demands	1	2	3	4	5
I can always tell when my baby is finished breastfeeding	1	2	3	4	5

BSES-SF scores range from 14 to 70 with a score of 50+ considered high self-efficacy (Nanishi et al., 2015). There were 232 matched responses from the same respondents at Phase 1 and Phase 2 for the BSES-SF scale. Breastfeeding self-efficacy scores were determined by comparing Phase 1 and 2 longitudinal data. Validity estimates were taken from the first dataset (Phase 1, N=727) with the mean BSES-SF scores ($M= 58.07$, $SD 9.98$) indicating high breastfeeding self-efficacy (Table 3).

Table 3: Phase 1 (n=727) Self-efficacy – high or low

Self-efficacy	Score range	n	%
High BSE	50 and over	588	80.9
Low BSE	50 + under	139	19.1
Total		727	
Missing		251	

Mann-Whitney U test, Kruskal-Wallis tests, and tests using Spearman co-efficient were used, where appropriate, for the comparative factors (Parity, Location, Length of current breastfeeding, Maternal Age) and other variables related to breastfeeding self-efficacy as data is non-parametric. Hierarchical multiple regression was used to assess the ability of the four comparative factors to predict levels of Breastfeeding Self-Efficacy, the sole continuous outcome variable.

An alpha level of .05 (two-tailed) was used for most statistical tests (VandenBos, 2010), with a significance level of <.001 in tests of multiple and logistic regression (Pallant, 2010).

The range of scores possible for the BSES-SF is 14 to 70 with 50 deemed the cut-off point for low and high self-efficacy for intervention purposes (Nanishi et al., 2015). The average score for respondents on Phase 1 (n=727) is high at 58.1. For Phase 1, 80.9% (n=588) of mothers had high self-efficacy with 19.1% (n=139) having low self-efficacy.

Results:

Demographics

The mean age of respondents was 33.7 years (SD=6.12) with the majority between 30-39 years' (n=549, 78.7%); Irish born (n=595, 83.6%); educated to third level (n=527, 76.8%); married (n=557, 78.2%); in employment (n=452, 63.5%); working full-time in the home (n=182, 25.6%) or self-employed (n=56, 7.9%); and living in an urban location (N=437, 61.4%) (Table 4).

Demographics (Phase 1, N=938)

Table 4: Demographics (Phase 1, N=938)

Description	Detail	n	%	N=	%
Age of Mother	20-29 years	73	10.5		
	30-39 years	549	78.7		
	40+	76	10.7	698	100.0
Country of Origin	Ireland	595	83.6		
	UK	52	7.3		
	EU	38	5.3		
	Other	27	3.8	712	100.0
Ethnic Origin	Irish	586	82.3		
	Any other White	108	15.2		
	Other (mixed)	18	2.5	712	100.0
Education Level	Third Level	527	76.8		
	PLC/Diploma	111	16.2		
	Secondary Level	48	7.0	686	100.0
Relationship status	Married	557	78.2		
	Domestic partner/ civil union/cohabiting	131	18.4		
	Single	14	2.0		
	Divorced/Separated	10	1.4	712	100.0
Occupation	Employee (full/part-time)	452	63.5		
	Home/family	182	25.6		
	Self-employed	56	7.9		
	Student/Unemployed	22	2.2	712	100.0
Location	Urban	437	61.4		
	Rural	275	38.6	712	100.0

Breastfeeding status (N=938)

The majority were multiparous (n=524, 54.1%), over a third breastfeeding more than 12 months (n=365, 39.3%), and over a quarter 6 to 12 months (n=244, 26.3%). More than half intended to breastfeed more than 12 months (n=550, 64.8%) and a quarter for 6 to 12 months (n=218, 25.7%). The majority were 'exclusively breastfeeding' at hospital discharge or 48 hours after birth (n=803, 85.6%) (Table 5).

Table 5: Breastfeeding Status Phase 1, (N=938)

Breastfeeding Status	Detail	n	%	N=	%
Currently breastfeeding	> 12 months	365	39.3		
	6 to 12 months	244	26.3		
	3 to 6 months	187	20.2		
	< 3 months	132	14.2	899	100.0
Intending to breastfeed	> 12 months	550	64.8		
	6 to 12 months	218	25.7		
	3 to 6 months	67	7.9		
	< 3 months	14	1.6	849	100.0
Feeding on discharge (at 48hrs, if homebirth)	Exclusively breastfeeding	803	85.6		
	Combination feeding	104	11.1		
	Expressing breastmilk only	31	3.3	938	100.0
Current infant feeding	Breastfeeding and solid food	461	49.1		
	Exclusive breastfeeding	242	25.8	712	100.0
	Breastfeeding, formula, solid food	53	5.7		
	Formula feeding and solid food	43	4.6		
	Combination (breast/formula)	34	3.6		
	Formula feeding only	21	2.2		100.0
	Expressed breastmilk only	7	0.7		
	Other	77	8.2	938	100.0

Main Reason for attending BSGS (N=829)

Women reported that the main reason they first attended a BSG was 'to meet other breastfeeding mothers' (n=247, 29.8%) rather than with a breastfeeding problem (n=196, 23.6%). They continued to attend BSGs for this reason – 'to meet other mothers' (n=219, 33.5%) with other reasons considered 'extremely important' were: 'to get breastfeeding support' (n=219, 33.8%), and 'to get help with problems' (n=200, 31.6%).

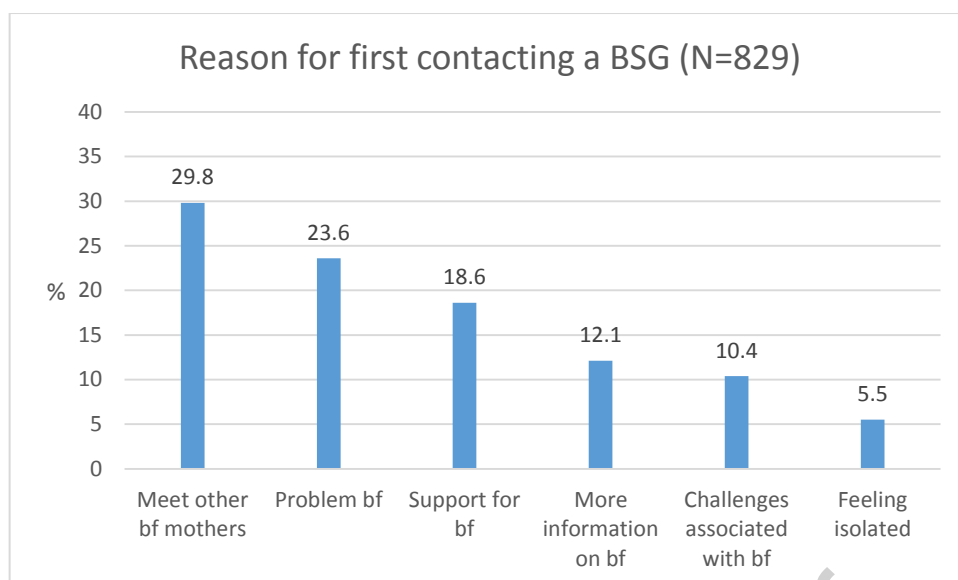


Figure 1: Reason for first contacting a BSG

Knowledge and use of BSGs

Mothers reported that they found out about the existence and availability of Breastfeeding Support Groups from two main sources: three-quarters obtained information online (n=583, 72.3%) with 65% (n=526) from their Public Health Nurse (n=526, 65.3%). It should be noted that Public Health Nurses (PHNs) engage with mothers after birth and least likely to receive information from their General Practitioner (GP) (n=135, 16.7%). Over half of respondents were aware of three main face-to-face BSGs in their local area, Public Health Nurse BSGs (n=501, 62.2%), La Leche League (n=462, 57.3%) and Cuidiú (n=435, 54%).

More than half of respondents (n=314, 58.8%) reported that they attend BSGs on a weekly basis with over half (n=482, 51.1%) accessing online BSGs and 29% attending PHN BSGs, La Leche League and Cuidiú respectively. The findings were that mothers attend many forms of BSGs and not just one type exclusively (Table 6).

Table 6: Knowledge and use of BSGs (Phase 1, N=943)

Description	Detail		n	%	N=	%
Primary source of information	Online		583	72.3		
	Public Health Nurse		549	78.7		
	General Practitioner		135	16.7%	806	100.0
Awareness of BSGs	Public Health Nurse run groups		501	62.2%		
	La Leche League		462	57.3%		
	Cuidiú		435	43.4%	810	100.0
Attendance at BSGs	All forms, Weekly		314	58.8%	841	100.0
	Online		482	51.1%		
	PHN BSGs		282	29%		
	LLL		285	29%		

Description	Detail		n	%	N=	%
	Cuidiú		275	29%	943	100.0

Breastfeeding supporter qualities

A significant finding was that 'listening skills' along with 'personal breastfeeding experience' (n=437,52%) considered particularly important to women in rural areas ($\chi^2(3) = 8.66, p = .034$). Other qualities considered 'extremely important' in a breastfeeding supporter were: 'knowledge of breastfeeding' (n=597,71%), 'empathy' (n=451,53.6%), and 'understanding' (n=444,52.8%),

BSG types

All forms of BSG were considered to increase the length of time a mother breastfeeds, particularly face-to-face support (n=660,89.4%). Online support groups were deemed to increase breastfeeding length Online support groups (n=587,79.5%) along with Facebook pages (n=593,80.4%).

Inferential statistics:

The four comparative factors, as previously outlined were: parity, location, length of breastfeeding, and maternal age. These four factors were compared to identify differences in attendance at BSGs. Breastfeeding self-efficacy was used as a continuous variable for analysis.

Parity

Multiparous respondents are more likely to attend than primiparous to 'meet other breastfeeding mothers' ($\chi^2(6) = 14.44, p = .013$). Primiparous mothers were more likely to get information from the PHN ($\chi^2(1) = 5.56, p = .018$), Ante-natal classes ($\chi^2(1) = 63.42, p < .001$), Lactation consultants ($\chi^2(1) = 6.06, p = .014$) or GP ($\chi^2(1) = 6.88, p = .009$).

Location

Higher proportions of respondents who attend Cuidiú were in Urban areas (n=160, 36.6%) than Rural areas (n=67,24.4%), ($\chi^2(1) = 11.66, p = .001$). Rural respondents were more likely to drive to BSGs (n=197,90.4%) than urban (n=210,69.3%) ($\chi^2(2) = 32.90, p < .001$) and more likely to drive for more than half an hour (n=180,65.5%) ($\chi^2(1) = 44.66, p < .001$).

Length of breastfeeding

There was a small, positive correlation between Length of current breastfeeding and continuing to attend BSGs for 'mothering support', $r_s = .09, n = 620, p = .025$, and 'to help other mothers' $r_s = .15, n = 627, p < .01$. This means that the longer a mother is breastfeeding, the more likely she is to continue to attend to get mothering (rather than breastfeeding) support and help other mothers.

Breastfeeding self-efficacy

A Wilcoxon Signed Rank test was conducted to explore the differences between Phase 1 (M=58.69, SD=8.95) and Phase 2 (M= 59.03, SD=9.65) as data were not normally distributed. There was no statistical difference between Breastfeeding Self-Efficacy for Phase 1 and

Phase 2, $z=-1.296$, $p=.195$, with effect size ($r=-0.06$). The median scores were $Md=59$ (Phase 1) and $Md=60$ (Phase 2).

Parity, Occupation, Location, Length of breastfeeding, and BSE.

A Mann-Whitney U test revealed multiparous respondents more confident ($Md=61$, $n=393$) than primiparous ($Md=58$, $n=334$) with Rural respondents ($Md=61$, $n=275$) having higher BSE than Urban ($Md=58$, $n=437$): $U=53089$, $z=-2.621$, $p=.009$, $r=-0.10$).

A Kruskal-Wallis Test revealed significant differences in BSE $\chi^2(3, n=712) = 22.026$, $p < .001$ with 'Looking after home/family' recording a higher median score ($Md=62$) than Self-employed ($Md=61$), Student/Unemployed ($Md=59$) or Employee ($Md=58$).

Using Spearman's correlation coefficient, there was a small, positive correlation between Length of breastfeeding and BSE, $r_s=.24$, $n=722$, $p < .01$.

Predicting levels of BSE

Hierarchical multiple regression was used to assess the four comparative factors to predict levels of breastfeeding self-efficacy. All four control measures were entered stepwise with 'exclude cases pairwise' option selected: Parity explained 1% of variance in BSE, $F(1, 691)=8.09$, $p=.005$; Location, total variance 1.6%, $F(2, 690)=6.75$, $p=.001$; Length breastfeeding, total variance 9.4%, $F(3, 689)=24.93$, $p < .001$; and Maternal Age, total variance 9.3%, $F(4, 688)=18.74$, $p < .001$. Total variance for model 9.8%, $F(4, 688)=18.74$, $p=.000$).

Three factors (Parity, Location, Length of breastfeeding) explained an additional 12% of the variance in BSE, after controlling for parity and location, (R^2 change=.079, F change (1, 689) =60.11, $p=.000$) (Table 7).

Maternal Age, considered important in the breastfeeding literature, was not a useful comparator.

Table 7: Hierarchical Multiple Regression – Model Summary

Model	df1	df2	Model Summary				
			F	Adjusted R square	R square change	F Change	Sig
1-Parity	1	691	8.09	.010	.012	8.094	$p=.005$
2-Location	1	690	6.75	.016	.008	5.365	$p=.001$
3-Length BF	1	689	24.93	.094	.079	60.110	$p=.000$
4-Maternal Age	1	688	18.74	.093	.000	.269	$p=.000$

In Model 4 (Table 8) three variables were statistically significant, with the Length of current breastfeeding variable recording a higher β value ($\beta=.284$, $p<.001$) than Parity ($\beta=.107$, $p=.006$) and Location ($\beta=.094$, $p=.010$). Parity, Location, and Length breastfeeding increased levels of breastfeeding self-efficacy.

Table 8: Hierarchical Multiple Regression – Model 4 detail

Model 4	95% CI for B		Coefficients (standardised)	
	Lower Bound	Upper Bound	β	Sig.
Variable 1 Prima/Multi	.628	3.665	.107	$p=.006$
Variable 2 Urban/Rural	.455	3.381	.094	$p=.010$
Variable 3 Length BF	1.966	3.311	.284	$p=.000$
Variable 4 Maternal Age	-.234	.136	-.020	$p=.604$

Discussion

A clear finding is mothers first contact a BSG ‘to meet other mothers’ (29.8%), rather than a breastfeeding problem (23.6%), with mothers continuing to attend to ‘meet other mothers’ (34%) and those breastfeeding more than 12 months considering it ‘extremely important’ to help other breastfeeding mothers. This suggests that mothers are using the support groups to ‘normalise’ their breastfeeding experience by increasing the amount of contact they have with other women who are breastfeeding. Breastfeeding is not viewed as the cultural norm in Ireland (Gallagher et al., 2015; McCarthy Quinn et al., 2019a) and elsewhere (Kim et al., 2017) making it additionally challenging to identify with, and become, a breastfeeding mother. Despite higher levels of breastfeeding elsewhere, this view also exists in other international contexts (Brown, 2015; Pérez-Escamilla et al., 2023).

Knowledge and personal breastfeeding experience

Three-quarters of mothers obtained information about face-to-face BSGs online with over half citing online support the most recently attended support group (51.1%) and almost a half using online forums daily (47.6%). Daily internet use by new mothers has been found in other research (McCarthy Quinn et al., 2019a; Plantin & Daneback, 2009) with social media widely used across all economic groups for infant feeding, health and nutrition information (Asiodu et al., 2015; Bensley et al., 2014). Widespread use of the internet is attributed to diminished support from family and friends (Alianmoghaddam et al., 2019), providing a means of expression and connection, particularly for mothers feeling isolated with a newborn (Brown & Shenker, 2021; Moon & Woo, 2021).

Personal breastfeeding experience and knowledge are highly valued in a breastfeeding supporter, qualities mothers perceive as lacking among health professionals (Bengough et al., 2022). PHNs are not required to have personally breastfed with training not mandatory or readily available (Mulcahy et al., 2012). Breastfeeding counsellors are required to have breastfed between 6 to 12 months and undertake accredited training programmes (ABA, 2018; ABM, 2018; BfN, 2014; Cuidiú, 2014a; IBLCE, 2017; LLLi, 2018) that includes knowledge of breastfeeding and counselling skills, taking one or two years to complete.

Breastfeeding support from trained peers has been shown to have many benefits, including the normalization of breastfeeding in the community, leading to a more supportive and accepting culture (Ingram et al., 2005; Youens et al., 2014) (Bengough et al., 2022; Leahy-Warren et al., 2017; McFadden et al., 2017).

Researchers and health organisations also acknowledge in-depth breastfeeding knowledge, experience and training is lacking in health professionals engaged with providing care of

women and babies (Bengough et al., 2022; McFadden et al., 2017). A recent systematic review recommends standardization in breastfeeding training programmes for health professionals with inclusion of practical breastfeeding skills and not just theoretical training (Mulcahy et al., 2022).

Breastfeeding goals and outcomes

The two main reasons given for continuing to attend BSGs were 'to get breastfeeding support' and 'to meet other mothers' with getting help with problems third indicating BSGs provide more than information support. The social aspect is in keeping with two of the key findings from the qualitative aspect of this study, particularly in relation to sharing of refreshments and the strong need other mothers felt for 'passing on' their experiences (McCarthy Quinn et al., 2019b).

Previous studies found large numbers of mothers did not breastfeed as long as they intended (Brown & Shenker, 2021; Shortt et al., 2013) with the first six weeks when mothers are most vulnerable to early breastfeeding cessation (Brown et al., 2014). Non-latching babies; , perceived lack of milk, and pain/sensitivity are the most cited reasons for breastfeeding cessation within hours or days postnatally (Brown et al., 2016). Perceived insufficient milk is the most cited reason for breastfeeding cessation at any time (Huang et al., 2022) resulting in introduction of commercial milk formula (Pérez-Escamilla et al., 2023) leading to decreased confidence in a mother's ability to breastfeed (Brown & Shenker, 2021; McCoy & Heggie, 2020).

Breastfeeding self-efficacy

This cohort were atypical among Irish women as they were planning to breastfeed for the recommended time (WHO, 2001, 2003, 2023), had high levels of breastfeeding self-efficacy from the outset, and already breastfeeding longer-term, in contrast to findings in other Irish studies (Begley et al., 2008; Carroll et al., 2015; Gallagher et al., 2015). The longer participants were breastfeeding, the more self-efficacious they were.

While the main object of BSGs may be to support breastfeeding mothers to continue as long as they wish to, other areas of a woman's life are evidently being influenced. Breastfeeding Support Groups facilitate diversity and acceptance of difference while also helping mothers to negotiate their own place in this new world of mothering and breastfeeding, cross over into new territory, and fulfil their own goals.

Breastfeeding supporter qualities

An unexpected finding was that similar numbers (29%) attended PHN groups, La Leche League and Cuidiú. Leahy-Warren et al. (2009) found 51.2% of PHNs facilitated groups in their area, although PHN Directors reported less than 25% were, indicating discrepancies in perceived services and lack of consistent support countrywide (Mulcahy et al., 2012). The PHN role in Ireland is deemed unique compared to other countries, is ill-defined and wide-ranging, incorporating activities and responsibilities that are normally done by different health professionals elsewhere (Hanafin et al., 2020). The PHN role is viewed as 'generalist', requiring engagement and interaction with primary, secondary and tertiary care along with a variety of care groups, from the very young to the elderly (Hanafin et al., 2020).

This makes it challenging for PHNs to become highly skilled in specialist areas such as breastfeeding support.

Strengths and Limitations of study

Strengths

The large sample size Phase 1 (N=978) was a major strength of this study, confirming that an online survey was highly effective in gaining access to large numbers of breastfeeding mothers. The response rate to Phase 2 (N=412) was also high facilitating 232 matched responses that enabled statistical analysis to be carried out in relation to Self-Efficacy.

This study, in providing data on women's perspectives of breastfeeding support rather than health professionals' perspectives has redressed the gap in the literature highlighted by a systematic review on peer support by McFadden et al. (2017). The study also addresses a key BFHI strategy of improved community support that includes strong peer networks and mother-to-mother support groups (WHO, 2018).

As most participants had already attended breastfeeding support groups by Phase 1, prior attendance may have already increased their breastfeeding self-efficacy, however, further research is required.

Limitations

A limitation of the study is that because the demographics section was placed at the end in line with the psychological literature at the time, the demographics data for many participants were incomplete. There were also challenges matching Phase 1 and 2 data as many participants could not recall which 4-digit code they had used.

There were only two continuous variables, breastfeeding self-efficacy and maternal age: maternal age did not show any significance with comparators while breastfeeding self-efficacy scores did not increase reducing the ability to perform certain statistical analyses.

Conclusion

Study findings indicate that breastfeeding women first attended BSGs to 'meet other mothers', and continued to attend for this reason, and not necessarily for breastfeeding problems. This indicates that mothers seek to normalise their experiences and use the groups to socialise with like-minded people. It is also clear that women who attended BSGs were already highly self-efficacious, motivated to breastfeed, and intending to breastfeed long-term while the longer participants were breastfeeding, the more self-efficacious they were.

Breastfeeding women primarily working in the home, followed by those self-employed, had higher breastfeeding self-efficacy than other groups. Breastfeeding self-efficacy scores need to be explored in other cohorts of women such as those that do not engage with breastfeeding support groups.

Recommendations are that greater interaction is needed between breastfeeding support groups and health professionals who support breastfeeding mothers, particularly general practitioners. Breastfeeding support groups need to be promoted as welcoming and

inclusive, supporting mothering generally, and not solely for breastfeeding problems. Breastfeeding support groups could consider replacing terms such as 'support group' which implies a problem, and 'meeting' which suggests formality.

Greater resources need to be allocated to promote awareness of breastfeeding groups and breastfeeding itself as 'normal' through wider marketing campaigns that target the community rather than just mothers. Groups need to be available in all communities and reaching a wider number of mothers from varying backgrounds.

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Appendix A

Demographics		Phase 1		Phase 2	
		n	%	n	%
Age of Mother	20-29 years	73	10.5	26	7.5
	30-39 years	549	78.7	278	79.9
	40+	76	10.7	44	12.6
	Total	698	100.0	348	100.0
	Missing	14		8	
Country of Origin	Ireland	595	83.6	294	82.6
	UK	52	7.3	24	6.7
	EU	38	5.3	23	6.5
	Other	27	3.8	15	4.2
	Total	712	100.0	356	100.0
	Missing	0		0	
Ethnic Origin	Irish	586	82.3	290	81.5
	Any other White	108	15.2	62	17.4
	Other (mixed)	18	2.5	4	1.1
	Total	712	100.0	356	100.0
	Missing	0		0	
Education Level	Third Level	527	76.8	271	78.6
	PLC/Diploma	111	16.2	58	16.8
	Secondary Level	48	7.0	16	4.6
	Total	686	100.0	345	100.0
	Missing	26		11	100.0
Relationship status	Married	557	78.2	273	76.7
	Domestic partner/ civil union/cohabiting	131	18.4	71	19.9
	Single	14	2.0	6	1.7
	Divorced/Separated	10	1.4	6	1.7
	Total	712	100.0	356	100.0
	Missing	0		0	
Occupation	Employee (full/part-time)	452	63.5	224	62.9
	Home/family	182	25.6	92	25.8
	Self-employed	56	7.9	29	8.1
	Student/Unemployed	22	2.2	11	3.1
	Total	712	100.0	356	100.0
	Missing	0		0	
Province currently living in					

Demographics	Phase 1		Phase 2	
	n	%	n	%
Ulster (NI) Total	57	8.1	23	6.5
Leinster Total	400	56.8	213	59.8
Connacht Total	67	9.5	30	8.6
Munster Total	149	21.2	69	19.4
Ulster (ROI) Total	31	4.4	14	3.9
Total	704	100.0	349	
Missing	7		7	

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Appendix B – breastfeeding status

Breastfeeding Status		n	%
Currently breastfeeding	> 12 months	365	39.3
	6 to 12 months	244	26.3
	3 to 6 months	187	20.2
	< 3 months	132	14.2
	Total	899	
	Missing	39	
Intending to breastfeed	> 12 months	550	64.8
	6 to 12 months	218	25.7
	3 to 6 months	67	7.9
	< 3 months	14	1.6
	Total	849	
	Missing	89	
Feeding on discharge (at 48hrs if homebirth)	Exclusively breastfeeding	803	85.6
	Combination feeding	104	11.1
	Expressing breastmilk only	31	3.3
	Total	938	
	Missing	0	
Current infant feeding	Breastfeeding and solid food	461	49.1
	Exclusive breastfeeding	242	25.8
	Breastfeeding, formula, solid food	53	5.7
	Formula feeding and solid food	43	4.6
	Combination (breast/formula)	34	3.6
	Formula feeding only	21	2.2
	Expressed breastmilk only	7	0.7
	Other	77	8.2
	Total	938	
	Missing	0	

KEY MESSAGES – SEPARATE DOCUMENT

Messages” file designation. This list of 3-4 bullet points written in complete sentences without abbreviations should contain the following information: • One statement about context of study (i.e., what is the gap in the knowledge base that is the rationale for doing this study?). • 1-2 statements about the core findings of the study. • One statement of the significance of the study (i.e., how does this research add to the existing knowledge base?).

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Declaration of competing interests:

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