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Supporting breastfeeding women from the perspective of the midwife: a systematic review of the literature

Running title: review breastfeeding support

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Abstract

Introduction

In 2003 the World Health Organization (WHO) recommended that infants should be fed exclusively with breastmilk until the age of six months. However, breastfeeding rates remain lower than recommended. The crucial period for breastfeeding support are the first two weeks after birth. During this period breastfeeding support from the midwife is needed. The aim of this paper is to gain an in-depth understanding of the role of midwives in their support of breastfeeding women, from their own perspective.

Methods

Two researchers independently conducted a systematic and comprehensive literature search. Studies needed an empirical qualitative research design (1), had to focus on the role of the midwife in the support of the breastfeeding woman from the midwife's perspective (2), and had to be published between January 2005 and December 2014 (3) in order to be included. Language restrictions were English, Dutch, German and French. Eight qualitative research studies were included, using mainly focus group and in depth interview studies, which were reported in 11 papers representing 231

midwives and 24 maternity nurses. All but one study concerned midwives working in hospital settings. A critical appraisal was performed of each study.

Results

Midwives value breastfeeding education and breastfeeding support as a significant part of their role as a postnatal midwife. However, the ways in which a midwife approaches and supports the breastfeeding woman vary. We distinguished two perspectives: “the midwife as technical expert” and “the midwife as skilled companion”. The “technical expert” midwife is mainly breast centered, focuses on techniques, uses the hands on approach and sees a woman as a novice. The “skilled companion” midwife is woman centered, focuses on the mother – infant relationship and uses a hands off approach during the breastfeeding support.

The midwives working in a hospital setting face many barriers performing breastfeeding support, such as time restraints, which makes it difficult for them to carry out their preferred role as “skilled companion”. These barriers can influence the breastfeeding support negatively. Supporting factors such as evidence based breastfeeding guidelines have a positive influence on the breastfeeding support.

Conclusion

Based on findings of a synthesis of qualitative research studies we conclude that the majority of the midwives provide breastfeeding support as a technical expert and a minority as a skilled companion. Midwives prefer to be a skilled companion but face many barriers in their working contexts.

Introduction

In 2003 the World Health Organization (WHO) recommended that infants should be fed exclusively with breast milk until the age of six months. Ideally, breastfeeding should be continued as an important component of the infant’s nutrition for up to two years of age and beyond (Dykes, 2005b; Renfrew et al., 2012; Fu et al., 2014). A Systematic Cochrane Review (Renfrew et al., 2012) demonstrates that compared to formula milk, breastfeeding promotes important health benefits for both the mother and child including a reduction of infant mortality and morbidity. The meta synthesis of Schmied et al. (2011) confirms these findings. Together with the WHO, the United Nations International Children’s Fund (UNICEF) encourages breastfeeding as the most optimal feeding worldwide. In 1991 the Baby Friendly Hospital Initiative (BFHI) was launched with the aim of giving clear guidelines to improve breastfeeding rates. But even with these strategies, breastfeeding

rates and in particular exclusive breastfeeding rates, remain lower than recommended (Schmied et al., 2011; Burns et al., 2012). In Flanders, 76,0% of women start with exclusive breastfeeding. On day six a decrease to 63,9 % is shown, and after three months only 30,1 % of the infants are breastfed exclusively (Kind en Gezin, 2014).

The most critical time period for breastfeeding are the first two weeks after birth. During this time, reasons for breastfeeding cessation are insufficient milk, breastfeeding difficulties (problems with attachment), insufficient weight of the baby and cracked nipples (Gross et al., 2011). Poor breastfeeding support can also lead to early cessation. During this period breastfeeding support from a healthcare professional, mainly the midwife, is mostly needed (Gross et al., 2011; Burns et al., 2012; Hall et al., 2014). This support has a considerable impact on the breastfeeding experience and the choices that the mothers makes. (Dykes, 2005a; Nelson, 2007; Schmied et al., 2011, Hall et al., 2014). The meta synthesis from Schmied et al. (2011) revealed that the woman is not always satisfied with the breastfeeding support she receives from the midwife during the first weeks after birth. This dissatisfaction is particularly seen in the hospital setting and less in the homecare setting, possibly because of fragmented care. The midwife or lactation consultant often fails to provide the support that the woman desires (Dykes, 2005a; Rayner et al., 2008; Schmied et al., 2011; Renfrew et al., 2012). Women want an authentic presence of the midwife with a facilitating approach. This means that the midwife has to be available when needed, take time to listen and sit with women, observe the breastfeeding and offer tips and practical help. Women also want to have the opportunity to build a relationship with the midwife through interaction and dialogue, to share experience and to receive reassurance and encouragement (Schmied et al., 2011; Renfrew et al., 2012).

Earlier research demonstrated which support is most valued by the breastfeeding woman and what they expect from the midwife (Dykes, 2005a, Dykes, 2005b; Schmied et al., 2011; Renfrew et al., 2012). Research about the opinions, beliefs, values and insights of midwives on their role as breastfeeding supporter, is rather limited. Therefore, the aim of this paper is to gain an in-depth understanding of the role of the midwife in supporting breastfeeding women from the midwife's perspective. Specific research questions to answer are:

1. How does the midwife experiences her role in the support of the breastfeeding woman?
2. What kind of support does the midwife provide to the breastfeeding woman, from the midwife's perspective?
3. What are the supporting factors and barriers the midwife experiences in her support of the breastfeeding woman?

Methods

Design

We conducted a systematic review of qualitative research studies.

Search methods

Search strategy

Two researchers (M.S. and E.W.) independently conducted a systematic and comprehensive literature search of the databases Medline, CINAHL, Web of Science and Cochrane for relevant papers published between January 2005 and December 2014. The following keywords were used in several combinations:

- [MeSH] "Breast Feeding" OR Breastfeeding OR Feeding support;
- [MeSh] "Midwifery" OR [MeSH] "Nurse Midwife" OR [MeSH] Advanced Practice Nurse OR Midwifery OR Nurse midwife OR Advanced Practice Nurse.

Inclusion and exclusion criteria

The focus of the research questions is to gain an in-depth understanding of the role of the midwife in supporting breastfeeding women from the midwife's perspective. Therefore, studies needed an empirical qualitative research design (1) Studies had to focus on the role of the midwife in the support of the breastfeeding woman (views, attitudes, experiences, interventions, facilitators or barriers) from the midwife's perspective (2), and had to be published between January 2005 and December 2014 (3) in order to be included. Language restrictions were English, Dutch, German and French. Studies exclusively focusing on views from the perspective of breastfeeding women, studies including complicated births and studies that were not primary qualitative research studies were excluded (table 1). Breastfeeding support after a complicated birth differs from breastfeeding support after an uncomplicated birth for example a premature birth (birth < 37 weeks gestation). There are more breastfeeding challenges to overcome after a premature birth (Goyal et al., 2014).

Search outcome

Two researchers (M.S.) and (E.W.) independently screened the electronic data bases. In cases of doubt or different opinions, a third researcher (J.L.) was consulted, and decisions about the inclusion

were taken in consensus. All included papers were object of a full text review and were read by at least two researchers to ensure that they met the same inclusion criteria.

The electronic searches yielded 748 papers of which 219 duplicate articles were rejected. Based on the screening of the title and abstract of 529 papers, 28 were considered as relevant and underwent a full article review. Of these, 16 articles were excluded leading to 12 papers (see Table 1).

Critical appraisal of studies

We selected the QARI (The Joanna Briggs Institute, <http://www.joannabriggs.edu.au/services/sumari.php>) for the critical appraisal of studies. This tool consists of 10 criteria and is a coherent instrument in the evaluation of the quality of qualitative studies (Hannes, 2011). The critical appraisal of each study was performed by at least two researchers to ensure that they met the same criteria.

After the critical appraisal, Bäckström et al. (2010) was excluded due to a low score of 1, the methods were not clearly reported (table 1). In this review we included eight qualitative research studies which were reported in 11 papers (table 2), representing about 231 midwives and 24 maternity nurses. The studies mainly used in depth interviews. Ten articles (Dykes, 2005a; Furber and Thomson, 2006, 2007, 2008, 2010; Nelson, 2007; Rayner et al., 2008; Burns et al., 2012, 2013; Rayner et al., 2013) had a good quality score with a range from 7 to 9. McLelland et al. (2014) scored moderate (score 5). We did not exclude the latter study because it is the only study that included community based maternal and child health (MCH) nurses (n=12). In this context, Sandelowski, & Barroso (2002) address the importance of not excluding qualitative papers with valuable findings for reasons unlikely to invalidate the findings.

Table 2 covers the 11 papers included in the review and provides an overview of included studies focusing on the support of breastfeeding women from the perspective of the midwife. The majority of the studies were performed in Australia and the UK. The majority of the included midwives were employed in a hospital setting. Only one study included the perspective of midwives in the homecare setting (McLelland et al., 2014).

Data-extraction and analysis

To analyze the findings of the qualitative studies, we conducted a *thematic analysis*. A thematic analysis involves both induction and interpretation of findings. The inductive approach avoids specifying key concepts in advance that form the categories under which the data from included studies are to be summarized (Thomas and Harden, 2008; Tong et al., 2012).

The data-extraction and analysis process involved several steps and was performed by two researchers independently. Firstly, the reported findings of each primary study were read several times and coded line by line. Secondly, all free codes were organized in an overall conceptual scheme that goes beyond the interpretations of the primary studies. Thirdly, by means of peer debriefing, we discussed and adapted the conceptual scheme. In the next phase, all findings of primary studies were re-read in order to refine the conceptual scheme. Finally, we described the several concepts of the scheme into analytic themes (Thomas and Harden, 2008; Tong et al., 2012). No software was used for analyzing the data.

Results

Our analysis of the literature shows that the midwife values breastfeeding education and breastfeeding support as significant in her role as a midwife, which gives her a sense of satisfaction (Furber and Thomson, 2008; Rayner et al., 2008; Burns et al., 2012; Burns et al., 2013; McLelland et al., 2014). However, the ways in which the midwife approaches and supports the breastfeeding woman varies. We distinguish two perspectives on how the midwife experiences her role in the support of the breastfeeding woman, namely, “the midwife as technical expert” and “the midwife as skilled companion”.

1. *Perspectives about the role of the midwife in the support of breastfeeding women.*

The midwife as technical expert

Breast centered

From this perspective, as described by the midwives in the aforementioned studies, midwifery care is breast centered rather than women centered. The midwife focusses on the body as a physical object. The production of and the provision of breastmilk as ‘liquid gold’, is the priority for the midwife (Dykes, 2005a; Burns et al., 2012; Burns et al., 2013). Therefore, the ability to attach the infant on the breast is highly praised and gives some midwives a sense of status (Burns et al., 2012; Burns et al., 2013). In the study of Burns et al. (2013) eighty percent of the interactions between midwives (n=76) and women were breast centered and the priority was the transfer of milk to the baby from a technical point of view.

Focus on technique

This midwife can be described as the “expert midwife”, she is the technical midwife who uses the hands-on approach. Hands-on means that the midwife literally attaches the baby to the breast when supporting the breastfeeding women. Burns et al. (2013) “the expert midwife can be described as the teacher and supervisor of the woman’s use of her ‘breastfeeding equipment’”. Other studies support these findings (Dykes, 2005a; Furber and Thomson, 2007; Burns et al., 2012).

The women as novice

The midwife as technical expert positions the woman as the novice or student. She will provide information in a directive manner to the breastfeeding women, who is lacking knowledge, experience and skills (Dykes, 2005a; Burns et al., 2013; McLelland et al., 2014).

The midwife as skilled companion

Women centered care

From this perspective, midwifery care is women centered instead of breast centered. Burns et al. (2013) and Rayner et al. (2008) found that these midwives regarded breastfeeding as a component of the developing mother-infant relationship. Burns et al. (2013) revealed by means of a discourse analysis that in less than ten percent of the interactions (n=76 midwives), the midwife prioritized the mother – child relationship as central to the breastfeeding experience.

In the women centered approach, the preferred style of support was “tuning in” to the woman’s feelings and preferences regarding breastfeeding, followed by hands-off breastfeeding support if possible. The woman and her unique needs are the center of care. The midwife builds an atmosphere of trust by using the inclusive pronoun “we” when interacting (Burns et al., 2013) and women were treated like unique persons (Rayner et al., 2008). For instance, the midwife promotes breastfeeding but respects the choices of the woman (Nelson, 2007; Burns et al., 2013). In this way, the midwife takes the role of companion in the care process.

2. Attitudes and care interventions of midwives in the support of breastfeeding women.

The midwife as technical expert

Managing breastfeeding

Out of 11 papers, six describe attitudes and care interventions of midwives as technical experts (Dykes, 2005a; Furber and Thomson, 2007, 2010; Burns et al, 2012; Burns et al., 2013; McLelland et al., 2014). In this perspective, breastfeeding is an activity that is technically managed. The midwife

uses the hands – on approach to teach the woman how to position and attach the baby on the breast. This often happens without seeking the woman's consent because the midwife feels that she has a right of access to the breast (Dykes, 2005a; Burns et al, 2012; Burns et al., 2013).

The primary concern is the transfer of milk to the baby (Dykes, 2005a; Burns et al, 2012; Burns et al., 2013). If the baby **does** not feed properly and there is a concern about the intake of the 'liquid gold', the midwife tries to retrieve some breastmilk (hand expression) (Burns et al., 2012).

Midwife: Probably at this stage we'll just get it out and get it into her, because there is a bit of a knack to it and if you were up it's easier you know if you were standing in front of a mirror you can sort of see where to squeeze.[midwife hand expressing for the woman]. (Quote from Burns et al., 2012)

Expert support

Women were encouraged to call the expert for additional help when necessary. When the midwife comes for help and advice, the focus lies on this baby and the breastfeeding and on the status of the milk arrival (Dykes, 2005a; Burns et al., 2013). Care is fragmented because the midwife often leaves as soon as the baby is attached, due to other duties and priorities. As a result of the fragmented care in hospital settings it is difficult to build a relationship between the midwife and the woman (Dykes, 2005a; Furber and Thomson, 2007; Burns et al., 2013).

Supervision

Several studies observe that midwives take on a supervising role (Dykes, 2005a; Burns et al., 2012; 2013; McLelland et al., 2014). After the midwife teaches the woman how to put the baby on the breast, they check to see if the woman learned how to breastfeed properly (Burns et al., 2013; McLelland et al., 2014). During the supervision the midwife is focused on correcting possible faults in the mothers technique. They want to make sure that the breastfeeding is going well and the baby is getting enough milk from the breast (Dykes, 2005a; Burns et al., 2012; Burns et al., 2013). From the perspective of midwives as experts, supervision by the expert midwife is needed because woman lack experience and are novices (Burns et al., 2013; McLelland et al., 2014).

Communication

Information is often given in an paternalistic style. Studies that gave specific attention to the use and meaning of 'language' found that women were referred to as 'girls', 'sweetie' or 'ladies' (Furber and Thomson, 2010; Burns et al., 2012). This language can impair women and can have a negative influence on the mothers confidence and self – reliance (Furber and Thomson, 2010).

Based on participant observations of midwives and women, Burns et al. (2012) observes an instrumental and objectifying way of communication and interaction with women. Midwives use language that focusses on the breast and the nipples. They construct the women's body as the milk producing machine and the breast as something independent from the women (Burns et al., 2012).

The midwife as skilled companion

Individual breastfeeding support

Out of 11 papers, four describe attitudes and care interventions of midwives as skilled companions (Dykes, 2005a; Nelson, 2007; Rayner et al., 2005; Burns et al., 2013). In the role of companion, the midwife provides hands-off support and focusses on interacting with the woman. This hands-off support shows the confidence in the mother's and infant's abilities to breastfeed autonomously (Burn et al., 2013).

The midwife in the role of a companion, adjusts her breastfeeding support according to the needs of each unique woman. From this perspective, there are several ways to breastfeed and the delivered advice and support is an interplay between the woman and the midwife (Nelson, 2007; Rayner et al., 2008). The midwife's job is not done once the baby is on the breast. The companion midwife stays bedside to observe the breastfeeding session so she can give individual breastfeeding support to the woman if necessary. She overcomes temporal barriers to make time for the breastfeeding woman (Dykes, 2005a).

Recognize the women

Two studies address the importance of recognizing the self-confidence of the women (Rayner et al., 2008; Burns et al. 2013). Rayner et al. (2008) emphasizes that this is especially the case for first-time mothers. Focus-groups with 40 midwives indicate the importance of an open ended communication style to give women the opportunity to dominate and lead the discussions. By doing this, they supported the woman in the experience to be in control over the breastfeeding process (Burns et al., 2013).

3. Factors that facilitate or hinder the midwife to support the breastfeeding woman

Barriers

The findings of the majority of included studies show that the midwife prioritize breastfeeding and believe that it is the best feeding choice for both the woman and the child (Furber and Thomson, 2008; Rayner et al., 2008; Burns et al., 2012; Burns et al., 2013; McLelland et al., 2014).

We can distinguish both external context factors (time restraints, staff levels) and personal factors (frustrations regarding poor interprofessional collaboration, personal experiences, negative beliefs in breastfeeding policies) which make it difficult for them to carry out their preferred role to promote and support breastfeeding.

Time restraints

Hospital routines and the large numbers of visitors interfered with the breastfeeding support. Midwives felt rushed, short-staffed or busy, which impacted the time they spent with the mother providing breastfeeding support. Information given to the mother then was often given in a written format (Dykes, 2005a; Nelson, 2007; Rayner et al., 2008; Furber and Thomson, 2010).

Many midwives want to provide care by the use of the hands off approach, because they think this is the most appropriate method for assisting the breastfeeding mother. Concurrently, they are confronted with time constraints that make it almost impossible to meet the expectations of the 'women centered' midwifery care (Dykes, 2005a; Burns et al., 2013). Midwives report that when the ward got busy, they had no time to observe and sit by a whole breastfeeding session (Burns et al., 2013; McLelland et al., 2014).

"It's just easier and quicker to lean in over the top and to put those little babies on ..." (Burns et al., 2013).

In the study of Furber and Thomson (2008) the midwife states that it could be an 'intense relief' when a baby was attached. This 'relief' may express the feeling of being liberated from a time consuming activity. Sometimes, the midwife describes that making time for the woman requires courage. Some midwives describe feeling intimidated by colleagues with a different view on breastfeeding support who consider it as too time consuming (Furber and Thomson, 2008).

"If I help a woman with breastfeeding during the day on the ward, I'm going to spend the time that I want. I know that other midwives will be looking at me saying: "Why's she doing that and not doing this?" (Furber and Thomson, 2008).

Staff levels

The majority of included studies identified the issue of staff levels as having a major impact on the breastfeeding support by midwives (Furber and Thomson, 2006; Furber and Thomson, 2007; Nelson,

2007; Rayner et al., 2008; Rayner et al., 2013; McLelland et al., 2014). Especially evening shifts and night shifts are problematic. Midwives don't have the time to encourage exclusive breastfeeding, babies are often crying, women are tired, emotional and exhausted. All these factors make that at night supplements are more frequently given to the baby than during the day (Nelson, 2007).

We're under pressure from work, we're busy, not got enough time, we've got too many women, we're trying to help 10 women to establish feeding and all the babies are yelling in the night and we've got to do something (Furber and Thomson, 2007).

Providing qualitative breastfeeding support is related to the experience and educational background of midwives (McLelland et al., 2014). So, not only the lack of staff may influence the quality of breastfeeding support as provided by midwives (Rayner et al., 2013). Rayner et al. (2013) mention the difficulty of finding qualified staff to provide good care.

Frustrations

Midwives spent a lot of time with the women and are confronted with the ups and downs in the breastfeeding process. On the other hand, many women seem to consider their pediatrician as the main breastfeeding authority (Nelson, 2007). Consequently, midwives feel frustrated and dissatisfied about this because conflicting advice is often given by various professionals (Nelson 2007; Furber and Thomson, 2008; Rayner et al., 2013). Midwives also feel annoyed when pediatricians intrude with their decision making about feeding challenges or when colleagues do not agree with their plan of care (Furber and Thomson, 2008).

Personal experience

One study addresses the possible positive influence of having personal breastfeeding experience with own children by giving 'real live' suggestions and 'real support' in the breastfeeding practice (Nelson, 2007). Nelson (2007) describes through in-depth interviews with **midwives** that the midwife with a positive breastfeeding experience felt a special connection with the breastfeeding woman and she had a greater commitment to breastfeeding than colleagues with no breastfeeding experience or a negative experience. The midwife with a negative experience or those who formula-fed had no difficulty in supporting a woman's decision to formula feed, seem to be more supportive to a woman's request to bottle-feed her baby in the nursery. Midwives who aren't mothers themselves followed more strictly the rules on their ward about breastfeeding recommendations (Nelson, 2007).

No belief in policy guidelines

Furber and Thomson (2006) found in their research that although the midwife is aware that giving an exclusively breastfed infant a bottle with artificial milk is not evidence based, there are midwives who break the rules and give breast-fed babies bottles of formula milk at night in de nursery care, sometimes secretly (Furber and Thomson, 2006). Some midwives also stated that they ignore policy recommendations if they didn't agree with the guidelines (Furber and Thomson, 2006).

I know from experience, I've seen them and they've said I really don't want to feed anymore and I have said 'Right, we'll give the baby a bottle, you go back to bed, have a sleep. I'll look after your baby in the nursery (Furber and Thomson, 2006).

Supporting factors

Along with the barriers that have a negative influence on the breastfeeding support, the implementation of common evidence based guidelines concerning breastfeeding and job satisfaction are described as supporting factors regarding the breastfeeding support of midwives.

Common guidelines and evidence based practice

The literature states that the use of common evidence based guidelines, based on the WHO guidelines regarding the ten steps to successful breastfeeding, gives good breastfeeding management by midwives. These guidelines should be the base of breastfeeding care (Furber and Thomson, 2006; Nelson, 2007).

Education has to be accessible for the midwives so that they can keep up with the latest new breastfeeding information, which is evidence based (Nelson, 2007).

Job satisfaction

When the midwife provides breastfeeding support to the woman it is important that she is satisfied with her job. Job satisfaction stimulates them to provide good patient care. The collegiality between midwives is mentioned as important for midwives' job satisfaction (Rayner et al., 2008).

Discussion

We conducted a systematic review of qualitative research studies and carefully selected **eight studies, reported in 11 articles**, about the attitude of the midwife and her role in supporting breastfeeding women. The findings contribute to a more in-depth understanding of the attitude and role of the midwife in supporting breastfeeding women on the one hand, and provides us with

important reflections about the context and culture in which midwives provide this care on the other hand.

Burns et al (2013) revealed in their study that in 80 percent of the interactions (n=85) between midwives and women the midwives provide breastfeeding support as a technical expert. The latter studies did not quantify the qualitative data. However, our thematic analysis describes that out of 11 papers six described mainly midwives sharing technical oriented characteristics (Dykes, 2005a; Furber and Thomson, 2007, 2010; Burns et al, 2012; Burns et al., 2013; McLelland et al., 2014).

Midwives state that they often want to be a companion but that it is difficult to provide this kind of support because they are faced with many barriers in their daily work environment (Dykes, 2005a; Burns et al., 2013; McLelland et al., 2014). Further research in home care settings is needed to investigate whether a home care setting offers a more facilitating context for midwives to be skilled companions.

The nature of the support given by the midwife also depends on the wider culture of the organization and the culture of care (Schmied et al., 2011). The Western society is strongly orientated towards science and technology and the medical system is a technocratic model of medicine. The main value here is mind – body separation where the individual is separated into components and the body is seen as a machine (Davis-Floyd, 2001; Dykes, 2005b). This reflects on the midwife as a technical expert, her care is breast centered instead of women centered (Dykes, 2005a; Burns et al., 2012). The technocratic model of care dominates the medical care, which may explain why in hospital settings the majority of midwives demonstrate characteristics of the midwife who provides breastfeeding support as technical expert.

The skilled companion midwife focusses on the humanistic model of care, this model recognizes that mind and body are inseparably linked to each other. These midwives consider it important to connect with the women and getting to know them as individuals (Davis-Floyd, 2001).

The meta synthesis of Schmied et al. (2011) included studies from the US, UK, Australia and one from Tanzania and New Zealand and concluded that women prefer a midwife who provides breastfeeding support as a skilled companion. A possible hypothesis is that women living in a Western 'medicalized' society may prefer a technical expert midwife. However, the research studies included in this review were also conducted in medicalised countries (UK, US, Australia and Sweden). Women from these countries still confirmed that they prefer a midwife that is a skilled companion. In reality the two perspectives, the midwife as a technical expert and the midwife as a skilled companion, can interfere

with each other. Depending on the situation and the needs of the individual women a midwife can either use a more technical approach or can be a companion for the woman.

Hospitals accredited with the WHO/UNICEF, “Baby Friendly Initiative”, use breastfeeding guidelines that are based on the ten steps to successful breastfeeding. These ten steps have a positive influence on the breastfeeding outcomes and the breastfeeding support by the midwife. The “Baby Friendly Initiative” subscribes the humanistic perspective of care which encompasses midwives as skilled companions. However, one study (Furber and Thomson, 2006) reveals that midwives sometimes break the rules and ignore policy recommendations used on the ward.

We have no information whether the settings of included studies were accredited or not. Only Dykes (2005a) mentioned that the maternity units selected for the study didn’t have the label. Consequently, further research is needed whether “Baby Friendly Initiative” accreditation may function as facilitating factor for midwives to take on a skilled companion role. Also further research should take into account the educational level of the midwives.

The findings of this review are constrained by the scope and quality of included studies. The rather small number of identified studies that we could include can be described as the major limitation of this literature review.

The systematic and careful methodological process contributes to the quality of this review. We have documented our methods carefully and are explicit about the methods used for searching, critical appraisal and data synthesis. The whole process was executed by at least two researchers (M.S., E.W.) and supported by a third researcher (J.L.) which contributes to the trustworthiness of the analysis.

The critical appraisal based on the QARI (Hannes et al. 2011) showed that the majority of included papers were of rather good methodological quality. Midwives working in home care settings were underrepresented in the review, which shows that this setting should receive more attention in future research.

Conclusion and implications for practice

This literature review examined the role of the midwife in the support of the breastfeeding woman from the perspective of the midwife. There are two perspectives in which the midwife approaches the breastfeeding woman and provides support, “the midwife as technical expert” and “the midwife as skilled companion”. The literature revealed that the majority of the midwives provide breastfeeding support as a technical expert and the minority of the midwives provide support as a

skilled companion. However, women want their midwife to be a companion (Burns et al., 2012; Schmied et al., 2011).

Midwives, when working in a hospital setting, face many barriers in their job such as time restraints, staffing, personal experience and no belief in policy guidelines. These barriers make it difficult for them to carry out the role they believe in, although, there are situations where midwives are able to overcome barriers (Burns et al., 2013). These situations need to be explored more in depth in order to plan change management. For example, the midwife can have an authentic presence even if there is a lack of continuity of care or limited time, if she is able to show empathy, affirmation or encouragement (Dykes, 2005a; Schmied et al., 2011). Recognition is essential because most of the women lack the self – confidence and need to be confirmed that what they are doing is right (Rayner et al., 2008; Burns et al. 2013). When care is fragmented, because of the busyness of the ward, good communication between the midwives is necessary so that they don't give conflicting advice (Dykes, 2005a; Furber and Thomson, 2007; Burns et al., 2013). While addressing the mother, the midwife must not be paternalistic, because this can impair the woman and can negatively influence the mothers' self-confidence (Furber and Thomson, 2010). When the midwife works in a team it is important to use common, evidence based guidelines, based on the WHO guidelines regarding the ten steps to successful breastfeeding, and be faithful to them. And when supporting the breastfeeding mother the midwife should adjust her care to the needs of the mother and her baby, meaning that the midwife in some cases must fluctuate between the role of technical expert and skilled companion, depending on the needs of the mother. These recommendations can positively influence the breastfeeding experience of the mother.

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