The early postpartum experience of previously infertile mothers

Authors: Ladores S and Aroian K

Summary: This descriptive phenomenological US study examined the lived experience of 12 previously infertile women (aged 27 to 43 years) becoming new mothers. From face-to-face interviews analysed using Colaizzi’s approach, two main themes emerged, a lingering identity as infertile and gratitude for the gift of motherhood. These themes established unrealistic expectations of perfect motherhood, and when unable to live up this expectation, feelings of inadequacy, guilt, and shame.

Comment (MS): This paper will be of interest to midwives for a number of reasons. A significant proportion of women giving birth in Australia will have done so following infertility treatment. The specific needs of women who have successfully achieved motherhood following infertility treatment have been of interest to midwives since the first successful birth following IVF in 1978. In the early years when treatment was difficult to access and success rates were low there was speculation that this group of women would be more anxious during pregnancy with a higher risk of depression after the birth due to the pressure of treatment cycles and fear of failure. This speculation was not supported in the early literature and the literature cited within this paper confirms the continued inconsistencies in findings of studies investigating the experiences of previously infertile mothers. It is clear though, that the women in this study did have difficulty accepting and enjoying their pregnancy due to the fear of impending loss or failure – this is reflective of the early work of Katz Rothman where she described the “tentative pregnancy”. The mothers in this study described how they remained within their infertile identity even after giving birth, and expressed extreme gratitude for their babies. They described the self-imposed need to be the perfect mother possibly to demonstrate their gratitude. One very interesting aspect of this was the determined motivation to breastfeed as they felt this enabled them to “do something natural” after their unnatural conception. Women who subsequently reported difficulties with breastfeeding described feelings of depression due to the compounding sense of failure. It is clear that despite the discrepancies in the literature, this paper confirms that women who have experienced infertility may have difficulty in adjusting to the pregnancy and transitioning to motherhood. While implications for practice are described they are within a “women” as opposed to “woman” centred framework. The authors suggest that these women should be targeted and provided support from another previously infertile mother to prepare her realistically for motherhood. They mention the need for screening for depression and anxiety and for the need for referral to mental health services when detected. There is no mention of the benefits that could be achieved by providing these women with continuity of care from a known midwife. The benefits of this model of care are now well described and this group of women would be the ideal beneficiaries. Midwives in Australia should be aware of this research and recognise the importance of supporting women through their journey, creating opportunity to build trust and enable the woman to share her thoughts and fears. It is through the development of a relationship that the midwife can come to know the woman and encourage her to share her concerns and begin to prepare realistically for birth and motherhood.


Abstract
Italian fathers’ experiences of labour pain

Authors: Tarlazzi E et al.

Summary: This phenomenological, Italian, in-depth interview study examined the experience of a partner’s labour pain from the point of view of six fathers. Colaizzi’s method identified five core themes including: labour pain is something you have to go through; a silent presence that gives courage; ‘I hope I can stay until the end of the birth’; ‘I didn’t know that would happen’; and fathers’ need to ‘recharge their batteries’.

Comment (KB): In Italy, almost 85% of women choose to have their partner remain with them during labour, yet few studies have focussed on the meaning of this experience for fathers. In order to explore this further these authors explored the experiences of six first-time fathers’ labour pain. The in-depth interviews, which took place within days following birth, would suggest that the fathers are unprepared for the events that transpire during labour. The men were unprepared for the change that occurred in their partner’s behaviour or indeed the strategies that the women selected for coping with the pain of labour. The men expressed experiencing high levels of anxiety, which increased as they were left to interact with their labouring partner without the presence or continued support of the midwife. They affirmed that despite attending antenatal classes they still enter the labour process without knowing what to expect during their partners’ labour.

The findings from this small, qualitative study underline the importance of focussing on the role and preparation of fathers as well as the need for further research into men’s experiences of labour. Men would value pre-emptive direction during antenatal education on the role they can play during labour. This study provides a platform for a much larger study with the purpose of reaching a deeper understanding of the fathers’ needs and feelings during their partners’ labour and birth.

Reference: British J Midwifery 2015;23(3):188-194

Abortion law across Australia – A review of nine jurisdictions

Authors: de Costa C et al.

Summary: The legal status of abortion in Australia and its implications are reviewed across state and Commonwealth jurisdictions. Australian abortion law is determined by states and has been since before Federation, and as a result there are now nine state and federal sets of laws concerned with abortion. The definition of lawful abortion varies; in some jurisdictions it is necessary to establish a serious risk to the physical or mental health of the woman. The certification of two doctors may also be required, particularly for later-term abortions. Physical restrictions on access may also occur with abortion being required to take place in a hospital in South Australia and the Northern Territory. In ACT, abortion has been removed from the criminal law altogether. These variations in law and restrictions arising from them are not consistent with aspiration for a universal and accessible health care system.

Comment (MS): Midwives may wonder why I have selected this paper – I think it is important to remember that access to safe abortion is “an essential strategy for achieving the Millennium Development Goals to improve maternal health, promote gender equality and reduce poverty”. The International Confederation of Midwives also acknowledges within the basic competency document describing the midwives scope of practice the need for midwives to “have the knowledge and/or understanding of policies, protocols, laws and regulations related to abortion-care service”. This paper describes the differences in access to abortion services and the level of criminality associated with the practice across Australia. Abortion is an emotive subject and those midwives who have a religious objection to providing abortion services should have that right respected. This does not however negate the responsibility of a civilised society to provide for the basic health needs of women. As a result of the current level of disparity and confusion around the states, some women could be disadvantaged. Additionally some practitioners may be fearful of legal consequences of performing abortion as they move between states and work within different codes and jurisdictions. As midwives, regardless of our personal beliefs, it is important that we recognise and accept the principles of equity and justice. The wide variation in access to safe abortion and the legal considerations and consequences surrounding providing a service described within this paper highlight the need for national reform. The current situation in Australia is placing women and practitioners at risk and the disparity in access cannot be justified.


Influence of acupuncture on the third stage of labour: A randomized controlled trial

Authors: López-Garrido B et al.

Summary: In a single-blind randomised controlled trial, Spanish researchers assessed the use of acupuncture to reduce the length of the third stage of labour in 76 puerpertal women. In patients receiving acupuncture at the Ren Mai 6 point, the average time to placental expulsion was 5.2 minutes versus 15.2 minutes in a sham treatment group (needle insertion site the same, zero level but shifted to the left of the anterior midline).

Comment (KB): This interesting study was conducted in Madrid in Spain and is the first study to explore the beneficial effect of using acupuncture during the third stage of labour. The purpose of the study was to compare the length of the third stage of labour between women who received acupuncture at the Ren Mai 6 point (thought to induce the contraction of the uterus) and women who received acupuncture at a placebo point. Three midwives were trained in the acupuncture technique. None of the three midwives trained in the acupuncture technique were primary caregivers during the labour or birth; their primary role was to perform acupuncture during the third stage of labour only. The management of the third stage was the same in both groups for all the women, and all the midwives involved in the study followed the same prescribed procedure. The procedure involved clamping the cord one minute after birth and then the acupuncture was carried out. The findings from the study demonstrate that the length to placental expulsion was significantly quicker in the intervention group, 5.2 minutes in comparison to 15.2 minutes in the control group, equal to a 9.5-minute average time difference between the two groups. In the control group, 31% of the participants experienced placental expulsion within 10 minutes. One woman in the control group experienced PPH due to uterine atony, with no complications identified in the remaining participants. The results of the study demonstrate that the use of acupuncture can reduce the length of the third stage of labour, however there are some other important points to consider, not least that the clamping of the cord occurred soon after birth and most cases before the cord had stopped pulsating, followed by the routine use of oxytocin following the expulsion of the placenta. There were other limitations in this particular study, for example there was no measurement of blood loss, and the study only included low risk women. Nevertheless, the results of this study confirm that acupuncture in the third stage of labour can decrease the length of this stage of labour.

Reference: J Midwifery Womens Health 2015;60(2):199-205

The Belgian, French and Dutch midwife on trial: A critical case study

Author: Eggermont M

Summary: This European analysis of 100 legal cases involving midwifery medical negligence when assisting labour/delivery in a hospital was conducted to develop judicial recommendations in order to avoid midwifery medical liability when providing intrapartum care. The most common cause of midwifery liability was not identifying fetal distress through fetal monitoring (15/47), followed by not recognising symptoms of a specific pathology (10/52), particularly placental abruption and uterine rupture. A third cause of liability was an inaccurate response to complications (3/12) while the fourth was exceeding the professional competencies of the midwife (9% of cases).

Comment (MS): This is an interesting paper as it reports on legal cases heard across three European countries where midwifery care was examined by the courts in the context of civil and criminal charges. It will come as no surprise that the review of cases mirrors the findings of confidential inquiries conducted into stillbirths and neonatal deaths, which identified misinterpretation of fetal heart monitoring, and failure to detect the pathology within a deteriorating patient as the main failures in midwifery judgement leading to poor outcomes. It is clear from this paper that education leading to competence across the scope of midwifery practice along with the midwife having the confidence to challenge poor practice are key factors in promoting optimal maternity care. This knowledge is used within many jurisdictions to mandate competence based assessment in these skills on an annual basis for all midwives not just to reduce the risk of poor outcomes, but to satisfy the requirements of the insurer. The costs associated with medical malpractice in maternity cases are increasing universally and resulting in greater and greater demands by insurance companies to mitigate the risk. This greater emphasis on identifying and managing risk alongside the increasing fear of litigation are anecdotally cited as the reasons behind the increase in interventionist birth. It is important therefore to read this paper and respond rather than react. One of the things that comes across clearly is the need for a mutually professional collaborative relationship between the obstetrician and the midwife. The review demonstrates that referral to a doctor does not necessarily negate the accountability of the midwife. If the midwife believes the risk remains she is obliged to seek a second opinion. Building relationships between professionals and between a woman and her carers is the key to providing safe maternity care. Working together to create a mutually supportive environment where interdisciplinary trust and respect are promoted could prevent communication failures and professional boundary violations. The blanket introduction of risk management policies and mandatory education will be ineffective if the model of care creates a disconnect between the woman and her carers. Changing the focus of maternity care from a detect and manage the risk fragmented care model to one of promoting optimal safe birth within a woman-centred context of care model enables a more individualised approach to care. Midwives working within this kind of an environment have reported lower levels of stress anxiety and burnout and it could be argued are therefore less likely to make errors of judgement. This approach should be encouraged in an attempt to reduce the current spiralling rates of birth intervention.

Reference: Midwifery 2015;31(5):547-53
A strong body of foundational and emerging research suggests that multisensorial stimulation—or the concurrent stimulation of tactile, olfactory, auditory, and/or visual stimuli—benefits the social, emotional, cognitive, and physical development of babies.

A baby’s brain creates up to 1.8 million new synaptic connections per second between 2 months of gestation and two years after birth, and a baby’s experiences will determine which synapses will be preserved.1 Multisensorial stimulation—what a baby feels, smells, hears, and sees—helps promote the long-term survival of synaptic connections.1 Stimulation is essential early in development; within the first 3 years of life, there is rapid development of most of the brain’s neural pathways supporting communication, understanding, social development, and emotional well-being.2

**Multisensorial Enrichment Increases Alertness in Preterm Infants**

<table>
<thead>
<tr>
<th>Week 1</th>
<th>Week 2</th>
<th>Week 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multisensorial enrichment</td>
<td>30.1%</td>
<td>33.4%</td>
</tr>
<tr>
<td>Standard preterm care</td>
<td>7.8%</td>
<td>11.1%</td>
</tr>
</tbody>
</table>

Stimulating multiple senses sends signals to the brain that strengthen the neural processes for learning. Through consistent multisensorial experiences, research shows that babies gain healthy developmental benefits, such as reduced stress in healthy and preterm infants34 and better quality and quantity of sleep in healthy babies,5 as well as improved weight gain which led to earlier hospital discharge in preterm infants.5

Multisensorial stimulation—what a baby feels, smells, hears, and sees at every moment—helps promote the long-term survival of synaptic connections during brain development.1

Everyday experiences in a baby’s life can develop and stimulate his or her senses and provide parents an opportunity to nurture their baby’s ability to learn, think, love, and grow. A simple ritual of bath time and massage is an ideal opportunity to create a multisensorial experience. Bath time provides an opportunity for increased skin-to-skin contact (touch stimulation)7 and direct eye contact,8 as well as the introduction of new textures, sights, sounds, and smells that can stimulate a baby’s tactile, visual, olfactory, and auditory senses. The sense of smell, in particular, is directly linked to emotional memory,9 a mother’s scent can help soothe a crying baby,10 while a pleasant scent during bath time is shown to promote relaxation in both baby and parent.11

**Making Bath Time Part of a Routine Improves Sleep**

<table>
<thead>
<tr>
<th>Week</th>
<th>Change in Sleep %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td>0%</td>
</tr>
<tr>
<td>Week 2</td>
<td>3%</td>
</tr>
<tr>
<td>Week 3</td>
<td>6.2%</td>
</tr>
</tbody>
</table>

When bath time is part of an everyday ritual, the benefits have been shown to help generate a predictable and less stressful environment for the baby and parents.5

Although science has made advances in understanding the long-term benefits of multisensorial stimulation, there is more to be done to translate this research into everyday practice. By encouraging parents to view everyday rituals, such as bath time and massage, as opportunities for multisensorial stimulation, experiences can be created that can contribute to a lifetime of healthy development.

**References:**
Missed opportunities: A qualitative exploration of the experiences of smoking cessation interventions among socially disadvantaged pregnant women

Authors: Gamble J et al.

Summary: This South Australian study conducted in-depth interviews (analysed using an inductive approach and an open coding framework) to privilege the experiences and views of six pregnant women from low socioeconomic backgrounds during a smoking cessation intervention in metropolitan Adelaide. The over-arching theme was ‘missed opportunities’ with four interrelated sub-themes, which all encapsulated predominantly negative experiences. Interest in quitting was evident among participants but smoking behaviour was largely unchallenged by the didactic communication style of maternity care professionals. Maternity care professionals or Quitline workers only superficially managed participants’ information and support needs. Smoking cessation interventions and support need to be more personalised and sensitive to the needs of women with complex socio-economic disadvantages.

Comment (KB): Currently there is limited evidence available exploring the perspectives of pregnant women who have participated in smoking cessation programs. The women’s voices are often marginalised within the discourse of current literature. This study is the first Australian study to explore the perspectives of a purposive sample of six pregnant women who were part of a smoking cessation intervention. All the women lived in lower socioeconomic status areas in South Australia. The main objectives of the study were to describe the women’s views and experiences of a smoking cessation intervention and its efficacy. All the women were aware and acknowledged the health risks associated with smoking in pregnancy and accepted that midwives would raise the issue and the risks of smoking with them. Despite their pre-existing knowledge, the women felt they were told information that they already knew and actually felt ‘lectured’ about the risks. The style of communication from some of the maternity health care professionals was considered too coercive, didactic and authoritarian. The women reported that they would have preferred discussions that were collaborative and respectful. This didactic style of communication resulted in a lost opportunity for midwives to deliver individual smoking cessation advice. The women articulated that the stress of pregnancy as well as coping with daily burdens were themselves barriers that prevented them from quitting smoking. Furthermore, the women reported there was a lack of consistent, evidence based information and support about pharmacotherapy options. The women supported the option of intensive support, including face-to-face individual peer counselling and support groups. They were also enthusiastic about the introduction of financial incentives for smoking cessation among pregnant women. This study does have some limitations, for example it consisted of a small sample size (n = 6) and recruitment came from only one social group. Nevertheless, the findings do provide some important insights about why current smoking cessation programs may not be effective. Midwives should also consider the values and attitudes that they currently adopt, which may devalue empowerment. Women who smoke and how those personal feelings may be reflected onto the women; resulting in the women feeling patronised and judged. It is also important to provide pregnant women with robust and consistent information.


Abstract

No Man’s ‘Land’: An exploration of the traumatic experiences of student midwives in practice

Authors: Davies S and Coldridge L

Summary: A qualitative descriptive study from the Northwest of England, using semi-structured interviews, assessed 11 student midwives perceptions of traumatic birth, its impact on them and how they were supported. Five main themes emerged: wearing your Blues depicted the ‘bleak’ landscape of practice; ‘No Man’s Land’ concerned traumatic experiences of a smoking cessation intervention and its efficacy. All the women were aware and acknowledged the health risks associated with smoking in pregnancy and accepted that midwives would raise the issue and the risks of smoking with them. Despite their pre-existing knowledge, the women felt they were told information that they already knew and actually felt ‘lectured’ about the risks. The style of communication from some of the maternity health care professionals was considered too coercive, didactic and authoritarian. The women reported that they would have preferred discussions that were collaborative and respectful. This didactic style of communication resulted in a lost opportunity for midwives to deliver individual smoking cessation advice. The women articulated that the stress of pregnancy as well as coping with daily burdens were themselves barriers that prevented them from quitting smoking. Furthermore, the women reported there was a lack of consistent, evidence based information and support about pharmacotherapy options. The women supported the option of intensive support, including face-to-face individual peer counselling and support groups. They were also enthusiastic about the introduction of financial incentives for smoking cessation among pregnant women. This study does have some limitations, for example it consisted of a small sample size (n = 6) and recruitment came from only one social group. Nevertheless, the findings do provide some important insights about why current smoking cessation programs may not be effective. Midwives should also consider the values and attitudes that they currently adopt, which may devalue empowerment. Women who smoke and how those personal feelings may be reflected onto the women; resulting in the women feeling patronised and judged. It is also important to provide pregnant women with robust and consistent information.

Comment (MS): This small qualitative study undertaken in the Northwest of England will present a picture familiar to many Australian Midwifery students. Students described events they found to be traumatic during their training and also discussed the wider impact working within a fragmented hospital based model of care had on them. The negative effects of working within a disconnected, fragmented model of care centred on the needs of the institution as opposed to the woman is a central theme that could be replicated within groups of midwifery students across Australia. Similarly the descriptions of midwives who are over worked, stressed and disconnected from women would not be out of place in the descriptions of midwifery in some parts of Australia too. There remains a gap between the ideal way of providing maternity care, which should involve continuity of care from a known midwife, and the reality, which for most women in Australia is fragmented institutionalised care. One of the major enablers to move towards implementing the ideal is a workforce ready and able to move towards providing continuity of care. Supporting and enabling students is therefore a vital key to changing things for the future. It is encouraging to see the connection students had with women and as the authors say we must find ways to support and protect students and enable them to retain this connection as they work through the inevitable complexities of practice. Where possible, students should be taken through this learning within a continuity of care model. Midwifery practice presents students with clinical challenges, which can be distressing, but where midwives feel supported through these situations they will be in a better position to support rather than push blame onto the student. Similarly where midwives are nurtured and cared for within a supportive working environment they will be better positioned to support and nurture women. This small but important paper reminds us that “the them is us”, and we all have a responsibility to be part of the solution.

Reference: Midwifery 2015;May 12 [Epub ahead of print]
Abstract

Reference: NZ College of Midwives Journal 2015;51:11-6

Midwifery in New Zealand has a long established model of partnership with women and accessing continuity of care from a known midwife is the norm for most women in New Zealand regardless of risk. There is increasing evidence that this model of care is what women want and provides improved outcomes across many parameters. It is disappointing therefore that legislative reform enabling midwives to move into private practice, and a maternity reform agenda encouraging public providers to offer continuity-of-care models, very few women can access this care in Australia. One of the reasons offered anecdotally is that midwives do not want to work in this way, with fears voiced by some that it increases the risk of burnout. There is growing evidence that working within a continuity-of-care model is actually protective against burnout and this paper provides important evidence of the factors that sustain midwives and make this model of care viable and more importantly possible for the majority of midwives. The paper identifies five key strategies, which could easily be incorporated into any private or public models including meeting regularly to discuss practice and other issues, and having a manageable workload. Not surprisingly having time off “was one of the most significant features of sustainable practice” and this can be facilitated in a number of different ways. Reducing financial stress by having appropriate arrangements and ensuring good structures and processes are in place to introduce new midwives to the practice were also highlighted as essential to ensuring ongoing sustainability. This paper is encouraging as it confirms that working this way is possible and will therefore inspire and motivate midwives in Australia to take the step forward and give caseload a go.

Reference: NZ College of Midwives Journal 2015;51:11-6

Abstract

Barriers to breast-feeding in obese women: A qualitative exploration

Authors: Keely A et al.

Summary/Comment (MS): This descriptive, qualitative study from Scotland used semi-structured face-to-face interviews to explore the factors that influenced breastfeeding practices in 28 obese women who had either stopped or were no longer exclusively breast feeding at 6–10 weeks following birth. In spite of health promotion campaigns, breastfeeding rates in the UK continue to remain low in comparison with the rest of Europe and Australia. Maternal obesity has increased in the last two decades and more recently has emerged as an influencing factor for breastfeeding uptake and duration. Obese women are less likely than normal weight women to initiate breastfeeding and more likely to stop breast feeding earlier. Of the 28 women participating in this particular study, 19 gave birth by emergency caesarean, two had a forceps birth and seven had a spontaneous vaginal birth. The high number of women in this study giving birth via caesarean section would seem to support the current evidence already available, which demonstrates that maternal obesity increases the risk of giving birth via a caesarean section. Key findings from the study supported previous studies in that the women who gave birth via a caesarean section had a delay in skin-to-skin contact and for many in this group they could not remember the first time they breast-fed their baby following birth. Many women in the study reported the lack of privacy available on a four-bedded postnatal ward as a barrier to breast feeding. Several of the women continued to struggle with privacy even at home with a constant stream of visitors visiting the home following their discharge from hospital. A small number of the women spoke about the physical experience of breastfeeding in regard to their physical size, believing that the shape and size of their breasts made breastfeeding challenging. Several of the women communicated that they were very self-conscious about exposing their breasts in public, stating that having large breasts made it much more difficult for them to be discreet when breast feeding in public. The opportunity to visit NHS breastfeeding support clinics proved to be helpful to a small number of women in the study. However, many of the study participants appeared to be unclear about the actual purpose of the clinic and would have preferred to receive advice and support from health professionals in their own home. This seems to suggest the specialist clinics were underutilised by the women. Almost all the women were concerned about their milk supply with some of their partners sharing similar concerns. The partner was often involved in the decision to introduce formula. Such findings would seem to suggest there is also a need to increase the knowledge and education of partners. Overall the findings of this exploration study would seem to suggest that obese women who make the decision to breast feed require extra support to do so in terms of self-efficacy and emotional well-being. Further education to women about the function of NHS breastfeeding clinics and support groups is required so they understand the specific function and purpose of these clinics. Further research is also required to assess the usefulness of extended breastfeeding support for this particular group of women.

Reference: Midwifery 2015;31(5):532-9

Abstract

Authors: Keely A et al.

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