Understanding Mothers' experiences and Wishes Related to Breastfeeding Counselling in the Helsinki Maternity and Child Health Clinics

A Thematic analysis

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Abstract:
There are undeniable benefits to breastfeeding for both mother and child. The WHO recommends exclusive breastfeeding for the first six months of a child's life and to continue for up to two years and beyond. However, statistics show that only few women in Finland breastfeed according to these recommendations. This study was conducted in collaboration with the City of Helsinki. The aim of this study is to provide insight into mothers' experiences and their wishes for breastfeeding counselling within the maternity and child health clinics in the City of Helsinki. The research questions were: what were the mother's experiences and how did they perceive the counseling they received at the maternity and child health clinic? What are the elements associated with good breastfeeding counselling? What kind of breastfeeding counseling and support did the women express they would want? The data was originally gathered by the breastfeeding coordinator Nina Kivilaakso in connection to a different study. The data consisted of the answers to an open-ended question in the originally distributed questionnaire. A qualitative thematic analysis was conducted. The findings identified that mothers had positive, negative and neutral experiences of breastfeeding counselling. As well as identifying their expressed wishes for improved breastfeeding counselling. Several sub themes were identified within the themes. The findings of this study are the result of analyzing mothers' experiences of breastfeeding counselling, and gaps were identified within the data. The findings offer valuable guidance in identifying those areas where breastfeeding counselling can be improved within the maternity and child health clinics. It could provide further valuable insight to research the experiences of the nurses working within the maternity and child health clinic, and their perceptions concerning resources for breastfeeding counselling.

Keywords:	Breastfeeding counselling, BFHI, Maternity and Child Health Clinics in Helsinki
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Tiivistelmä:
Imetyksellä on kiistattomat hyödyt sekä äidille että lapselle. WHO suosittelee täysimetystä kuusi ensimmäistä kuukautta lapsen elämässä, imetyksen jatkamista aina kahteen ikävuoteen, ja siitä eteenpäin. Tilastot osoittavat, että vain harva nainen Suomessa imettää näiden suositusten mukaan. Tämä tutkimus suoritettiin yhteistyössä Helsingin Kaupungin kanssa. Tutkimuksen tavoite oli saada käsitys äitien kokemuksista ja toiveista liittyen imetysohjaukseen äitiys- ja lastenneuvoloissa Helsingissä. Tutkimuskysymykset olivat: mitkä olivat äitien kokemukset ja käsitykset neuvolasta saadusta imetysohjauksesta? Mitkä ovat hyvään imetysohjaukseen liitettävät ominaisuudet? Minkälaista imetysohjausta ja tukea äidit ilmaisivat haluavansa? Tutkittavan aineiston keräsi alun perin imetys koordinaattori Nina Kivilaakso liittyen toiseen tutkimukseen. Aineisto koostui alkuperäisessä jaetussa kyselyssä esitettyyn avoimen kysymyksen vastauksista. Tehtiin kvalitatiivinen temaattinen analyysi. Löydöksissä ilmeni, että äideillä oli positiivisia, negatiivisia ja neutraaleja kokemuksia imetysohjauksesta. Tämän lisäksi tunnistettiin äitien ilmaisemat toiveet paremmasta imetysohjauksesta. Useita ala teemoja tunnistettiin näiden teemojen sisällä. Tämän tutkimuksen löydökset perustuvat analyysista äitien kokemuksista imetysohjauksesta, ja aukkoja havaittiin aineistossa. Löydökset tarjoavat arvokasta opastusta havaitsemaan ne alueet missä imetysohjausta voisi äitiys- ja lastenneuvolassa parantaa. Olisi arvokasta jatkossa tutkia äitiys- ja lastenneuvolassa työskentelevien hoitajien kokemuksia, ja heidän käsityksiä resursseista liittyen imetysohjaukseen.

Avainsanat:	Imetys ohjaus, BFHI, äitiys- ja lastenneuvola Helsinki
Sivumäärä:	50
Kieli:	Englanti
Hyväksymispäivämäärä:	

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List of abbreviations

BFHI - The Baby-friendly Hospital Initiative

GDPR - General Data Protection Regulations

UAS - University of Applied Sciences

UN - United Nations

UNICEF - United Nations Children's Fund

WHO - World Health Organization

YHKÄ - Yhtenäisten käytäntöjen kehittämisen malli

FOREWORD

We would like to thank our collaborative partners Leeni Löthman-Kilpeläinen and Nina Kivilaakso with the City of Helsinki, for giving us the opportunity and trusting in us to conduct our research.

We would also like to thank our supervisors Pamela Gray from Arcada UAS and Arja Suikkala from Diaconia UAS. We would not have succeeded in our research process without your support and guidance.

Helsinki, February 2020
Julia Lydén & Livia Zakowski

1 INTRODUCTION

It is widely accepted that breastfeeding has a beneficial impact on both mother and child. Breastfeeding is a natural way of providing the best nutrition for young children, which supports their development and growth. Promoting breastfeeding is a global health priority as it can be directly related to the United Nations (UN) Millennium Development Goals and the new revised Sustainable Development Goals as breastfeeding reduces child mortality rates and improves both infant and maternal health. Also, breastfeeding is a sustainable method of feeding your child, which is important in this era of climate change, as it doesn't add to the environmental burden. Additionally, breastfeeding doesn't add to the financial burden on families as it is a cost-effective mode of providing good nutrition to your child. Promoting breastfeeding also promotes gender equality and serves to empower women, and societies should promote this through enabling women to continue breastfeeding when returning to work (Rollins et al. 2016; UN 2019A; UN 2019B; Victora et al. 2016). Policies to promote breastfeeding, adhering to the Baby-friendly Hospital Initiative (BFHI), cultural and political factors, and support from family, employers and the community as a whole help facilitate higher levels of breastfeeding (UNICEF 2018B). Breastfeeding also benefits society as a whole by decreasing increased human capital through higher intelligence in breastfed individuals (Rollins et al. 2016).

Breastfeeding rates in Finland are quite low. While most women initiate breastfeeding, according to the latest available statistics it has been found that only 9% of infants approaching six months are still exclusively breastfed. Also, children are on average only breastfed 7-8 months which doesn't come close to the recommendations made by the WHO (Hakulinen et al. 2017). Health care professionals are in a critical position in promoting breastfeeding through the counseling and support they offer to breastfeeding mothers. Currently the City of Helsinki is promoting the BFHI in its' maternity and child health clinics in an attempt to improve the quality of breastfeeding counseling and promoting breastfeeding. This is done in accordance with the YHKÄ model (yhtenäisten käytäntöjen kehittämisen malli), where practices are developed based on evidence (Hotus 2010). In this study the focus is on women's experiences of breastfeeding counseling and support within the maternity and child health clinics in Helsinki. The aim of this study is to understand mothers' experiences of breastfeeding counseling, identify what mothers

experience as good counselling, and what kind of improvements for support and counseling they would want within the Maternity and Child Health Clinics in the City of Helsinki. The goal is to provide valuable information that will hopefully improve breastfeeding counseling, ensuring that it meets the actual needs of breastfeeding mothers.

2 BACKGROUND

The World Health Organization (WHO) recommends exclusive breastfeeding for the first six months of a child's life, and to continue alongside proper nutrition for up to two years and beyond. Adhering to the recommendations is one of the most effective ways of improving child survival and promoting wellbeing as it is a cost effective, hygienic and sustainable method of providing nutrition to a child. Most mothers are able to breastfeed their babies. However, it is important that women receive the support they need as difficulties, especially in the beginning, are common (UNICEF, 2018A; Victora et al. 2016; WHO 2018).

According to the newest available statistics in Finland, the latest available statistics show that 66% of all children approaching 6 months were breastfed, but only 9% were exclusively breastfed. Over a third of children one year old were still receiving breast milk. However, the average length that children were breastfed was between 7-8 months, while exclusive breastfeeding only lasted about two months (Hakulinen et al. 2017). Research shows that certain groups have a higher risk of not initializing or maintaining breastfeeding. Those of low education and low socioeconomic status have statistically lower breastfeeding outcomes (Artieta-Pinedo et al 2012, Sarki et al. 2018, Laugen et al. 2016). Low affectional support from surrounding also shown to decrease the length of breastfeeding (Laugen et al. 2016; Wang et al. 2018; Keevash et al. 2018). Obesity and smoking amongst mothers have also shown to have a negative effect on breastfeeding rates (Babendure et.al 2015, Gilbert et al. 2014).

It is widely recognized that there are several health benefits of children being breastfed. Breastfeeding provides the child with nutrition, but also contains antibodies that protect the baby from infectious diseases, such as diarrhea and pneumonia. The benefits of being breastfed go beyond childhood, decreasing the likelihood of obesity and type II diabetes in adolescence and adulthood, and it has even been found that breastfed individuals can perform better on intelligence tests (UNICEF, 2018A; Victora et al. 2016; WHO 2018). Breastfeeding also provides lower risk of mortality, as studies show that there is a reduction in deaths from sudden infant death syndrome among breastfed children in high-income countries (Victora et al. 2016).

The benefits of breastfeeding are not restricted to children, as breastfeeding also benefits the mother. It has been found that breastfeeding decreases the risk of breast cancer as well as ovarian cancer (Chowdhury et al. 2015; UNICEF 2018a; Victora et al. 2016). It is suggested that the risk reduction increases with the increased length of time a woman breastfeeds (Williams & Smith, 2018). Breastfeeding has been found to decrease the risk of developing type II diabetes, which can potentially have a huge impact on overall health (Chowdhury et al., 2015; Victora et al. 2016 ; Williams & Smith, 2018).

2.1 Mothers' experiences of breastfeeding counselling

Women do not rely exclusively on health care professionals for breastfeeding support and counseling. However, due to the nature of the health care system in Finland health care professionals working within the maternity and child health clinics have the opportunity to provide valuable information, support and counseling as they follow women throughout their pregnancy, during the postpartum period, and throughout infancy. In this section the focus is on previous research related to the perceptions and experiences of mothers regarding breastfeeding counseling and support. In Finland breastfeeding counselling provided within the maternity and child health clinics is based on the the national strategy for enhancing breastfeeding (kansallinen imetyksen edistämisohjelma 2018-2022) and the WHO guidelines.

Previous research appears to have somewhat conflicting results related to mothers' experiences of breastfeeding counselling. Some studies show that many women report that they felt they had received the information they needed with regard to breastfeeding, while at the same time reporting that there were some areas where they would have wanted more information and guidance. Most women reported receiving some education or support during pregnancy, after delivery in the hospital, and during the child's first year, it was still found that some women experienced receiving no support during one or more of these time periods. Some even reported receiving little or no help when specifically expressing challenges with breastfeeding (Dietrich Leurer & Misskey 2015; Cross-Barnet et al. 2012). Another short-coming in providing breastfeeding support and counseling was women's experience of receiving conflicting advice from health care professionals and perceiving them as incompetent and non-supportive (Ericson & Palmér 2018;

Spencer & Fraser 2018; Kronborg et al. 2014). The areas where breastfeeding women felt that they would have needed more information and support included practical, tips management of milk supply, understanding the baby's cues for frequency and length of feeding, proper latch and different breastfeeding positions, how to care for nipples, milk expression and pumping, breastmilk supplements as alternate nutrition, realistic knowledge about the most common breastfeeding challenges, and support in the woman's transition into motherhood. Lack of support in these areas are commonly associated with poor breastfeeding outcomes. These knowledge gaps identified by breastfeeding women should be addressed by those providing breastfeeding counseling and support (Ericson & Palmér 2018; Dietrich Leurer & Misskey 2015; Kronborg et al. 2014). An authentic presence and facilitative style of counselling have been deemed as effective in providing breastfeeding support, while a reductionist approach and disconnected encounters are found to be counterproductive. With the conclusion that person-centered communication skills and continuity of care are of importance in regard to breastfeeding support (Spencer & Fraser 2018; Schmied et al. 2011).

2.2 Breastfeeding challenges

It is common for women to experience various challenges related to breastfeeding. Usually these challenges can be overcome through effective breastfeeding counselling. The purpose of the BFHI is to ensure women's access to breastfeeding counselling (WHO 2019[A]; THL 2017[A]). Challenges can be related to either mother or the child, or both. Especially first-time mothers experience difficulties with latching during the early period breastfeeding. Latching difficulties can cause pain while breastfeeding. In addition, an improper latch can cause problems with milk production, causing insufficient weight gain (Gianni et al. 2019; Hakulinen et al. 2017; Mauri et al. 2012, Spencer et al. 2014). One possible contributing factor in improper latch and breastfeeding challenges is anterior and posterior tongue tie and upper-lip tie (Pransky et al. 2015). In severe cases of upper lip- and tongue tie where there are obvious negative effects on breastfeeding, recognition and surgical treatment of tongue- and upper lip-tie can have significant improvement in breastfeeding outcome (Ghaheri et al.2017). However, the effects of surgical treatment of tongue- and lip tie on breastfeeding outcomes are inconclusive and more research within this specific subject is still needed (Hakulinen et al. 2017; O'Shea et al. 2017).

Women who are experiencing challenges with breastfeeding may feel insecure in their ability to provide sufficient nutrition for their child (Hakulinen et al. 2017; Mauri et al. 2012, Spencer et al. 2014). The nature of breastfeeding can be seen as both mentally and physically demanding, and so the challenges can be described as not being only physical, but also mental. This highlights the importance of good communication and a facilitating style of breastfeeding counselling (Spencer & Fraser 2018; Spencer et al. 2014).

2.3 Interventions for breastfeeding counseling and support

The topic of breastfeeding and breastfeeding support and counseling has been extensively studied for decades, and much evidence has been found to support the positive effects of counseling and support on breastfeeding outcomes. The WHO 10 steps to successful breastfeeding also incorporate this. In a review where focus was solely on breastfeeding initiation, it was found that education and counseling given by a healthcare professional, or in the form of peer support interventions, did have a slight positive effect on initiation of breastfeeding. This was prevalent especially among low-income women and women of ethnic minorities. This is a valuable finding, as breastfeeding rates are generally lower among these women (Belogun et al. 2016). It has also been found that the educational level and socioeconomic status of the breastfeeding woman seems to have the greatest effect on breastfeeding outcome (Laugen et al. 2016 ; Sarki et al. 2018). It has also been found that when breastfeeding support is applied, peer and professional support, it increases duration and exclusivity of breastfeeding (McFadden et al 2017). However, evidence also suggests that breastfeeding outcome can improve when good social support is applied, and so breastfeeding duration is largely affected by the support the woman receives (Laugen et al. 2016). A multidimensional intervention study confirms this. It included one-to-one consultation with a lactation consultant, as well as postpartum support and inclusion of the partner in the intervention. This multidimensional approach also proved to have a positive effect on breastfeeding rates and outcome and included the aspect of social support by including partners in the intervention (Alberdi et al. 2018).

Studies suggest that individual counseling had better results than group counseling and that a needs-based, one-on-one, informal sessions were found to have the most positive

effect on breastfeeding initiation (Haroon et al. 2013; Belogun et al. 2016). However, it has also been found that women who attend antenatal breastfeeding counseling groups are more likely to have better breastfeeding experiences (Artieta-Pinedo et al. 2012, Parry et al. 2018). It appears that any type of support can have beneficial effects on initiation and duration of breastfeeding, but when looking at the reports of mothers' experiences of breastfeeding support, individual and one-on- one counseling was more representative as being supportive (Ericson & Palmér 2018; Schmied et al. 2011).

2.4 The Baby-friendly Hospital Initiative

The Baby-friendly Hospital Initiative (BFHI) was developed by the WHO and United Nations Children's Fund (UNICEF) almost 30 years ago in 1991. This initiative was launched as a result of the Innocenti Declaration of 1990. The BFHI is a global effort that seeks to protect, promote and support breastfeeding (WHO 2019[A]; THL 2017[A]). The initiative is implemented in units caring for pregnant women, women giving birth and those who have given birth, as well as children of recommended breastfeeding age. The purpose of the BFHI is to enable a good start to breastfeeding in the delivery hospital, to support exclusive breastfeeding for the first six months of a child's life and promote breastfeeding to continue beyond the first six months alongside other proper nutrition for at least up to one year of age and thereafter. Originally the initiative was developed for implementation in the delivery- and postpartum care units but has since then been adapted for use in postnatal outpatient care as well as pediatric units (THL 2017[A]).

At the core of the implementation of the BFHI are the ten steps to successful breastfeeding. These were developed by the WHO and UNICEF during the launch of the BFHI. For a hospital or care unit to receive the BFHI certification, they must prove to adhere to the ten steps criteria. The ten steps are divided under two headings, critical management procedures and key clinical practices. The steps within critical management procedures are specifically aimed at those in management positions and those in charge of policies in units caring for breastfeeding women and infants. The steps within key clinical practices are directed more towards those working directly with breastfeeding women within their clinical work. It is important that both management and those in clinical practice comply with the ten steps to successful breastfeeding.

The ten steps to successful breastfeeding were revised in 2018, and currently contain the following exactly as presented by the WHO:

Critical management procedures:

1a. Comply fully with the International Code of Marketing of Breast-milk Substitutes and relevant World Health Assembly resolutions.

1b. Have a written infant feeding policy that is routinely communicated to staff and parents.

1c. Establish ongoing monitoring and data-management systems.

2. Ensure that staff have sufficient knowledge, competence and skills to support breastfeeding.

Key clinical practices:

3. Discuss the importance and management of breastfeeding with pregnant women and their families.

4. Facilitate immediate and uninterrupted skin-to-skin contact and support mothers to initiate breastfeeding as soon as possible after birth.

5. Support mothers to initiate and maintain breastfeeding and manage common difficulties.

6. Do not provide breastfed newborns any food or fluids other than breast milk, unless medically indicated.

7. Enable mothers and their infants to remain together and to practice rooming-in 24 hours a day.

8. Support mothers to recognize and respond to their infants' cues for feeding.

9. Counsel mothers on the use and risks of feeding bottles, teats and pacifiers.

10. Coordinate discharge so that parents and their infants have timely access to ongoing support and care (UNICEF 2018[A]; WHO 2019[B]).

It has been found that the BFHI has had the desired improved effect on breastfeeding and has since its launch been adapted in more than 152 countries (WHO 2019A). When all the steps are followed, families get the best possible guidance and support for successful breastfeeding (THL 2017). Evidence shows that adherence to the BFHI ten steps to successful breastfeeding have positive impact on all length of breastfeeding worldwide (Pérez-Escamilla et al. 2016).

2.5 The Baby-friendly Hospital Initiative within the Finnish Maternity and Child Health Clinics

In Finland health services are available to everyone. Municipalities provide and fund the services offered to the population. Health services consist of primary care and specialized medical care. Primary care consists of the municipally organized services and are offered at municipal health centers (Ministry of social affairs and health 2019).

Expecting mothers are monitored throughout their entire pregnancy at the maternity and child health clinics, which are within the primary care sector. The purpose of this is to secure the health and well-being of the expectant mother, the fetus, and the newborn infant. After the child is born, the maternity and child health clinics continue to monitor the health and well-being of the infant and family as a whole, through regular visits at the clinics. The purpose is to secure the health of the child, supporting the parents, and ensuring the child has the possibility to healthy growth, development and overall well-being (Helsingin kaupunki 2019).

Providing women with breastfeeding counseling and support is part of the care offered to families through the maternity and child health clinics in Helsinki. The maternity and child health clinics adhere to the Finnish national strategy (kansallinen imetyksen edistämisohjelma 2018-2022) for enhancing breastfeeding (Hakulinen et al 2017). Breastfeeding counselling is initiated when the woman starts her visits at the clinic during pregnancy. Usually women are cared for by an assigned worker in the maternity and child health clinics, and once the child is born the child is when possible monitored by the same worker. Breastfeeding counseling and support continues to be offered after the child is born during the visits to the clinic or as needed. The City of Helsinki has a handbook for breastfeeding counseling which the workers base their counseling and support on. Also, the maternity and child health clinics in Helsinki adheres to a program called the baby- and family-friendly program, which is adapted from the BFHI (Helsingin Sosiaali- ja terveystoimiala 2019; Helsingin Sosiaali- ja terveystoimiala 2018).

The BFHI adapted for the public health sector in Finland is based on the baby-friendly initiative in community health services created in Norway and Canada, which were originally adapted from the WHO ten steps to successful breastfeeding. The guidelines in Finland are crystallized in the maternity clinics' baby- and family-friendly initiative –

seven steps. The initiative provides an evidence-based set of guidelines for providing mothers and families with adequate breastfeeding counseling, as well as support of early interaction and parenting. The maternity and child health clinics in Finland have committed to following the initiative as well as using the self-evaluation tool to measure the realization of the initiative and are among the first countries to do so. The maternity and child health clinics' baby- and family-friendly initiative – seven steps in Finland are as follows:

1. Having a written WHO recommended baby- and family-friendly initiative policy
2. Training staff and upholding knowledge and expertise
3. Breastfeeding counseling of expecting families
4. Breastfeeding support and maintaining lactation
5. Supporting exclusive breastfeeding until 4-6 months of age and continuing partial breastfeeding for up to one year or longer if so desired by the family. Solid foods should be introduced to taste at 4-6 months of age according to individual readiness.
6. Creating a breastfeeding positive atmosphere
7. Ensuring breastfeeding support and continuation of care

(Hakulinen et al. 2017)

The adaptation of the BFHI to community health services is important as women spend less and less time in the hospital after giving birth. This means that women rely increasingly on community health services through the maternity- and child health clinics for breastfeeding counseling and support. It has been found that the BFHI increases exclusive breastfeeding up to six months, but also all total duration of breastfeeding (Bærug et al. 2016; Pérez-Escamilla et al. 2016). When the baby-friendly initiative is implemented flexibly and with a family-centered approach, it can help women overcome barriers to breastfeeding. This further highlights the relevance of adhering to the BFHI in community health. However, it has been suggested that the focus should be more on empowering women rather than focusing on reaching outcomes (Groleau et al., 2016).

3 AIM AND RESEARCH QUESTIONS

The aim of this study is to provide insight into how mothers experience breastfeeding counseling, and to investigate what kind of support is provided and what kind of support and counseling they would want within the Maternity and Child Health Clinics in the City of Helsinki. The aim of our study is in accordance with the aim of the breastfeeding project initiated by Nina Kivilaakso, the breastfeeding coordinator of the City of Helsinki maternity and child health clinic in Munkkiniemi. The goal is to provide valuable information that will improve breastfeeding counseling, ensuring that it meets the actual needs of breastfeeding mothers. This is in accordance with the YHKÄ-model, which the City of Helsinki is using to establish the BFHI within the public health sector. The provided findings will enable promotion of different types of breastfeeding counseling and support within the maternity clinics of Helsinki, but also on a national level.

This study was conducted through performing an analysis of qualitative data collected in a breastfeeding project that was initiated by the City of Helsinki in 2018. The methodology will include analysis of the data collected as part of the breastfeeding project initiated by the City of Helsinki from mothers of 0-1-year-old children, exploring their experiences of breastfeeding counseling at maternity clinics in Helsinki. Differing from the study conducted by the City of Helsinki, our study will not include the experiences of the nurses at the maternity clinics.

In order to reach the aim of this study the following research questions have been posed:

1. What were the mothers' experiences and how did they perceive the counseling they received at the maternity and child health clinic?
2. What are the elements associated with good breastfeeding counselling?
3. What kind of breastfeeding counseling and support did the women express they would want?

4 METHODOLOGY

The nature of this study is qualitative. In qualitative research the aim is to study phenomenon as they naturally occur. For the purpose of this study the researchers will focus on mothers' experiences and needs of breastfeeding counseling within the municipality of Helsinki. The data was initially collected for another study (Vauva- ja perhemyönteisyysohjelman jalkauttaminen Helsingin neuvoloihin) by Nina Kivilaakso in her role as breastfeeding coordinator of the City of Helsinki maternity and child health clinic in Munkkiniemi for the purpose of enhancing the BFHI within public sector.

The authors of this research report were given the task to analyze only part of the data. The data analyzed in this study consists of the written answers to an open-ended question by mothers to children between 0 to 12 months in the Helsinki region. The mothers participated in the breastfeeding counseling questionnaire distributed in February 2018. A thematic analysis was conducted on the collected textual data. For the analysis the Step-by-Step guide to thematic analysis by Maguire & Delahunt (2017) was used, drawing on the framework presented by Braun & Clarke (2006).

4.1 Data presentation

The material analyzed for the purpose of this study was originally collected by Nina Kivilaakso. It was collected between 4.2-24.2.2018 through electronic questionnaires delivered to clients with children between 0 to 12 months within the maternity and child health clinics of Helsinki. To receive the questionnaire the parents had to have filled out a consent to the electronic services in Pegasos patient records. The mothers were sent a link to the questionnaire by text message to their phone and could be answered at their convenience. The questionnaires held both structured and one open-ended question. The data was therefore both quantitative and qualitative in nature. The data was given to the authors as a whole and consisted of an excel table containing all the returned questionnaire answers as well Questback Essentials analysis report, including the statistical reports.

The original questionnaire was made by Nina Kivilaakso in the Questback Essentials program. The themes in the questionnaire arose from previous research the seven steps to

successful breastfeeding created for the maternity and child health clinics. The questionnaire development and data collection was done by Nina Kivilaakso, the breastfeeding coordinator of the City of Helsinki maternity and child health clinic Munkkiniemi (See Appendix 1). It was drafted using previously created reliable scales regarding breastfeeding counseling experiences. Permission for the use of the scales were confirmed with the creator Leena Hannula. The questionnaire was sent out to 5026 mothers of children aged between 0 to 12 months. There were 1433 responses to the questionnaire, of which 744 posted an answer on the open question. The answers to the open-ended question varied in length, from being one sentence answers to an entire page. Some answers were only comments related to a specific area of breastfeeding counselling, whereas others described their experiences not only related to breastfeeding counselling, but their experience of breastfeeding as a whole. The data consisted of written answers in Finnish amounting to 84 pages of text containing almost 42000 words. The researchers of this study have translated certain quotes for the purpose of this research report.

In the original questionnaire there was very little demographic information collected. Only marital status and level of education were included. However, these are relevant as both have been found to have a correlation on breastfeeding outcome. Out of the 744 women that answered the open-ended question in the original questionnaire, 713 (95,8%) reported as either being married, in a common law relationship or being in a registered relationship. 31 (4,2%) reported being single. The level of education among the 744 respondents was high, as 626 (84,1%) of the women had a higher-level education (minimum university of applied science degree).

Due to the rich nature and large amount of data, for the purpose of this study and in accordance with the wishes of the collaborative partner at the City of Helsinki, the researchers performed the thematic analysis only on the open-ended question answers (question 22, see appendix 1). No quantitative analysis was performed as the data analyzed for the purpose of this study was restricted to the qualitative material.

4.2 Data analysis

To analyze the material a thematic analysis was performed according to the step-by-step guide by Maguire & Delahunt (2017). The method follows the six-step process to thematic analysis presented in the framework by Braun & Clarke (2006). The model enables a methodical analysis of data using established techniques in qualitative analysis. The six steps described by Maguire & Delahunt (2017) are step 1. Becoming familiar with the data, step 2. Generate initial codes, step 3. Search for themes, step 4. Review themes, step 5. Define Themes and step 6. Write up (Maguire & Delahunt 2017).

To improve the reliability of this study, in the initial stages of data analysis, the researchers read through the data in its entirety several times to get acquainted with the material. After which, the researchers separately took notes of the impressions generated by the material. When generating the initial codes, the researchers compared notes on initial impressions of the data. The researchers decided early on to organize the codes according to the research questions: mothers' experiences of breastfeeding counseling, the elements associated with good breastfeeding counselling and expressed wishes on improved breastfeeding counseling. After this the material was divided and each researcher took to coding. During this stage the researchers remained in close contact, and coding was discussed throughout the process, both by creating new codes and dismissing codes irrelevant to the research questions. Discarded codes included those relating to experiences with previously breastfed children and experiences of breastfeeding counselling during the stay in the hospital.

When searching for themes researchers worked together and methodically went through all the generated codes organizing them into themes and sub themes. Most of the arising sub themes were evident in that they were simply brought up by many of the respondents. Some sub themes were less represented in the data but were still found to be a significant finding. This is in accordance with the method presented by Maguire & Delahunt (2017), who suggest that there isn't necessarily a direct correlation between the amount of times something is mentioned in the data, and its' significance as an identified theme (Maguire & Delahunt 2017). The authors then together proceeded to compare and comprise the findings from the whole data before the final thematization and writing of the research

report. An example of how the themes were generated can be seen in figure 1. as seen below.

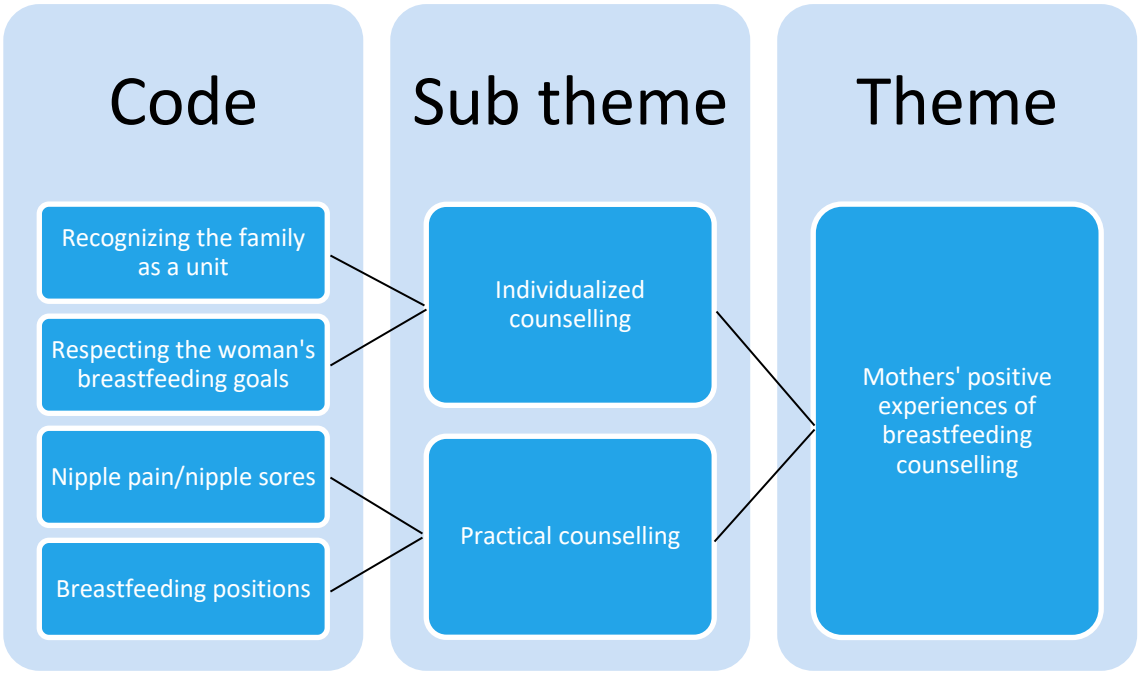

Figure 1. Example of generating codes, sub themes and themes

After generating the initial themes and sub themes the researchers proceeded to review and define the themes together. This included going back to the data and considering if the generated themes made sense and reflected the content of the data. The process of reviewing and defining themes was not a straight line, but rather a continuing process throughout the analysis. Even while writing out the findings, small adjustments were made to the final themes. Throughout the process of the thematic analysis, the researchers have worked meticulously together, and the findings reflect this. When writing up this final report the researchers once again went back to the initial data to retrieve quotations for each theme to make the results easier grasp by the readers and make the process more transparent for better validity.

4.3 Ethical considerations

In conducting research, one must take into consideration ethical aspects of research. It is important to consider these aspects already at the planning stage of the study, in order to overcome any potential ethical conflicts. It is the researchers duty to present the findings in a transparent, honest and accurate way (Kylmä & Juvakka 2007).

Due to the nature of this study, there are some ethical considerations, which need to be addressed. The major consideration is that originally Nina Kivilaakso, the breastfeeding coordinator of the City of Helsinki maternity and child health clinic Munkkiniemi who initiated the project and designed the questionnaire for the data collection, didn't mention other researchers' participation in data analysis in her letter of consent to the participants. When analyzing data, it is important to maintain the anonymity of the participants. No data should be possible to link to a certain respondent, as it would compromise the respondents right to confidentiality (Paunonen & Vehviläinen-Julkunen 1997). This was taken into consideration as the questionnaires were answered anonymously, and participants can't be identified through their answers, and so their right to confidentiality is maintained. Also, when the questionnaire (see appendix 1) was originally designed by Nina Kivilaakso, the breastfeeding coordinator of the City of Helsinki maternity and child health clinic Munkkiniemi, the General Data Protection Regulations (GDPR) were taken into consideration. In addition, the authors of this research report applied and were granted research approval from the City of Helsinki before accessing and initiating data analysis, see Appendix 2.

When starting the process of this study many steps had to be taken. The researchers first got into contact with Nina Kivilaakso, and together a plan was made of what the City of Helsinki actually wanted to get out of the data. The researchers then presented the idea of the study to the teachers at Arcada University of Applied Sciences (UAS) and Diak UAS, after which a research plan was drafted. This was presented to the head of the Social Services and Health Care Division Leeni Löthman-Kilpeläinen. Small adjustments were made to please both parties. Contracts were signed, and the research plan was sent to be accepted first by Arcada UAS and thereafter to the ethics committee of the city of Helsinki. The researchers did not receive the data before the research permit was granted, maintaining good research ethics. The data has been properly kept throughout the research process, with no one but the researchers of this study having access to the material.

5 FINDINGS

The research questions focused on mothers' experiences of breastfeeding counselling and the nature of counselling they would want. As the data was approached with these research questions in mind, the findings reflect this. The four major themes identified within the data were Mothers' positive experiences of breastfeeding counselling, Mothers' negative experiences of breastfeeding counselling, Mothers' neutral experiences of breastfeeding and Mothers' expressed wishes for improved breastfeeding counselling. Several sub themes were identified within three of the major themes and will be presented more comprehensively. The findings have been visualized in Figure 2., as seen below.

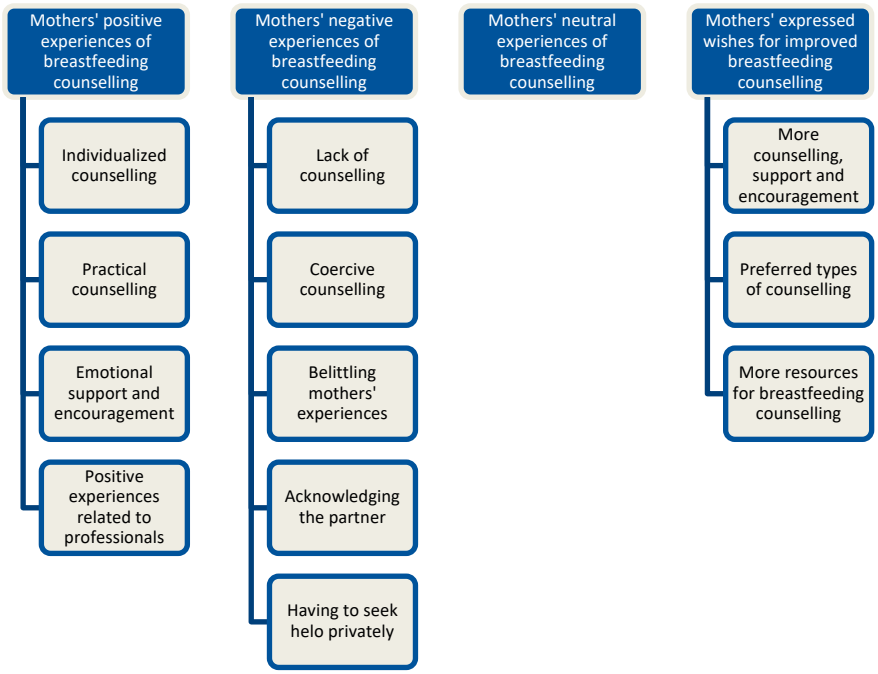

Figure 2. Visualization of findings

5.1 Mothers' positive experiences of breastfeeding counselling

A large number of responses in the data regarding mothers' experiences of breastfeeding counselling were positive. Within this theme several sub themes were identified and are further explained individually. The sub themes were *Individualized counselling, Practical*

counselling, Emotional support and encouragement and *Positive experiences relating to professionals.*

5.1.1 Individualized counselling

Individualized counselling presented itself as being versatile, respecting the mother's needs, goals and wishes concerning breastfeeding and recognizing the family as a unit. Individualized counselling also included respecting the mother's mode of feeding and supporting her decision not to breastfeed or to partially breastfeed.

> "... I feel that breastfeeding and my personal wishes have been supported and for example initiating solids wasn't rushed, on the contrary, I was encouraged to continue exclusive breastfeeding according to my wishes to about half a year of age."

> "I was very satisfied, that my decision to cease breastfeeding wasn't questioned but every mother is trusted, that she is able to make decisions regarding her own child."

> "Breastfeeding was not an easy journey and I got help and we were directed to the breastfeeding outpatient clinic. I just didn't want to or have the energy to go at that point so we continued with formula and I pumped milk for bottle feeding. Our solution was respected, which I greatly appreciate!"

Individualized counselling was experienced by mothers as positive and something they wanted. Providing individualized counselling was experienced as supportive and facilitating regardless of the mother's mode of feeding. This also included supporting women wanting to partially breastfeed when returning to work.

5.1.2 Practical counselling

Practical counselling was expressed as something valued in breastfeeding counselling. Mothers expressed appreciation for counselling related to feeding intervals and recognizing the baby's hunger signals. Also, support for bottle feeding, tapering down supplementation and initiating solid foods alongside breastfeeding were experienced positively. Being counselled about various breastfeeding positions and being counselled while observed during breastfeeding were appreciated by mothers. Concrete advice on dealing with breastfeeding challenges like nipple pain and nipple sores, or challenges related to the baby, such as baby's tummy troubles were experienced as helpful.

> "Breastfeeding counselling was sensitive. The position was corrected and other positions were suggested, but not pushed."

> "The support of the maternity- and child health clinic and public health nurse in tapering down supplementation was significant. Due to the serious complications in the beginning I would not have dared to start tapering down

supplementation without weight checks and borrowing a scale. With the support of the maternity- and child health clinic we succeeded to taper down supplementation almost completely. “

“...nipples were very sore and broken because I was breastfeeding in the wrong way when nobody showed me how, then when we came to the maternity and child health clinic they showed the right way to breastfeed and it was a real salvation! After that breastfeeding went really well!”

Mothers expressed an appreciation for very basic practical breastfeeding counselling. This was not just the case among first time mothers, but was also identified as a positive counselling experience among mothers with previous breastfeeding experience.

5.1.3 Emotional support and encouragement

Even though many women expressed the need for practical hands-on-counselling, emotional support and encouragement also plays a big part. Emotional support and encouragement were expressed as taking the mother’s needs into account and mothers feeling validated. Counselling that was viewed by the mothers as being supportive and encouraging was non-coercive in nature and the matter of breastfeeding was brought up.

“We didn’t need a lot of support anymore from the maternity and child health clinic, but encouragement and emotional pepping yes, and we got that!”

Creating a baby-friendly environment was experienced by mothers within the maternity and child health clinics through arranging for breastfeeding friendly spaces within the facilities as well as workers perceived as breastfeeding positive and helpful both in person and when communicating by telephone.

5.1.4 Positive experiences relating to professionals

Mothers often expressed having positive experiences relating to professionals. Within this sub theme the mothers especially reported positive experiences related to the nurse working in the maternity and child health clinics. This is understandable, as this is the main contact the client has with the clinics. Positive experiences were often expressed as associating positive attributes to the nurse. These attributes included nurses recognizing their own limitations, having good interpersonal skills, being kind, encouraging and non-pressuring, being professional and competent as well as being respectful of the mother’s knowledge and advocating for the mother. Also, positive experiences of mothers relating to the maternity and child health clinic nurse included respecting personal space, providing individual care and respecting the mother’s breastfeeding decisions and goals.

> "In our own maternity and child health clinic they're very encouraging of breastfeeding and our own nurse is up to date on matters concerning breastfeeding"

> "Competent and friendly service and specifically in a way where the nurse respected my own knowledge and wishes. Nothing was pushed, but alternatives were presented. I didn't need much breastfeeding advice and the nurse supported my own breastfeeding improvements I'd made before the appointment."

> "Thanks to the advice and encouragement breastfeeding has succeeded exceptionally well! The home visit, where I got to practice using a breastfeeding pillow with the guidance of our nurse, was excellent. Now breastfeeding is pain free, easy and I feel confident. It is also comforting to know, in case there are setbacks, that we have a reliable breastfeeding professional to contact without hesitation. It is also nice that I have been working with the same person throughout the pregnancy and postpartum period. That's how we've built trust and asking for help is natural."

Mothers also expressed positive experiences related to the breastfeeding counsellor available through the maternity and child health clinics in Helsinki. These also often related to positive attributes similar to those attributed to the maternity and child health clinic nurse such as being positive, empathetic, supportive, listening to the mother and validating her. Mothers also often associated their positive experiences related to the breastfeeding counsellor from receiving practical counselling, such as help relating to proper latch, pain while breastfeeding, baby's tantrums at the breast, breastfeeding positions and treating thrush.

> "The appointment with the breastfeeding counsellor helped more and our problems began to resolve little by little. A thousand thanks for that!"

> "...I got an appointment with the breastfeeding counsellor who gave me concrete hands on counselling for breastfeeding. That was our salvation. She also told us facts that helped me through my child's breast tantrum phase..."

There are also various group meetings arranged through the maternity and child health clinics for breastfeeding mothers.

> "The breastfeeding support group at the maternity and child health clinic was a really great thing: good educator, the solution to my problem, peer support. Thank you for this!"

Some mothers expressed that these groups had a positive effect on breastfeeding as they provided knowledge and information.

5.2 Mothers' negative experiences of breastfeeding counselling

Many mothers described having negative experiences of breastfeeding counselling in the maternity and child health clinics. Thus, the theme Mothers' negative experiences of breastfeeding counselling was identified within the data. Within this theme there were

also several sub themes identified. The subthemes were *Lack of counselling, Coercive counselling, Belittling mothers' experiences, Negative experiences relating to professionals, Acknowledging the partner* and *Having to seek help privately.*

5.2.1 Lack of counselling

The title in itself presents the key element within this sub theme. Many mothers expressed a general lack of breastfeeding counselling within the maternity and child health clinic. Some mothers even expressed receiving no breastfeeding counselling. This lack of counselling was described richly in the data. Often mothers felt there was a lack of resources for breastfeeding counselling in that appointments were too busy and there was no real time to focus on breastfeeding.

> "We didn't get information, more than "it's good to breastfeed your baby", or " it's okay to mix with formula" but there is no time on the appointment where there is time to talk about breastfeeding! They are just asking if the baby eats or not"

It was also often left to the mothers to ask for counselling rather than it being offered, and so many expressed feeling as though breastfeeding was not a priority in counselling and that there was a general lack of support for breastfeeding. First time mothers felt that the counselling should start from a very basic level and not assume that there is any previous knowledge on the subject. They also brought forth that it would be preferred that the health care worker would be the one to initiate the discussion.

> " I wish for more breastfeeding counselling. Some clients might find it awkward to ask what they might think are silly questions, so it is very important that the nurse makes suggestions and asks questions about breastfeeding..."

Often mothers expressed that counselling was outsourced and that it was left to the mothers themselves, in that they were often referred to other channels such as Facebook groups (Imetyksen tuki ry) or websites on the internet for breastfeeding counselling. Also, many mothers were given written instructions rather than in person counselling, and this was considered an ineffective method of counselling.

Some mothers experienced the counselling they were provided with as superficial and as not being personalized, practical or realistic. Often mothers felt there was a shared assumption that breastfeeding is easy, and thus experienced lack in counselling when problems would arise. Many also felt that they had received insufficient information on where

to turn in acute problems relating to breastfeeding and that they had not been informed about their entitlement to breastfeeding counselling and support. Those mothers who identified as being a rare case (e.g. having a premature baby, twins, baby with hip dysplasia etc.), often felt they fell in between, and received insufficient breastfeeding counselling.

> "I wish that they would make a separate twin-breastfeeding package within the maternity and child health clinics that could be distributed to all future mothers of multiples and the nurses would familiarize themselves with this..."

Mothers expressed that counselling within the maternity and child health clinics wasn't realistic, but created a false image of breastfeeding in that they weren't made aware of the possible initial challenges or emotional effects of hormonal changes. Those mothers who for various reasons couldn't breastfeed, and experienced disappointment in this, often felt their needs were not met.

> " When it became clear that I don't have enough milk, and my milk production was ending when my child was only 2 weeks old, it felt hurtful that the nurse highlighted why formula is bad and breastfeeding is good, when she knew breastfeeding wasn't possible. The maternity and child health clinic can't help sufficiently in breastfeeding challenges, and they lack knowledge in what to do if breastfeeding isn't possible. They also don't have information about formula or daily bottle feeding."

The women who for various reasons chose to not fully breastfeed also expressed the need for more emotional support. They felt that they did not get the same validation as mothers and often felt pressured and experienced guilt when visiting the maternity and child health clinic. Mothers expressed that the practical aspect of not breastfeeding was also poorly managed, and a general lack of know-how reigned among the nurses at the maternity and child health clinic regarding this. Mothers would have wanted more practical counselling on bottle feeding, specifically baby paced bottle feeding as well as pumping breast milk. Mothers felt bottle feeding counselling and counselling on how to partially breastfeed was lacking. Mothers felt that the only aspect of feeding which was counselled was breastfeeding. They would have wished for more neutral information and discussion about this. Mothers felt they would have wanted to be presented with options, rather than breastfeeding and bottle feeding being presented as being opposed to each other.

> "In the maternity and child health clinic I got the feeling, that I'm only good enough when constantly offering the breast, and that pumped milk given in a bottle by my husband isn't enough."

Some mothers experienced that counselling was poorly timed in that the subject wasn't approached when it was actually relevant. Often mothers who weren't first time mothers

expressed not receiving counselling but were met with the assumption that they knew how to breastfeed even though they expressed wanting counselling.

> ”It would be nice, if breastfeeding counselling was offered during pregnancy to all expectant women (even those not expecting their first child)”

Mothers also expressed that there often was a lack of continuity and consistency in counselling due to that nurses at the maternity and child health clinics often switched. Often when presenting questions about breastfeeding, the answers were perceived by mothers as ambiguous and indirect, often expressed in medical jargon without making sure the mother understands.

Among many mothers there was also an experienced lack of support of exclusive breastfeeding, and many felt pushed to formula supplementation or initiating solid foods rather than enhancing breastfeeding. Mothers felt that the baby’s weight gain acted as a measure of breastfeeding success rather than the mother’s experience of breastfeeding and that their expressed personal breastfeeding goals were not considered.

5.2.2 Coercive counselling

Many mothers described experiences of feeling coerced by the breastfeeding counselling they received. They described a general feeling of pressure to succeed, in that breastfeeding was often presented as the only option to feed your baby. Mothers experiencing pain while breastfeeding often felt their experience was belittled. Mothers felt that the focus was on the baby rather than taking the mother’s well-being into account. Many felt the importance of exclusive breastfeeding was over-emphasized, and that the individual needs and wishes of the mother weren’t acknowledged. Mothers choosing to partially breastfeed or supplementing totally with formula, felt they were made to feel guilty for this.

> “... the whole time breastfeeding had been a struggle. All our lives got easier at once when I finally made the decision to give up and switch to formula completely. I felt that in that situation I didn’t receive any support for my decision from health care professionals and I felt I had failed completely. The breastfeeding friendly atmosphere has become guilting, if in no situation the so called “official” advice can’t be anything else then, try breastfeeding even with your head under your arm.”

Within this sub theme, however, mothers also expressed that there is too much focus on the baby’s weight gain (too much or too little), and that often problems with breastfeeding

were solved by pushing mothers to supplement with formula. Often counselling was perceived as going against recommendations, was non-useful and poorly timed. This was especially experienced when mothers felt pressured to stop breastfeeding at night. Often this kind of advice felt conflicting with recommendations and that no motivation was provided for these recommendations. Some mothers even expressed feeling that the nurse's personal ideas would affect counselling.

> "...breastfeeding counselling in the maternity and child health clinics is pretty objective and doesn't take into consideration individual needs as well as it should. Or maybe the thing is more so, that there is a lot of variation between workers and in some exceptional cases the maternity and child health clinic worker's own ideas come through too much in breastfeeding counselling."

> "I feel that it is often forgotten that the WHO recommends breastfeeding for AT LEAST 2 years. In addition I've also encountered, that the maternity and child health nurse advises to reduce breastfeeding, based on their own experiences or opinions of length of breastfeeding and that a child over 1 doesn't need breastfeeding. It would be good to remember not to advise according to one's own opinions but rather according to the WHO guidelines and research."

There is a discrepancy within this sub theme in that while some mothers experienced counselling according to guidelines as rigid and not taking the mother's situation into account, others expressed the opposite and felt counselling didn't adhere to the guidelines and was rather dependent on the person providing counselling. Regardless of the individual situation, coercive counselling was expressed by mothers as adding to the pressure of succeeding at breastfeeding, and was not perceived as helpful or good breastfeeding counselling.

5.2.3 Belittling mothers' experiences

Mothers facing various challenges with breastfeeding often felt their experiences were belittled. In general mothers often felt they were told things were normal, and that their experience wasn't validated. This was the case for some mothers experiencing pain while breastfeeding or excessive let down, mothers to babies with reflux or excessive spit up issues, mothers to babies with allergies, and mothers to babies with lip- and tongue tie.

> "My child was diagnosed with tongue tie, and I didn't get enough counselling about this, how this affects breastfeeding and on the other hand my whole problem was belittled and my experiences about this weren't even believed"

Mothers also often felt belittled in not receiving help in practical matters such not having to use aids (i.e. nipple shield) while breastfeeding. Often mothers felt their physical and emotional well-being weren't considered.

5.2.4 Negative experiences relating to professionals

Many mothers expressed having had negative experiences relating to professionals at the maternity and child health clinic. Many of these experiences related to the maternity and child health clinic nurse and her negative attributes. These negative attributes were experienced as the nurse not recognizing her own limitations and being incompetent, having poor problem-solving skills, being non-supportive, discouraging and having a judgmental attitude. Also, some experienced that the nurse was timid or embarrassed when talking about breastfeeding.

Some experienced the nurse as being non-professional and lacking knowledge when it comes to breastfeeding. Often mothers would meet with different nurses, and they would feel that the nurse hadn't familiarized themselves with the family's situation. Due to having met with several nurses at the maternity and child health clinic many mothers also felt that there were inconsistencies between nurses when it comes to breastfeeding counselling.

> "There are huge differences between nurses, and I've had a lot of substitutes due to vacations etc. During this whole time I think I've had 6 nurses. The baby is developing well, so we haven't had any extra appointments. Our own nurse is very positive about breastfeeding and I experienced getting advice and support from her. I can't say the same for all of them..."

The respondents' experiences relating to the doctor at the maternity and child health clinic were that they didn't support breastfeeding and that they didn't offer advice even when directly asked. Mothers often felt pressured by the doctor to supplement with formula or initiating solid foods, rather than enhancing breastfeeding.

The negative experiences relating to the breastfeeding counsellor available at the maternity and child health clinic were mainly that there weren't enough resources for this. Mothers expressed frustration with long waiting times, and that this help was offered too late. Many even expressed not having known about this resource and not being offered the possibility of meeting with the breastfeeding counsellor even when dealing with breastfeeding challenges.

> "... I got an appointment with the breastfeeding counsellor at the maternity and child health clinic 2 months after the delivery. Breastfeeding didn't work out at all at this point and the baby has been bottle fed since birth. I feel these cases should be handled right away, so that the mother could learn to breastfeed and it would be a pleasant experience. For me it was the opposite. The counselling was good after having waited those two months, but unfortunately it was too late."

> "...When I needed counselling, I had to wait two-three weeks before I got an appointment with the breastfeeding counsellor. In the worst case scenario breastfeeding could stop completely during that time, if the problems are severe..."

Some mothers expressed negative experiences relating to group meetings at the maternity and child health clinics (perhevalmennus, avoneuvola, ryhmäneuvola). Some mothers felt these groups were pressuring and created false images of breastfeeding. Often in group situations exclusive breastfeeding was presented as the only option, and other modes of feeding were completely ignored.

> ”The breastfeeding counselling given at the family guidance group meeting before the baby was born was very superficial and added to the feeling of guilt of failing at breastfeeding, as it emphasized that breastfeeding success is dependent on the mother's will and motivation…”

Mothers also found these groups as insufficient in providing breastfeeding counselling and the content not being based on facts or according to current guidelines. For example, mothers had been advised to stop breastfeeding at night, supplement with formula or initiating solid foods early, contrary to the current guidelines.

5.2.5 Acknowledging the partner

Some mothers felt that their partner was ignored when it concerned breastfeeding counselling, that the partner wasn't really taken into consideration at all and talking about the role of the partner in breastfeeding felt pretentious. Some mothers experienced that their partners weren't supported in being breastfeeding supporters, and that partners participating by bottle feeding the baby was considered substandard to breastfeeding. Also, some mothers felt that breastfeeding counselling for the partner was poorly timed, in that it was offered too early in the pregnancy when breastfeeding didn't feel relevant.

> ”My spouse wasn't asked anything about breastfeeding, and he wasn't supported in supporting breastfeeding.”

> ”Breastfeeding was brought up with my husband on our first visit at the maternity and child health clinic. We've remembered this discussion afterward amused.”

Acknowledgment of the partner in breastfeeding counselling was not brought up among very many of the mothers in the data. This was still identified as something significant, as those mothers who did bring forth their experiences related to partner acknowledgment in breastfeeding counselling expressed it as being ineffective in supporting partners.

5.2.6 Having to seek help privately

Even though the maternity and child health clinics offer breastfeeding counselling, it was evident in the data that some mothers found this insufficient. The sub theme *Having to seek help privately* arose from the experiences of those mothers who had resorted to using the services of the private sector.

> ”I googled private breastfeeding counsellors myself and got someone to come for a home visit just with a couple of days notice, who was very competent and might have even saved breastfeeding continuing.”

> “Breastfeeding guidance could be done while breastfeeding the baby and more than once. That is how I managed to get latch right, when my private midwife looked at my breastfeeding and helped us get it right. She also showed us many different positions we could use. This type of help wasn’t offered by any nurse, nor in the hospital, nor in Neuvola.”

Many mothers with babies with tongue- and lip tie resorted to services within the private sector. Mothers often felt there was a lack of knowledge within the maternity and child health clinic concerning tongue- and lip tie, that the problem wasn’t taken seriously and information on the matter wasn’t given. They felt that the baby’s tongue- and lip tie were recognized too late when problems with breastfeeding had already arisen. Often when this was the case, mothers didn’t receive help and were even referred by the maternity and child health clinic to seek help within the private sector. Those mothers expressed receiving expert treatment privately through surgical correction of the baby’s tongue- or lip tie, and many felt this had improved breastfeeding.

> “The baby was diagnosed with lip- and tongue tie within the private sector. Especially the tongue tie caused problems with breastfeeding. I was tipped about these by the breastfeeding counsellor, but before that it hadn’t been recognized within the maternity and child health clinic and probably I wouldn’t have gotten help for this within the public sector. We also met with a private breastfeeding counsellor after the operation. So we had problems especially with severe pain while breastfeeding but gradually we overcame these. However, we had to find this professional help ourselves.”

Mothers who had resorted to seeking help privately expressed the counselling they received as being individualized and concrete, the mode of counselling being more flexible (e.g. home visits), and the providers being perceived as experts.

5.3 Mothers’ neutral experiences of breastfeeding counselling

This theme presented itself from the data as a stand-alone theme. No sub themes were identified within the theme. However, many of the mothers who wrote responses expressed their experience of breastfeeding counselling as a neutral experience.

”It was my experience that one gets quite little support for breastfeeding from the maternity and child health clinic. On the other hand I didn’t have problems, and didn’t ask for help, so I didn’t have a great need for it. It is possible that I would have gotten a lot more support if I had had problems with breastfeeding.”

The mothers who had neutral experiences of breastfeeding counselling often expressed not having received counselling, encouragement or support, but not having had or expressed any need for it. These types of statements were reoccurring within the data and identified as a significant finding.

5.4 Mothers’ expressed wishes for improved breastfeeding counselling

This theme arose from the data through the mothers expressed wishes for improved breastfeeding counselling within the maternity and child health clinic. Within this theme the following sub themes were identified: *More counselling, support and encouragement, Type of counselling* and *More resources.*

5.4.1 More counselling, support and encouragement

As the title of this sub theme suggests, many mothers simply expressed a wish for more breastfeeding counselling. This was felt to improve mothers’ preparedness when facing possible breastfeeding challenges. Especially first-time mothers expressed a wish for more counselling, but also multiparas expressed that they would have wished for more counselling. Mothers expressed wishes of meeting more expertise within the maternity and child health clinics and being referred to low-threshold support already during pregnancy (imetyksen tuki ry etc.)

“...I’d wish that the complexity of breastfeeding was tackled better in the maternity and child health clinics in the future. It’s not like in the textbooks for everyone (especially for first time mothers).“

“…Multiparas should also be given a lot of information about breastfeeding.”

“Women should be informed already during pregnancy about the possibility of low threshold support, for example Facebook-groups. It would also be beneficial to address the possibility of breastfeeding disappointment, and quite honestly say that breastfeeding might not be as easy as it appears in the movies. That there’s tantrums at the breast, 24/7 cluster feeding, constant night feedings, hormone sweating etc.”

Mothers expressed a wish for more encouragement and support, especially considering insecure mothers and meeting their needs. Both women who did and did not succeed

expressed that they would have wanted more emotional support. The women who succeeded expressed a wish for a "pat on the shoulder" and validation for their success. Mothers wished for support in creating a positive outlook on breastfeeding, reaching personal breastfeeding goals (e.g. six months exclusive breastfeeding), and support even when breastfeeding is going well.

> "... I don't recall hearing praise, but that doesn't really belong in Finnish culture. It would be nice to hear."

> "Maybe it would be good, that this success was somehow praised and encouraged – this kind of action could encourage some more insecure mother to continue breastfeeding for longer."

Mothers experiencing challenges related to breastfeeding, or mothers experiencing a failure to breastfeed expressed wanting more emotional support. Overall mothers expressed a wish to be validated in their experience of breastfeeding and being respected in their choices. Those mothers who were either partially breastfeeding or supplementing totally with formula would have wished for a more merciful and accepting attitude within the maternity and child health clinic.

> "... I feel greater focus is needed to support those mothers, who'd want to breastfeed, but for some reason it just doesn't work. Many experience a sense of failure, because the positive effects of breastfeeding are emphasized, but it's not always just a matter of the mother's choice, but because of the baby or the circumstances breastfeeding just isn't always successful. In those situations most mothers would need a lot of support and understanding from the maternity and child health clinic."

Some mothers specifically wished for counselling on how to wean the baby off the breast, some specifically stopping night feedings, and felt a lacking support in this decision. They would have wished for direct counselling, discussion and support in meeting their goals, even when it meant breastfeeding cessation.

Mothers also expressed a wish for counselling being offered at the right time. Mothers wished for counselling to happen already during pregnancy, so that they would be more prepared for initial challenges.

> "If breastfeeding is to be advanced and to get more women to exclusively breastfeed up to 6 months, then counselling should be given in the maternity and child health clinic at the right time (immediately after birth), give all mothers the basic facts about breastfeeding and take mothers' concerns seriously."

> "One would wish for more time to talk about breastfeeding and its benefits, more counselling, advice and support already before the baby is born… At the nurse appointments there is a need for more time to go into breastfeeding and for example breastfeeding positions during the first visit with the baby. I don't think it's enough to just glance when for instance checking for proper latch."

Women also expressed a wish for more breastfeeding counselling after the baby is born. Often critical time passes between the family being discharged from the delivery ward, and their first visit with the maternity and child health clinic nurse. At this point the mother may have already faced many challenges regarding breastfeeding, without receiving timely counselling.

5.4.2 Preferred types of counselling

Within this sub theme many mothers expressed wishes related directly to the type of breastfeeding counselling they would have wanted. Different types of counselling were identified, and included individualized counselling, practical counselling, realistic counselling during pregnancy and evidence-based counselling.

Mothers expressed wishes concerning individualized counselling included meeting the mother as well as the baby as an individual and respecting the mother's right to self-determination.

> "I wish that different wishes were considered and not giving the same recommendations to everyone."

> "Babies differences should be better taken into consideration, All babies aren't the same."

Also, mothers who identified as being a "special case" (i.e. cesarean-section mothers, mothers to twins etc.) would have wished for counselling specifically targeted for them.

> "I wish that they would make a separate twin-breastfeeding package within the maternity and child health clinics, that could be distributed to all future mothers of multiples and the nurses would familiarize themselves with this..."

Much like those positive experiences of mothers relating to practical counselling, many mothers expressed a want of more practical counselling. Mothers would have wished for counseling related to feeding intervals, including breastfeeding on demand and night feedings. Also, women would have wanted more counselling related to breast health, such as avoiding infections and blocked milk ducts, experience of milk coming in and how to increase milk supply, treating nipple sores, expressing breast milk, and using breast shield. Mothers would have wanted more counselling on dealing with potential initial challenges such as feeding a sleepy baby, reading the baby's hunger cues as well as knowing your baby gets enough milk, breastfeeding positions, the benefits of skin to skin contact, baby's proper latch, recognizing cluster feeding periods, dealing with tantrums at the

breast and teething. Mothers would have wished for practical counselling in person while being observed while breastfeeding, as well as being informed about how bound you can be when breastfeeding. When it was relevant, mothers also expressed a wish for practical counselling on initiating solid foods and recognizing the baby's readiness for this.

> ”It would be good to give information and support about breastfeeding already during pregnancy… An information package about the benefits of breastfeeding, baby paced breastfeeding, cluster feedings, breast tantrums etc. would be very good. It would also be good to be aware of the signs that the baby gets enough milk.”

Mothers also would have wanted practical counselling when wanting to wean the baby off the breast or when wanting to cease breastfeeding. Mothers often expressed a need for practical advice to stop night feedings and lacking direct counselling for this but receiving ambiguous advice.

Mothers who were partially breastfeeding or not breastfeeding at all expressed a want for more practical counselling. In general, mothers wished for nurses within the maternity and child health clinic would have more know-how about bottle feeding to provide practical counselling for this. Mothers would have wanted practical counselling relating to baby paced bottle feeding and pumping breast milk. Mothers would have wanted mode of feeding presented neutrally, that partial breastfeeding or feeding with formula are also valid options when breastfeeding isn't possible, or these are simply the mother's choice. Women also wished for realistic counselling especially related to the possibility of breastfeeding disappointment. Also, mothers would have wanted the maternity and child health clinic to facilitate realistic expectations regarding breastfeeding. Mothers would especially have wanted to be informed already during pregnancy about potential initial challenges with breastfeeding and not creating a false image of what it is to breastfeed.

> “...during pregnancy I got pretty superficial information about the keys to successful breastfeeding from the maternity and child health clinic. I feel that possible problems and their solutions should be counselled much more already during pregnancy, and not just give a romantic image about what breastfeeding in reality is… I experienced a bitter breastfeeding disappointment just because of the lack of knowledge...”

Mothers expressed a wish for evidence-based counselling, that was based on current facts and the WHO guidelines while still respecting the mother's personal wishes and goals. Mothers also wanted to counselling portraying the benefits of breastfeeding, both when exclusively breastfeeding and partially breastfeeding.

5.4.3 More resources for breastfeeding counselling

In general mothers wished for more resources to ensure quick and easy access to breastfeeding counselling. Mothers expressed specifically that they would have wanted more resources for the breastfeeding counsellor within the maternity and child health clinic. This included improving availability by training more experts, so mothers would not have to wait for appointments to receive comprehensive support for breastfeeding. Mothers wished that the maternity and child health clinics would ensure consistent quality in counselling by educating all personnel participating in caring for families in breastfeeding counselling.

> "I'd wish that it was easier and a shorter waiting period to get to the breastfeeding counsellor, or that the nurses received substantially more education related to the matter."

> "It would have been beneficial to get an appointment with the breastfeeding counsellor immediately to deal with breastfeeding challenges with a newborn. I had to wait several weeks for the appointment. The maternity and child health clinics could have more persons with extensive knowledge in breastfeeding, so that one wouldn't have to wait for appointments. The more time that passes, the harder it is to deal with the problem."

Also, some mothers wished for the possibility of the breastfeeding counsellor doing home visits. Some even suggested there should be an automatic visit with the breastfeeding counsellor once the baby is born to ensure quality in breastfeeding counselling. Mothers also had wishes for the breastfeeding counsellor to be present for family guidance groups. There was also a wish for experienced mothers to participate in family guidance groups to share their experience of breastfeeding so as to give a realistic testimony of breastfeeding. In general mothers would have wanted there to be groups for breastfeeding mothers to provide peer support.

> "I would warmly recommend one coaching session for this and having real people come talk about their own breastfeeding experience."

Mothers also wished that there were visits at the maternity and child health clinic that focused specifically on breastfeeding and breastfeeding challenges. Some suggested there should be rotating walk in visits focusing on breastfeeding (avoneuvola). Also, mothers would have wanted more options for home visits as breastfeeding is mostly done in the home.

Some mothers suggested better accessibility to counselling by offering phone counselling, or internet chat services that were available outside office hours. Mothers would also

have wanted there to be availability to breast pumps and quiet areas for breastfeeding within the maternity and child health clinics.

5.5 Summary of the findings

The findings identified that mothers had positive, negative and neutral experiences of breastfeeding counselling. The analysis also identified mothers' expressed wishes for improved breastfeeding counselling within the maternity and child health clinics. Mothers clearly experienced individualized, practical and realistic breastfeeding counselling as positive and preferred, and that they would have wanted this already during pregnancy to be prepared for potential breastfeeding challenges. Counselling that mothers felt as going against the WHO guidelines was experienced as confusing and coercive, and many expressed a wish for consistent counselling among workers within the maternity and child health clinics. Mothers had both negative and positive experiences related to professionals, which affected their experience of breastfeeding counselling.

Mothers experiencing challenges with breastfeeding also expressed a want for validation and support. While many expressed a want for adherence to the WHO guidelines in breastfeeding counselling, others felt these were too rigid and that mothers facing challenges weren't presented with options, and that those who were partially breastfeeding or supplementing totally felt pressure and guilt.

Mothers to children with lip- and tongue tie had often resorted to seeking help within the private sector, and wished for better recognition and treatment options within the public sector. There was also an expressed want for more counselling, support and encouragement, and a general wish for more resources within the clinics for breastfeeding counselling.

6 DISCUSSION

In Finland women have access to world class public healthcare during pregnancy and post-partum, it is available for everyone and free of charge. Due to this Finland is ranked the fourth safest country in the world to be born (UNICEF 2018c). Nevertheless, there seems to be inconsistency in the content of counselling provided within the maternity and child health clinics. The healthcare system in Helsinki follows the national strategy for enhancing breastfeeding (kansallinen imetyksen edistämisohjelma 2018-2022) (Hakulinen et al 2017), yet many commented that the quality and amount of counselling was bound to specific healthcare workers. Even though the statistical report from the original data showed the majority of women perceived to have gotten enough or good counselling, many still feel that more is needed.

According to the findings in this study, this experience of inadequacy was partially due to a lack of resources (having to wait for appointments), as well as some expressing a lack of knowledge among health care workers. This could result in mothers resorting to using private sector services. At times this was even suggested by workers within the public sector. Especially when women were facing difficulties breastfeeding caused by lip- and tongue tie, women would seek help privately. Mothers felt their experience was belittled by workers within the public health care sector, whereas the private sector offered help in forms of surgical correction and expert breastfeeding counselling. In Finland the maternity and child health clinic follow the strategy for enhancing breastfeeding (kansallinen imetyksen edistämisohjelma 2018-2022), and according to this strategy the first intervention is to strive to improve latch by providing breastfeeding counselling. There is little evidence to suggest that surgical correction of lip- and tongue tie significantly improve breastfeeding outcomes. However, this is considered in severe cases (Hakulinen et al. 2017). Despite the strategy encompassing this specific breastfeeding challenge, many mothers felt compelled to seek and receive help elsewhere. These women expressed being satisfied with the results of surgical correction and experiencing improved breastfeeding. This raises the question of why such a discrepancy between the national guidelines and the actions of the private sector occur.

The maternity and child health clinics' baby- and family-friendly initiative – seven steps in Finland state that there should be a written WHO recommended baby- and family-

friendly initiative policy, which all personnel should be familiar with and comply with (Hakulinen et al. 2017). Many mothers expressed disappointment that some nurses within the maternity and child health clinics did not follow the WHO guidelines even though personnel have committed to following these within the parameters of the baby- and family-friendly initiative policy when counselling breastfeeding mothers. This caused some mothers to express mistrust in the nurse's competence in matters of breastfeeding. It becomes evident from the data that some mothers have a strong knowledge base about the WHO recommendations to breastfeeding. Mothers expressed quite clearly that they wanted nurses to follow the guidelines and nurses should be better informed in these. The same observations of mothers' preferences to the adherence to the WHO guidelines in breastfeeding counselling have been made in a recent publication in Sweden by Blixt et al in 2019. Similar findings were made among mothers breastfeeding long-term (over 6 months), in that they often faced ridicule and doubt among health care professionals, even though the WHO clearly recommends long-term breastfeeding (Dowling & Brown 2013).

Within the data it was evident that some mothers had had negative experiences related to professionals. This contributed to an overall negative experience of breastfeeding counselling. While it is not realistic that professionals would be able to please everyone, it is important that professionals recognize their importance as ambassadors for breastfeeding through breastfeeding counselling. Mothers' negative experiences with professionals can cause fear around breastfeeding and result in a fear of receiving similar treatment in future health care contacts related to breastfeeding, and even fear of breastfeeding itself (Vas Goncalves 2017; Palmér 2019). Since studies show that previous negative experience of breastfeeding can influence future experiences, health care professionals are in a key position in providing these mothers with counselling and support when faced with this disappointment. This would facilitate mothers to work through this disappointment and trauma before initiating potential future breastfeeding.

Mothers' image of breastfeeding does not come solely from their experiences of breastfeeding counselling within the maternity and child health clinics. The researchers recognize that this image is influenced by various variables, such as cultural attitude towards breastfeeding, the woman's previous experiences and contacts with breastfeeding, as well

as exposure to breastfeeding related coverage within media and social media, and so on (Keevash et al 2018). However, within the findings mothers expressed a lack of realistic counselling within the maternity and child health clinics, and so they also expressed a wish for more realistic counselling. The findings suggest that mothers experience receiving a false image and being ill prepared for the reality of breastfeeding. This was especially expressed among mothers who had experienced challenges related to breastfeeding or failure to breastfeed and the related feelings of disappointment. These findings were supported by previous research, in that women express a gap between their expectations versus what the reality of breastfeeding is (Palmér et al 2015; Spencer et al 2014; Hargreaves & Crozier 2013). This gap in expectation versus reality, especially among those women who have experienced a failure to breastfeed, can become a trauma that might affect even future experiences of breastfeeding. Women who have experienced this type of trauma might more easily give up on breastfeeding with their next child or even opt to not breastfeed at all (Palmér 2019; Vas Goncalves 2017). It can thus be argued that it would be important to provide women with a realistic image of breastfeeding during pregnancy through counselling within the maternity and child health clinics. This is in accordance with the strategy for enhancing breastfeeding (kansallinen imetyksen edistämisohjelma 2018-2022) (Hakulinen et al. 2017). However, there is a conflict between the strategy, which should be followed within the maternity and child health clinics, and what the mothers' experienced. Mothers clearly expressed that they would have wanted more counselling during pregnancy. When providing breastfeeding counselling it is important to ascertain that mothers have understood the content of counselling (Leurer & Misskey 2015). This raises the question whether there is a possibility that the health care professionals are providing counselling, but not reassuring that mothers are internalizing the information they're given.

In the findings the theme *positive experiences of breastfeeding counselling* as well as within the theme *wishes for improved breastfeeding counselling*, the matter practical counselling was identified. Mothers had experienced practical counselling as something positive, and also something they would have wished for. Practical counselling presented as concrete and hands-on, providing mothers with the practical skills to breastfeed. While it was evident in the findings of this study as well as other research that some mothers were well informed about breastfeeding and the WHO guidelines, there were also those

that wished it wasn't assumed that they had any previous knowledge and experience and felt the need for being counselled starting from the basics of breastfeeding (Blixt et al. 2019; Cross-Barnet et al. 2012; Dietrich Leurer & Misskey 2015; Spencer et al. 2014).

It was evident within the findings that mothers valued being met as an individual when receiving breastfeeding counselling. To provide effective breastfeeding counselling and facilitating mothers' positive experiences of counselling, it is important that the health care professionals provide counselling in a way that make mothers feel heard, not belittling their experience and being non-coercive (Blixt et al 2020). This especially expressed among mothers who identified as being a special case (e.g. twins, premature baby etc.). Some expressed the need for counselling targeted specifically for their situation.
Mothers also expressed that they wanted the baby and family to be met as a unique unit. This is in accordance with the seven steps for the baby- and family-friendly initiative within the maternity and child health clinics, step 3. (Hakulinen et al. 2017). Mothers experienced the culture within the maternity and child health clinics as being focused more on weight curves rather than considering the baby as an individual, which in turn caused mothers to feel pressure with breastfeeding. These findings are supported by previous research (Blixt et al 2019; Hargreaves & Crozier 2013; Spencer & Fraser 2015). While some mothers felt that the constant weighing of the baby caused feelings of anxiety about producing enough milk for the baby, for some it was a reassurance and increased their confidence in providing sufficient nutrition for their baby. This further highlights the importance of meeting the individual needs of both breastfeeding mothers and their babies. This is equally true for mothers who for various reasons would not or could not breastfeed at all, and that they shouldn't be made to feel guilty or like substandard mothers because of their mode of feeding their baby (Hvatum & Glavin 2016). In this study it was also evident within the findings that that especially mothers who were having difficulties breastfeeding or even had ceased breastfeeding all together would have wanted emotional support and validation as being a good mother. Since breastfeeding can be a very touchy subject it is important to recognize that it is not always about counselling women to breastfeed but also being supportive and be able to ease the pain of not succeeding.

While the findings recognize the sub theme *acknowledging the partner* as a significant sub theme, it was surprising that this was not as prominent a theme as initially anticipated. In fact, quite few respondents brought up the matter of partners being acknowledged in breastfeeding counselling. However, those respondents who did bring it up had experienced a lack of adequate acknowledgment of the partner in breastfeeding counselling, and it was as such identified as a negative experience among the respondents. The limited testimony found to support this in the data, suggests acknowledging the partner in breastfeeding counselling as being less important than previously assumed. Similar findings have been made in a previous study by Hargreaves & Crozier (2013). However, previous research does suggest that partners play an important role as supporters of breastfeeding. Women whose partners support breastfeeding are more likely to initiate and continue breastfeeding. It can thus be argued that it is significant to acknowledge partners in breastfeeding counselling, providing them with the proper information and guidance to act as support to the breastfeeding mother (Alberdi et al 2018, Groleau et al. 2016; Laugen et al 2016; Namir et al 2017). Those women whose partners have a negative view on breastfeeding have a negative effect on breastfeeding outcome as found by Wang et al (2018). Partners may feel excluded from bonding with their child because of the exclusivity of breastfeeding (Earle & Hadley 2018; Wang et al 2018). A strategy to negate this feeling of exclusion might be to include fathers in breastfeeding counselling and facilitating other ways for fathers to bond with the baby, and as such supporting them as supporters of breastfeeding.

Within the seven steps for the baby- and family-friendly initiative within the maternity and child health clinics, breastfeeding presents itself as a continuum which isn't solely restricted to the first 4-6 months of the baby's life as stated in step 5., 6. and 7. (Hakulinen et al. 2017). Some mothers expressed pressure and lack of counselling and support from health care professionals when the baby was approaching 4-6 months of age. Some felt pressure to initiate solids, even though they would rather have continued exclusive breastfeeding or the mother did not feel their baby had the readiness for this. Some mothers also expressed being told to stop breastfeeding at night, which felt conflicting with the guidelines. Mothers also expressed they would have needed more counselling and support, when initiating solids was relevant. These findings are in line with previous studies (Blixt et al 2019; Dowling & Brown 2013).

7 CONCLUSION

There are indisputable benefits of breastfeeding for both mother and child. It is therefore important to provide proper breastfeeding counselling within the maternity and child health clinics, in accordance with the strategy for enhancing breastfeeding (kansallinen imetyksen edistämisohjelma 2018-2022), as well as the maternity and child health clinics' baby- and family-friendly initiative – seven steps in Finland (Hakulinen et al. 2017). The research questions presented for the purpose of this study were answered through the performed thematic analysis, and the findings reflect this. The findings of this study conclude that while the mothers often expressed having positive or neutral experiences of breastfeeding counselling, there were also those who expressed as having a negative experience. In addition, valuable insight into mothers' expressed wishes for improved breastfeeding counselling was acquired. The findings also identify elements of good breastfeeding counselling.

While the findings of this study did not bring any new insights concerning breastfeeding counselling, it was evident that there are still improvements to be made in breastfeeding counselling within the maternity and child health clinics in Helsinki.

7.1 Strengths and Limitations

One of the strengths of this study is that the researchers worked meticulously together throughout the whole research process. The findings of this report truly reflect the collaboration between the two researchers, which in turn improve the reliability of the findings. However, there were many limitations and challenges in performing this study.

Upon the initial familiarization with the data, it became evident that there were duplicates among the returned questionnaires. This was due to duplicate findings (identical answers) in the open-ended question answers. This led to the assumption that the data was flawed, and that unfortunately the statistical analysis performed in the Questback Essentials program was unreliable. This was an unexpected finding, and the Questback Essentials support was consulted to correct the flaw. As there was no identifying information on the respondents collected when gathering the data, there was no way to identify possible duplicates except among the open-ended answers. The researchers identified these, and found no more than 10 duplicate answers, and these were disregarded in the analysis.

However, as the questionnaires were sent by a link in a text message, those who received the message could in theory click the link and answer the questionnaire repeatedly. This is unlikely, but possible in theory and thus affects the reliability of this analysis.

There were also some shortages in the original questionnaire design. The questionnaire didn't consider whether the mothers were first time mothers or had children from before. The experiences of first-time mothers are different to those mothers with previous breastfeeding experience. Also, many mothers responded that their answers reflected their experiences of breastfeeding counselling with their first child. These answers were disregarded in the analysis, as standards of breastfeeding counselling might have changed since their first pregnancy.

The data for this study consisted only of the open-ended question answers of the questionnaire (see Appendix 1.), and so the findings of this study are only representative of those respondents. When looking at the statistical results within the Questback Essentials report on the questionnaire answers, it was clear that most mothers were satisfied with the level of breastfeeding counselling they had received in the maternity and child health clinics, while those who chose to answer the open-ended question tended to have had more negative experiences and expressed wishes for improved breastfeeding counselling. This affects the validity of the findings.

In addition, the findings of this report can't be generalized to all Finnish mothers. The majority (84,1%) of the 744 respondents were highly educated. Overall the women living in the Helsinki metropolitan area are more educated as compared to women in the rest of the country (Tilastokeskus 2019). Previous studies show that those of low education and low socioeconomic status have statistically lower breastfeeding outcomes (Artieta-Pinedo et al 2012, Sarki et al. 2018, Laugen et al. 2016). The findings of this study thus mostly represent highly educated mothers who have better breastfeeding outcome.

Another limitation to this study is that the original questionnaire was only sent out in Finnish. There are many immigrants living in the Helsinki area, and not all of those immigrant mothers have sufficient Finnish language skills to answer a questionnaire. This excluded the representation of these mothers in this study

7.2 Recommendations

The findings of this study are the result of analyzing mothers' experiences of breastfeeding counselling, and gaps were identified within the data. The findings offer valuable guidance in identifying those areas where breastfeeding counselling can be improved within the maternity and child health clinics. While the strategy for enhancing breastfeeding (kansallinen imetyksen edistämisohjelma 2018-2022), as well as the maternity and child health clinics' baby- and family-friendly initiative – seven steps in Finland (Hakulinen et al. 2017) provide an extensive set of guidelines, it can be interpreted through the mothers' experiences that the strategy and initiative aren't being consequently followed. However, there is also the chance that while counselling is being provided, it is not being ascertained from the mothers that the counselling is being properly internalized, as there was and expressed a lack of counselling during pregnancy. It would still be important to ensure all persons offering counselling and guidance to breastfeeding mothers be made aware of the policies and guidelines in accordance with the maternity and child health clinics' baby- and family-friendly initiative – seven steps in Finland, step 1. (Hakulinen et al. 2017).

Because of the language limitations of this study a wide range of immigrant women could not answer the questionnaire. These women also fall into risk of not receiving counselling because of the language barrier. It would be important to ensure that also these women get the counselling needed. Cultural differences should also be studied and taken into consideration. A recommendation would be to repeat the study with non-Finnish speaking women.

The focus of this study was on mothers' experiences of breastfeeding counselling, and the findings clearly identify a need for more resources for breastfeeding counselling within the maternity and child health clinic. It could provide further valuable insight to research the experiences of the nurses working within the maternity and child health clinic, and their perceptions concerning resources for breastfeeding counselling.
The findings also identified a lack of knowledge and willingness to help within the maternity and child health clinics concerning breastfeeding challenges related to lip- and tongue tie, and mothers often resorting to seeking help privately. It would be valuable to

find out why there is such a tangible discrepancy between practices between the public and private sector through further study.

The findings of this study included counselling as being perceived as coercive, and that there was an immense pressure on women to be successful at breastfeeding as though this were the only measure of a good mother. While the authors recognize the importance of enhancing breastfeeding, it would be important within the maternity and child health clinics to consider the possible effects of this pressure on the early interaction between mother and infant.

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APPENDIX 1. QUESTIONNAIRE BY NINA KIVILAAKSO

Liite 3 (1–4) Kyselylomake äideille.

Hei Sinä neuvolassa asioiva 0–1-vuotiaan lapsen äiti.

Tämä kysely koskee äitiys- ja lastenneuvolan terveydenhoitajan vastaanotolta saamaasi imetysohjausta. Vastataksesi kyselyyn imetysajan pituudella ei ole merkitystä. Kyselyyn vastaaminen on vapaaehtoista. Kyselyyn vastaaminen ei vaikuta Sinun tai lapsesi hoitoon neuvolassa millään tavalla. Kyselyn tuloksia voidaan hyödyntää imetysohjauksen kehittämisessä Helsingin neuvolassa. Toivon, että vastaat mahdollisuuksien mukaan jokaiseen kysymykseen. Kyselylomakkeen täyttämiseen Sinulta kuluu arviolta 15 minuuttia. Kyselyn laadinnassa on luvalla hyödynnetty osittain TtT Leena Hannulan väitöskirjan (2003) kyselylomaketta. Mikäli haluat kysyä lisää, voit lähettää kysymyksesi sähköpostitse Imetyskoordinaattori Nina Kivilaaksolle: nina.kivilaakso@hel.fi.

Lämmin kiitos osallistumisestasi!

Ympyröi oikea vastausvaihtoehto.

1. Lapsen ikä?

1) 0kk	5) 4kk	9) 8kk	13) 12kk
2) 1kk	6) 5kk	10) 9kk	14) >12kk
3) 2kk	7) 6kk	11) 10kk	
4) 3kk	8) 7kk	12) 11kk	

2. Koulutuksesi?

1) peruskoulu
2) ylioppilas
3) ammatillinen tutkinto
4) ammattikorkeakoulu- tai ent.opistotutkinto
5) ylempi korkeakoulututkinto
6) tieteellinen jatkokoulutus
7) muu, mikä _____

3. Siviilisäätysi?

1) naimaton
2) naimisissa/avoliitossa/rekisteröity parisuhde
3) leski

5. Lapsen ruokintatapa tällä hetkellä?

1) Täysimetys (vauva saa vain äidinmaitoa sekä tarvittavat vitamiinilisät tai lääkkeet)

2) Osittaisimetys (vauva saa äidinmaitoa ja äidinmaidonkorviketta)
3) Äidinmaidonkorvike
4) Imetys, kiinteät lisäruoat aloitettu
5) Osittaisimetys, kiinteät lisäruoat aloitettu
6) Äidinmaidonkorvike, kiinteät lisäruoat aloitettu
7) Lehmänmaito, imetys, kiinteät lisäruoat
8) Lehmänmaito, imetys, äidinmaidonkorvike, kiinteät lisäruoat
9) Lehmänmaito, äidinmaidonkorvike, kiinteät lisäruoat

6. Kuinka pitkään suunnittelit imettäväsi ennen lapsen syntymää?

1) 0kk	5) 4kk	9) 8kk	13) 12kk
2) 1kk	6) 5kk	10) 9kk	14) >12kk
3) 2kk	7) 6kk	11) 10kk	
4) 3kk	8) 7kk	12) 11kk	

7. Saitko imetysohjausta raskausaikana neuvolasta?

1) Paljon
2) Melko paljon
3) Jonkin verran
4) Vähän
5) En ollenkaan

8 Saitko imetysohjausta lastenneuvolassa lapsesi kanssa asioidessasi?

1) Paljon
2) Melko paljon
3) Jonkin verran
4) Vähän
5) En ollenkaan

9. Onko Sinulla ollut ohjauksen tarvetta imetykseen liittyen?

1) Paljon
2) Melko paljon
3) Jonkin verran
4) Vähän
5) En ollenkaan

10. Jos Sinulla on ollut avun tarvetta imetykseen liittyen, keneltä sait apua (voit ympyröidä useamman vastausvaihtoehdon):

1) Neuvolaterveydenhoitajalta
2) Imetyskouluttajalta
3) Sairaalan imetysohjauspoliklinikalta
4) Neuvolalääkäriltä
5) Neuvolan imetystukiryhmästä
6) Vertaistuen piiristä
7) Yksityiseltä palveluntarjoajalta
8) Perheentuki.fi-sivustolta
9) Internetin muilta imetystietosivustoilta (Naistalo, imetys.fi)

Seuraavat väittämät koskevat terveydenhoitajan vastaanotolla saamaasi imetysohjausta vauvasi kanssa. Ympyröi kokemustasi vastaava luku kouluasteikolla 4-10 (4= en ole tyytyväinen, 10= olen hyvin tyytyväinen)

11. Koin terveydenhoitajan antaman tiedon hyödylliseksi:

4 5 6 7 8 9 10

12. Sain riittävästi suullista ohjausta imetyksestä terveydenhoitajan vastaanotolla:

4 5 6 7 8 9 10

13. Sain riittävästi konkreettista ohjausta ja neuvoja imetykseen terveydenhoitajan vastaanotolla:

4 5 6 7 8 9 10

14. Saamani imetysohjaus terveydenhoitajan vastaanotolla oli yksilölliset tarpeemme ja toiveemme huomioivaa:

4 5 6 7 8 9 10

15. Mielipiteitäni ja itsemääräämisoikeuttani kunnioitettiin terveydenhoitajan vastaanotolla:

4 5 6 7 8 9 10

16. Ohjaus terveydenhoitajan vastaanotolla oli perhekeskeistä (äiti-lapsi- puoliso-suhteen muodostumista tukevaa):

4 5 6 7 8 9 10

17. Koin saavani apua imetysongelmaani terveydenhoitajan vastaanotolla:

4 5 6 7 8 9 10

18. Terveydenhoitaja perusteli hyvin imetyksestä kertomansa asiat:

4 5 6 7 8 9 10

19. Sain myönteistä palautetta terveydenhoitajalta omasta imetyksestäni:

4 5 6 7 8 9 10

20. Annettu ohjaus vahvisti kokemustani imetyksen onnistumisesta:

4 5 6 7 8 9 10

22. Vapaa sana: Mitä muuta haluaisit kertoa neuvolasta saamaasi imetystukeen liittyen?

_____
_____
_____

APPENDIX 2. RESEARCH PERMIT

12 §
Tutkimuslupa tutkimukseen "Improving Breastfeeding Counselling and Promoting the Baby-friendly Hospital Initiative"

HEL 2019-006961 T 13 02 01

Päätös

Perhepalvelujen johtaja päätti myöntää tutkimusluvan Julia Lydénin ym. tutkimuslupahakemukselle "Improving breastfeeding counselling and promoting the baby-friendly hospital initiative in the Helsinki maternity and child health clinics" (Ylempi AMK). Yhteyshenkilö on ylihoitaja Leeni Löthman-Kilpeläinen. Tutkimuslupa on voimassa 30.6.2020 saakka.

Tutkimuslupaan sovelletaan seuraavia ehtoja:

Tutkimusraportista ei saa olla tunnistettavissa tutkimukseen osallistuneita henkilöitä.

Tutkimuksesta ei tule koitua kustannuksia sosiaali- ja terveystoimelle.

Tutkija sitoutuu noudattamaan EU:n yleisen tietosuoja-asetuksen, tietosuojalain 1050/2018 sekä muun voimassa olevan lainsäädännön tutkijalle asettamia vaatimuksia.

Tutkija saapuu pyydettäessä maksutta esittelemään tutkimuksen tuloksia Helsingin sosiaali- ja terveystoimeen.

Sähköinen tutkimusraportti tai sen osoite toimitetaan sosiaali- ja terveystoimialan käyttöön osoitteella: helsinki.kirjaamo@hel.fi.

Päätöksen perustelut

Opinnäytetyön tarkoituksena on selvittää äitien kokemuksia imetysohjauksesta ja tuesta Helsingin neuvoloissa ja tämän perusteella parantaa imetysohjauksen laatua. Opinnäytetyön aineisto koostuu aikaisemman tutkimuksen (diaarinumero HEL 2018-013533) kyselyaineiston materiaalista, jonka käsittelyyn ja analysoimiseen haetaan tutkimuslupaa. Aineisto analysoidaan sisällönanalyysin avulla. Tutkimusaineisto luovutetaan tallenteena tai tulosteena tutkijoille yhteyshenkilön kanssa sovitulla tavalla. Aineisto ei sisällä tunnistetietoja. Tutkimusaineisto säilytetään tietoturvallisesti ja hävitetään tutkimuksen päättymisen jälkeen.

Lisätiedot

Anna-Katriina Tiili, kehittämissuunnittelija, puhelin: 310 43444
anna-katriina.tiili(a)hel.fi

Liitteet

1 Tutkimuslupahakemus
2 Tutkimussuunnitelma
3 Liite, tutkimussuunnitelma 4.12.2018
4 Täydennys tutkimuslupahakemukseen

Muutoksenhaku

Oikaisuvaatimusohje, sosiaali- ja terveyslautakunta

Otteet

Ote	Otteen liitteet
Hakija	Oikaisuvaatimusohje, sosiaali- ja terveyslautakunta
Yhteyshenkilö	Liite 1
	Liite 2
	Liite 3
	Liite 4