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ORIGINAL ARTICLE

A balancing act—midwives' and public health nurses' experiences with breastfeeding counselling

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Abstract

Aims and Objectives: To explore midwives' and public-health nurses' experiences of breastfeeding counselling in order to provide a deeper insight into breastfeeding counselling.

Methodological Design and Justification: A qualitative design was used, and qualitative content analysis was conducted to analyse the data in accordance with the phenomenological hermeneutic tradition.

Ethical Issues and Approval: The Norwegian Centre for Research Data approved this study. All participants provided written consent.

Research Methods: Four focus-group interviews were conducted on a sample of eight midwives and 13 public-health nurses in Norway.

Results: Three interrelated themes describing the meaning of midwives' and public-health nurses' experiences with breastfeeding counselling emerged from the analysis: Breastfeeding Counselling Means Responsibility for Collaboration and Facilitation, Being Confident as a Breastfeeding Counsellor Means Striving for Professional Competence and Supporting the Individual Breastfeeding Family Means Being Sensitive and Adapting to Novel Situations.

Study Limitations: The focus groups comprised a mix of midwives and public-health nurses, which may have inhibited honest declaration of these professionals' opinions of each other.

Conclusion: Midwives and public-health nurses regard structural factors and prioritising breastfeeding support in society as important for providing good breastfeeding counselling. Midwives and public-health nurses strive to find a balance between relying on their own competence, promoting breastfeeding in accordance with guidelines and respecting mothers' choices. Healthcare professionals require knowledge about breastfeeding, good clinical judgement, a listening attitude and openness to how breastfeeding affects mother's everyday life to provide good breastfeeding care.

KEYWORDS

breastfeeding care, breastfeeding counselling, breastfeeding families, breastfeeding guidelines, clinical judgement, focus-group interviews, midwives, Norway, public health nurses, qualitative content analysis

INTRODUCTION

Healthcare professionals play a key role in supporting breastfeeding mothers [1, 2]. Human milk is the best food for infants, and breastfeeding can protect mothers and their children from illnesses and improve their health [1]. The World Health Organisation (WHO) recommends exclusive breastfeeding for the first 6 months of life, and subsequently, breastfeeding combined with complementary food until the child is up to 2 years of age [3]. Over the last 20 years, the global promotion of breastfeeding has increased the prevalence of exclusive breastfeeding; however, the sale of breastmilk substitutes has concurrently increased, particularly in upper-middle-income countries [4]. Consequently, despite the largely positive development in this regard, interventions are needed to achieve the target of having, by 2030, 70% of mothers worldwide exclusively breastfeeding [4]. In high-income countries, a minority are breastfeeding in accordance with the WHO's guidelines, and in Norway, rates of exclusive breastfeeding have recently decreased [5].

BACKGROUND

Several factors affect breastfeeding, and multi-level interventions are needed to help women successfully breastfeed. Skilled breastfeeding counselling from healthcare providers has been shown to improve breastfeeding rates [1, 4, 6–9]. Mothers who have access to professionals with breastfeeding competencies are more likely to continue breastfeeding beyond the first week of the baby's life [10], because several breastfeeding problems can be prevented or solved by qualified breastfeeding counselling [1, 8, 11]. Studies of various healthcare professionals have highlighted that evidence-based education regarding breastfeeding empowers these professionals to support breastfeeding families [12, 13]. For example, one previous study reported that lactation-counsellor training courses could improve breastfeeding outcomes [14]. Unfortunately, however, there is a global lack of trained healthcare professionals with up-to-date knowledge and skills for supporting breastfeeding [1, 15–17].

Using clinical judgement that is based on knowledge of what can be done in specific situations is considered important for understanding various challenging breastfeeding situations [18] and directs how to act in a good way [19]. Being sensitively aware and open to the breastfeeding family's situation is an important competence [20]. Good breastfeeding care is characterised by a respectful dialogue that deals with the biological and technical aspects of breastfeeding, as well as acknowledges the mother's unique lived breastfeeding experiences [21, 22]. Midwives and public health nurses (PHNs) recognise that the ability to engage in sensitive communication with parents and having an empowered attitude are both important for providing breastfeeding counselling [23, 24], and communicating in a way that focuses on mothers' resources can help mothers to feel empowered and gain control of their breastfeeding-related situations [23, 25]. Empowerment is defined as 'a process by which people gain greater control over decisions and actions that affect their lives' [26], and is a central part of health promotion, which is defined as 'the process of enabling people to increase control over and improve their health' [27]. In health promotion, service users become experts on their own life situations and user participation is facilitated; this necessitates an attitude of encouraging the other person to use his/her resources and make his/her own choices, thereby facilitating good communication between the service user and the healthcare professional [28].

A key means of protecting, promoting and supporting breastfeeding is applying 'The Baby-Friendly Hospital Initiative' (BFHI) [4, 15]. The BFHI features 'Ten Steps to Successful Breastfeeding', which comprises guidelines and procedures for maternity and neonatal services worldwide; it was launched by the WHO and UNICEF in 1991 to support breastfeeding, and was updated in 2017 [29, 30].

In Norway, exclusive breastfeeding is recommended for the first 6 months, followed by breastfeeding combined with solid food until the child is at least 12 months old [31]. Midwives and PHNs at municipal child health clinics represent important breastfeeding counsellors in the period after mothers are discharged from hospital [28, 32]. Midwives and PHNs are nurses who have a bachelor's degree in nursing and a post-graduate or master's degree in midwifery or public health nursing [33, 34]. The midwife follows women during the pregnancy and performs the first home visit to the family after birth; the PHNs then follow the family, applying a standardised programme, in which breastfeeding is an important element [28]. In Norway, the BFHI has been adapted for integration into routine antenatal and child services at the community level [32, 35]; such 'Baby-friendly community health

services' have been found to increase the prevalence of exclusive breastfeeding up to the age of 6 months [11]. Additionally, a mother-to-mother support organisation, 'Ammehjelpen', works to protect and promote breastfeeding in Norway [36]. In Nordic countries, parents are offered parental leave, enabling both mothers and fathers to be involved in care for the child [37]; thus, the expression, 'breastfeeding family', is used to show that the father is involved with the mother and child [38].

There is a gap between recommended and current breastfeeding practices [4, 5], as well as a lack of studies regarding the experiences of midwives and PHNs in providing breastfeeding counselling. As midwives and PHNs have a crucial role in protecting, promoting and supporting breastfeeding [1, 2, 28, 32], the study aimed to reveal midwives' and PHNs' experiences regarding providing breastfeeding counselling for families, as this may provide a deeper insight into breastfeeding counselling.

METHOD

A qualitative design was used to explore and obtain new insights into the phenomenon of breastfeeding counselling [39]. Qualitative content analysis, adapted from Graneheim and Lundman's [40] approach, was used. The approach aligns with the phenomenological and hermeneutic tradition, where the manifest content is considered to be a phenomenological description of the text, and the latent content is considered the hermeneutic interpretation of the underlying meaning of the text [40, 41].

Recruitment and sample

A purposive sample of experienced midwives and PHNs in Norway was asked to participate in the study. To recruit midwives and PHNs, leaders of four child health clinics in small and large municipalities were contacted.

Inclusion criteria for the study: The participants should be educated midwives or PHNs, and work in 'Baby-friendly community health services'; this was to ensure they had experience of evidence-based breastfeeding counselling and could provide rich descriptions of the phenomenon. At least 1 year of experience providing breastfeeding counselling as midwives or PHNs in a child health clinic was also necessary; this was to ensure they were experienced with a range of different breastfeeding-related situations. Four focus group interviews with both midwives and PHNs represented in each group were planned. As many as 16 different child health clinics were contacted to recruit participants for the study. Overall, eight midwives and 13 PHNs from four child health clinics participated in the study (Table 1). Experience of breastfeeding counselling varied between 2 and 31 years; the average was 14 years. The research theme assessed that sufficiently enough rich and varied data were collected to describe the phenomenon [42, 43].

Data collection

This study was undertaken in four municipalities across three Norwegian counties. The number of inhabitants in the municipalities varied from approximately 7000 to over 200,000. Data were collected from May to August 2021. The times and locations for the interviews were arranged by the first author in cooperation with a contact person at each child health clinic. Four focus-group interviews were performed by the first author together with a co-moderator. Each group comprised a combination of 1–3 midwives and 2–4 PHNs. The interviews lasted approximately 2 hours. Data were collected using a semi-structured interview guide in order to ensure that the target questions were answered. The interview guide was sorted into three themes based on the WHO's competency-verification tool for implementing BFHI [44]: healthcare professionals' knowledge, attitudes and practical skills respectively. The questions in

TABLE 1 Participant characteristics ($n = 21$).

Profession	Code	Years of experience with breastfeeding counselling
Midwife		
Midwife	M1, M2, M3	5–15
Midwife	M4, M5, M6, M7, M8	16–31
Public health nurse (PHN)		
PHN	PHN1, PHN2, PHN3, PHN4	0–4
PHN	PHN5, PHN6	5–10
PHN	PHN7, PHN8, PHN9	11–15
PHN	PHN10, PHN11, PHN12, PHN13	16–31

the interview guide were modified across the four interviews, with small changes being made from the first one to the last one based on the experiences reported in the interviews. The interviews were audio-recorded, and the co-moderator also made notes during the interview to increase the quality of the subsequent transcriptions. The interviews were transcribed verbatim in their entirety by the first author.

Analysis

By following Graneheim and Lundman's approach to qualitative content analysis [40] each of the four interviews was read several times by all the researchers to obtain a sense of the whole. Then the transcribed interviews were extracted and collated into one text. Next, the text was divided into meaningful units which were condensed, abstracted and named with a code. The four researchers compared the codes based on similarities and differences and discussed and sorted the codes into categories, thereby representing the manifest content of the text. Furthermore, the underlying meaning and the latent content of the text were developed through reflections among the authors, and three themes based on the research question were formulated (Example of the analysis, see Table 2). The process of analysis involved a back-and-forth movement between the whole and parts of the text [40].

Ethical considerations

This study followed the guidelines of the Declaration of Helsinki and associated principles for ethical research [45]. The Norwegian Centre for Research Data (NSD) [46] approved this study (No. 798385). The participants gave their written consent to join the study, and could withdraw from the study and delete their given information at any time prior to analysis and publishing. The interview data were stored securely, ensuring the participants' anonymity.

FINDINGS

The meaning of midwives and PHNs lived experiences with breastfeeding counselling was described as the responsibility for collaboration and facilitation, striving for professional competence to be confident as a breastfeeding counsellor and being sensitive and adapting to novel situations and the individual breastfeeding family (Table 3).

TABLE 2 Example of a meaning unit, condensed meaning unit, code, category and theme from the analysis.

Meaning unit	Condensed meaning unit	Code	Category	Theme
'I have to say it was incredibly good to gain a little more knowledge, I would say it reassured me greatly'	Knowledge makes them feel good and reassured	Self-confidence as breastfeeding counsellors	More knowledge gives a feeling of confidence	Being confident as a breastfeeding counsellor means striving for professional competence

TABLE 3 Description of categories and themes.

Categories	Themes
Challenges and possibilities regarding collaborating with hospitals and doctors	Breastfeeding Counselling Means Responsibility for Collaboration and Facilitation
Importance of time, locations and collaboration for breastfeeding care	
More knowledge gives a feeling of confidence	Being Confident as a Breastfeeding Counsellor Means Striving for Professional Competence
Commitment to promoting breastfeeding and relying on one's own clinical judgement	
Individually oriented counselling	Supporting the Individual Breastfeeding Family Means Being sensitive and Adapting to Novel Situations
Involving the father of the breastfeeding family	
Breastfeeding counselling as a supportive practice	

Theme 1: Breastfeeding counselling means responsibility for collaboration and facilitation

Two categories were identified under this theme: 1. Challenges and possibilities regarding collaborating with hospitals and doctors; and 2. Importance of time, locations and collaboration for breastfeeding care.

Challenges and possibilities regarding collaborating with hospitals and doctors

As mothers left hospital soon after birth, the midwives and PHNs in the municipal health service felt that they had a great responsibility for the family during the maternity period.

Particularly, midwives and PHNs felt that if breastfeeding had not been established in the hospital or if the child had received infant formula, they needed to make greater efforts to help the mothers breastfeed. This could be a challenging situation:

> Epicrises may state that breastfeeding is going well, but the impression we get when the mothers are at home is different; the mothers may be feeling pain or using a breast shield or supplements with infant formula, so I wonder how they define that breastfeeding is going well? (PHN1).

The introduction of electronic-message communication between the hospital and the child health service improved communication, but the participants observed that families still needed to wait to receive support from the community health service after discharge from hospital.

According to the midwives and PHNs, some doctors in hospitals and general practitioners (GPs) in the municipal health service lack knowledge about breastfeeding; however, midwives and PHNs reported that when GPs have knowledge about breastfeeding it can be helpful for solving breastfeeding problems. To increase the knowledge of the GPs, PHNs took responsibility for giving them information about breastfeeding issues.

Importance of time, locations and collaboration for breastfeeding care

Sufficient time to provide breastfeeding counselling was expressed as essential by the midwives and PHNs, because it allowed them to use their competence and listen to what mothers needed:

> 'I feel I don't have enough time to give counselling in the way I want because it is very time-consuming with breastfeeding counselling' (PHN5).

To help the families, they endeavoured to make themselves available and be flexible with the hours they had during the week.

The midwives and PHNs found it frustrating when the child health clinics lacked sufficient equipment for breastfeeding counselling and meant that mothers should be offered a suitable place to breastfeed:

> 'It is quite strange that, in a Baby-Friendly Community Health Service, you don't have a good chair to breastfeed in. Breastfeeding in the hallway, at the entrance, it is not okay. You should not do that' (PHN4).

Good collaboration between midwives and PHNs working at the child health clinics was seen as important for continuity of breastfeeding care. Interprofessional collaboration included professional discourse and knowledge-transfer, which strengthened

the midwives and PHNs sense of confidence as breastfeeding counsellors:

> 'It is nice when we are together that there are things that midwives know much more about than me, and then you get such a transfer of knowledge, so I learn a lot from being together' (PHN9).

A particular strength of the collaboration was that both professionals could write in the same documentation system. Those who were stationed in the same building mentioned having closer collaboration regarding helping mothers with breastfeeding problems.

Theme 2: Being confident as a breastfeeding counsellor means striving for professional competence

Two categories were associated with Theme 2: (i) More knowledge gives a feeling of confidence; and (ii) Commitment to promoting breastfeeding and relying on one's own clinical judgement.

More knowledge gives a feeling of confidence

The midwives and PHNs reported that the first days after delivery have a crucial impact on breastfeeding outcomes. The midwives and PHNs feared not handling the breastfeeding counselling appropriately and felt that having responsibility for the baby's weight and health was demanding. They also stated that these situations required confidence in their professional assessments. However, their confidence was boosted when they succeeded in helping a family establish breastfeeding.

The participants described that being self-confident when providing breastfeeding counselling was important. The basic knowledge that they obtained from their post-graduate- or master's-level education as midwives or PHNs was not sufficient to make them feel confident as breastfeeding counsellors; even the most experienced midwives and PHNs felt they needed to better handle the situations they encountered. They believed that more knowledge would improve their abilities as breastfeeding counsellors:

> 'I have to say it was incredibly good to gain a little more knowledge, I would say it reassured me greatly' (Midwife [M6]).

To update their theoretical knowledge, they participated in lactation-counselling courses arranged by the Norwegian Institute of Public Health's breastfeeding unit, and perused Ammehjelpen's website:

> 'One must have knowledge and be up to date. I think that I have learned a lot about breastfeeding techniques in lactation-counselling courses, especially about soreness and ways to prevent it, how to help the baby latch on and assessment of tight tongue-ties' (PHN3).

They thought that the process of being approved as a 'Baby-Friendly Community Health Service' was educational and gave them more self-confidence as counsellors; however, they also hoped that the approval could be regularly re-evaluated, as this could ensure they maintained a high level of competency.

Commitment to promoting breastfeeding and relying on one's clinical judgement

The midwives and PHNs felt obliged to support breastfeeding in a manner that accords with the national recommendations and their personal knowledge regarding the advantages of breastfeeding. This commitment, combined with the importance of relying on their clinical judgement, was necessary for managing each individual family and situation:

> 'This is perhaps the balancing act I really experience; balancing professionalism with what the mothers want. I need to provide information about what is actually okay to do based on my own assessment of the situation' (PHN13).

To motivate mothers to breastfeed, the midwives and PHNs tried different approaches. For example, they explained the benefits of breastfeeding to the parents to help them make an informed choice:

> 'You would like them to be informed when they decide; to know the benefits of it both for themselves and the baby [...]; but how much should you pressure them? My job is to inform them of the benefits; I have taken on that in my work as a public health nurse' (PNH5).

Another way to motivate mothers to breastfeed was to inform them that their children were satisfactorily gaining weight during breastfeeding; this was based on the hope that this could help them feel more confident choosing exclusive breastfeeding for 6 months.

Discourses among experts in media concerning the timing of the introduction of solid food and tongue-tie-related breastfeeding problems made the midwives and PHNs unsure of their competence and challenged their clinical judgement. Treatment for tight tongue-tie had ethical implications because they did not know who could provide parents with professional help for free:

> 'They have had a lot of breastfeeding consultations, and then they have been and cut the tight tongue-tie, spend multiple thousand (...), ohh, I feel I was not helpful' (PHN4).

Theme 3: Supporting the individual breastfeeding family means being sensitive and adapting to novel situations

Three categories associated with Theme 3 were identified: 1. Individually oriented counselling; 2. Involving the father of the breastfeeding family and 3. Breastfeeding counselling as a supportive practice.

Individually Oriented Counselling

Breastfeeding counselling was considered a complex activity regardless of midwives' and PHNs' number of years of breastfeeding-counselling experience. Counselling demanded wide-ranging knowledge and the ability to adapt to novel situations:

> '[...] the challenges and the causes [...], they are so complex. I think it is very challenging, and every situation is..., you cannot just to do what you did last time, you have to reconsider the situation each time' (PHN1).

They wanted to help mothers while considering the physical and mental conditions and opportunities of the mothers and babies. To achieve this, they tried to customise counselling to the problems mentioned by the mothers. An example of an individually tailored situation was if the PHN interpreted that breastfeeding became so all-consuming for a mother that she had ceased interacting with her baby. A potential solution could be to advise the mother to stop breastfeeding; the midwives and PHNs stated that, while breastfeeding was important, it was more important that the mother had the energy to bond with her child:

> 'It has happened, not many times, but I have said: "I advise you to quit" because breastfeeding is so all-consuming, this interaction with the child, it will almost be absent because of the focus.' (PHN10).

Child-related challenges could also complicate the breastfeeding counselling, such as when children had reduced ability to suck from the breast. In some of these cases, despite determined efforts, breastfeeding could not be performed, and it was frustrating for the midwives and PHNs to be unable to help.

Another subject of concern was women who had been abused or violated and experienced breastfeeding problems. Some of these women seemed to be motivated to breastfeed, but also searched for opportunities to stop, and it was important to be aware that such traumas could be the real cause of some breastfeeding problems mothers attribute to other challenges (e.g. stating that their baby cries a lot during breastfeeding):

> Women who have been abused, are determined to breastfeed and feel that they should breastfeed, and despite this they almost throw up and wish to stop. Sometimes I think that breastfeeding counsellors are not good enough to understand what really the main problem is (M4).

The midwives and PHNs reflected on their ability to adapt to families' need for counselling. During the first months after birth, mothers are vulnerable, meaning they require good communication skills from the midwives and PHNs. Sensitive counselling was described as saying the right things and maintaining the correct distance. An attitude of being calm and listening when they met mothers was described as the most important.

Involving the father of the breastfeeding family

The midwives and PHNs described breastfeeding as a family matter. They thought the father should be included as a part of the breastfeeding family, and that he also should receive counselling.

Based on their experiences, the nurses felt that fathers were especially important during the first days after their discharge from the hospital:

> 'He is the one running the maternity ward at home. He is very important' (M4).

They tried to include fathers and give them the same information as mothers. Fathers could be good supports for mothers, allowing them to eat, rest and sleep, which are necessary for producing milk. Knowledge of how breastfeeding works could help fathers provide assistance. The participants felt that the fathers wanted to contribute and join the mothers and children at consultations at the child health clinic.

The midwives and PHNs emphasised that many of the fathers were so involved in breastfeeding that they could feel just as tired and exhausted as the mother and, therefore, had their own need for follow-up. They suggested that fathers needed to be supported and that their role in the breastfeeding family needed to be accepted. They felt that some fathers needed to hear that they were important caregivers:

> There are some fathers doubting they are not good enough, because the child calms down more easily with the mother, and the information that they are both caregivers, and now and then they give the father a little extra support for he can feel rejected (...), this is a part of the breastfeeding as well (PHN10).

According to the PHNs, both parents experienced stress worrying about how the father should feed the baby when the mother returned to work, as the baby would still need to be breastfed several times during the day. This affected the breastfeeding negatively, because to solve the problem, parents started to give their babies infant formula or solid food sooner than it was recommended:

> 'My experience is that the parents think: I have to start soon, I have to start with food quite early, and this affects the maintenance of the exclusive breastfeeding' (PHN9).

Breastfeeding counselling as a supportive practice

Providing counselling in such a way that mothers feel respected and supported regarding their feeding choices for their babies was described by the midwives and PHNs as important for helping the mothers master breastfeeding and avoid experiencing breastfeeding pressure. A mother who was afraid that she would not be able to breastfeed was told that she had a choice regarding whether to breastfeed or not, and that made her decide to try breastfeeding:

> 'We started by saying: you do not have to breastfeed. You can simply opt out [...]. You decide; and she said afterwards that this freedom of choice was crucial for her to have the strength to go ahead with it' (M7).

The midwives and PHNs felt that it was important to help the parents use their own resources to solve problems. They had found that most parents were good at asking for information at the child health clinic or searching for it themselves. They tried to help the parents remember how they had solved problems earlier in life, and to use the strength they had gained from these experiences to negotiate new situations.

Despite the midwives' and PHNs' attitudes that they should support the parents' choices about breastfeeding, it could be difficult to accept parents' decisions, especially if the parents stopped breastfeeding or started using formula without discussing the situation with the midwives or the PHNs:

> 'Some quit breastfeeding without involving us, they have started with formula, and I wonder what has happened and why did they not call us then? Well, then it is kind of done'(PHN13).

The midwives and PHNs felt that, considering the benefits of breastfeeding, a little pain/inconvenience was worth enduring. They wondered if some mothers ceased breastfeeding too early and were not willing to prioritise it.

DISCUSSION

Midwives and PHNs underlined the importance of structural factors for providing good breastfeeding care. They tried to find the balance between the challenge of relying on their competence as breastfeeding counsellors, their commitment to promote breastfeeding, and their support and respect for breastfeeding families.

According to the midwives and PHNs examined in our study, good collaboration, suitable time and locations are needed to facilitate good counselling; however, many reported a lack of time and equipment. McFadden et al. [6] highlighted that frequent face-to-face meetings with counsellors are the most effective form of counselling but, according to Dahl and Clancy [18], time pressure in public health services can limit PHNs' involvement and weaken their clinical judgement. The midwives and PHNs also found that structural determinants have an impact on their opportunities to provide good counselling, and this accords with Rollins et al. [1] and Neves et al. [4], who reported that

factors such as legislation, policy and financing influence breastfeeding. Thus, breastfeeding support, promotion and protection should be a national priority.

The midwives and PHNs in the present study reported a need for greater competence to handle challenging breastfeeding situations. This was particularly related to cases of children with suspected tight tongue-ties, parents wondering when they should start giving solid food, and mothers with various breastfeeding problems. Navarro et al. [14] highlighted that knowledge, skills and evidence-based education are among the factors that empower healthcare professionals as breastfeeding counsellors. The present study's findings underline that increasing specialised knowledge about breastfeeding issues is important for all healthcare professionals responsible for breastfeeding counselling.

The midwives and PHNs felt that it is also essential to be supportive and sensitive to individual families' needs. Giltenane et al. [23] and the WHO & UNICEF [44] have demonstrated that a listening attitude, good communication and learning skills are important for building trust and identifying breastfeeding families' needs. Meanwhile, Martinsen [20] stated that, to understand the patient and provide care, professional knowledge, which includes being open, perceptive and able to listen, is needed. Palmèr and Gustafsson [22] reported that healthcare professionals need to be genuine listeners to understand hidden breastfeeding stories, and a screening instrument [21] has been developed to support caring dialogues. However, it is important to be aware that such instruments can hinder openness to mother's individual needs. A listening and sensitive attitude was highlighted as especially important by the midwives and PHNs in present study; as some women are exposed to violence or abuse. Listening can help healthcare professionals understand if such abuse is the cause of their breastfeeding problems. According to Sørbø et al. [47] and Chanell Doig et al. [48], past and recent abuse of women can be associated with early cessation of breastfeeding and, thus, healthcare professionals must be aware of women who are experiencing these problems and provide support and care that allows them to find breastfeeding empowering and healing. According to Martinsen [19], care can be shown through practical work and, according to our findings, breastfeeding counselling that is characterised by trust, acceptance and engagement with the situation can give healthcare workers opportunities to provide appropriate care that can contribute to relieving families' challenges.

Although it is the mothers who breastfeed, the midwives and PHNs highlighted the importance of understanding fathers' need for breastfeeding-related counselling and care. This accords with Høgmo et al. [49], who found that including the father in counselling gives families an increased feeling of mastering the breastfeeding situation.

The midwives and PHNs experienced a dilemma between respecting the families' preferences concerning breastfeeding and their responsibility of recommending that they breastfeed in accordance with the guidelines. The midwives and PHNs observed that mothers who were encouraged to use their personal resources and make their own decisions about their children's nutrition were more likely to master breastfeeding. Similarly, Bäckström et al. [24], Giltenane et al. [23] and Swerts et al. [25] have also highlighted that treating breastfeeding mothers as resourceful and equal persons by providing them with information and practical help, and then respecting their subsequent choices, can empower the mothers. On the other hand, the midwives and PHNs found it challenging to accept when parents wished to opt out of breastfeeding or reduce breastfeeding before it was recommended. They tried to give care by listening to the individual women's desires and motivating them to breastfeed longer; this accords with what Martinsen [19] calls 'weak paternalism'. According to Martinsen [19], professional clinical judgement can help breastfeeding counsellors determine what represents good care for a breastfeeding family; however, this requires professional competence and a trusting relationship with the family.

METHODOLOGICAL CONSIDERATIONS

To achieve rigour in the study, the trustworthiness criteria of credibility, dependability, confirmability and transferability were applied throughout the research process [50].

The purposive sampling of experienced midwives and PHNs contributed to the study's credibility. The first author is herself a PHN with experience as a breastfeeding counsellor, which made it easier to gain trust and access to the field; to this end, the participants were informed of the author's background beforehand. It was important to have a reflexive attitude throughout the research process to become aware of how the first author's preunderstandings could affect the interviews and the interpretation of the findings.

Having both types of professionals in the same focus groups could be a limitation to this study because it could have prevented them from giving honest opinions about their collaboration; on the other hand, however, this could also have brought new perspectives on how the two different professions can collaborate to help families.

The quotes from the participants can enable readers to distinguish between the authors' descriptions of the

participant's experiences and the midwives' and PHNs' own voices. The members of the research team included three RNs, of whom two were PHNs and one was a nutritionist. All researchers discussed the findings and categories before agreeing on themes. A careful description of the research process strengthened the dependability of the study. The aspect of confirmability was ensured by writing reflexive notes during the research process and by holding discussions in the research team. The interviews were transcribed by the first author soon afterward.

To allow others to consider the transferability of the study [51], a clear description of the sample and context was provided. The COREQ (Consolidated Criteria for Reporting Qualitative Research) guidelines were used to provide greater transparency regarding how the study was conducted [52].

CONCLUSIONS AND IMPLICATIONS

The present study shows that midwives and PHNs perceive structural factors and the prioritisation of breastfeeding support in society as being important for providing good breastfeeding counselling. Strengthening healthcare professionals' competency in breastfeeding counselling may improve breastfeeding care. The findings also show how midwives and PHNs strive to find a balance in breastfeeding counselling between promoting breastfeeding according to recommendations and respecting mothers' choices.

Overall, to provide good breastfeeding care healthcare professionals must have knowledge about breastfeeding, clinical judgement skills, a listening attitude and ability to facilitate dialogues about ways breastfeeding affect a mother's everyday life. Clear breastfeeding-management guidelines and agreement on professional advice will provide breastfeeding counsellors more confidence.

More knowledge about healthcare professionals' experiences of supporting breastfeeding women who have been exposed to past and recent abuse is needed. Moreover, further development of mothers' and fathers' perspectives on breastfeeding counselling may assist understanding of the phenomenon of breastfeeding counselling.

Our study found that midwives and PHNs perceive breastfeeding counselling as a demanding task. Their experiences, as outlined in this paper, may inform how pre-service and in-service training can offer sufficient knowledge, competence and skills to empower healthcare professionals engaging in breastfeeding counselling. The findings presented in this study may be transferable to other contexts where healthcare professionals offer breastfeeding counselling.

AUTHOR CONTRIBUTIONS

Ingvild Lande Hamnøy designed the study and carried out the interviews supervised by the three other authors. Ingvild Lande Hamnøy transcribed the interviews and was responsible for the manuscript preparation. All authors were involved in the analysis. Berit Misund Dahl, Marianne Kjelsvik, and Anne Bærug contributed to critical manuscript revision and preparation. All authors have approved the final article.

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CONFLICT OF INTEREST STATEMENT

The authors declare that they have no conflict of interest.

DATA AVAILABILITY STATEMENT

The dataset analysed is not publicly available due to a written agreement between the researchers and the study participants stating that no one but the authors of this article may read the transcripts, but anonymised data can be obtained from the corresponding author upon reasonable request.

ETHICS STATEMENT

The Norwegian Centre for Research Data (NSD) (project number: 798385) approved this study.

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