Against all odds – Why UK mothers' breastfeeding beyond infancy are turning to their international peers for emotional and informative support.

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Abstract

The health benefits of breastfeeding are well documented and current recommendations are that women should breastfeed their child for two years and beyond. Despite this the UK has the lowest initiation breastfeeding rates in the world. Additionally, a considerably small percentage of women who do successfully initiate go on to breastfeed past infancy. This could in part be explained by the lack of support women receive when breastfeeding an older child. In this study we provide insight into women's experiences of healthcare interventions during the transition from breastfeeding an infant to a toddler. We conducted semi-structured interviews with 24 women with experience of breastfeeding at least one child past the age of twelve months. We used a theory driven thematic analysis to identify pertinent themes that ran through the interviews. As mothers progressed through their breastfeeding journey they faced increased social stigma. They also experienced a change in attitudes from healthcare professionals as support was replaced by judgement. This negatively impacted upon trust in healthcare professionals and the advice they offered. In response, the women turned to volunteering organisations and closed social media groups for emotional support and healthcare advice. These women experienced specific issues regarding breastfeeding in toddlerhood as opposed to infancy. They needed specialised interventions tailored for this. Social media was highlighted as a useful platform for supporting women who breastfeed beyond infancy. It allowed these women to feel part of a supportive international community and gain access to practical advice. Healthcare professionals should explore ways to engage in digital platforms to provide support to mothers' breastfeeding beyond infancy.

The World Health Organization recommends a woman to breastfeed exclusively for six months and continue for a minimum of two years and beyond to allow for optimum health benefits (WHO, 2018). It is universally acknowledged that these health benefits are significant, in both the long and short term, for mother and child (Horta and Victora 2013a 2013b). However, breastfeeding initiation and duration rates are extremely low in countries with a higher economic status (Victoria *et al* 2016). The UK, for example, is a country which has one of the lowest breastfeeding uptakes (UK Department of Health 2018). Additionally, of those women who do successfully initiate, a shockingly low 1% is thought to go on to breastfeed beyond six months (McAndrew et al, 2012). There are a number of researchers who have sought to understand the social, cultural and economic contexts which create barriers to breastfeeding (Godbout *et al* 2016; Santorelli *et al* 2013**,** Brown *et al* 2011; Dyson *et al* 2010; Hurst 2013; Dagher *et al* 2016; Mangrio, Persson and Bramhagen 2017; Boyer 2018). In response UNICEF (2016) urged the UK to develop a better national infant feeding strategy. However, to date breastfeeding research has largely focussed on the issues women face when initiating and establishing breastfeeding. This area is important, however, in order to develop effective support for woman to breastfeed beyond infancy, we have sought to understand the needs of the small percentage of mothers' breastfeeding during toddlerhood.

Background

There is a small selection of researchers who have sought to understand women's experiences of breastfeeding beyond infancy. These researchers highlight important attributes of this period of breastfeeding for mothers. These include; parenting style, the importance of the significant other, social stigma or language discourse (Faircloth 2009, Dowling and Brown 2013, Brockway and Venturato 2016, Tomori, Palmquist and Dowling 2016, Dowling & Pontin 2017, Newman and Williamson 2018). Cockerham-Colas *et al* (2012) has explored the influence, knowledge and

attitudes of health professionals towards breastfeeding beyond infancy and found that as the age of the child increased so did the negative attitudes of others. Gribble (2008) found that women breastfeeding a child two years or older sought breastfeeding role models for affirmation. These studies have all offered a valued insight into these women's experiences of breastfeeding during this period. Our study sought to contribute to these findings further, with emphasis on exploring how these women experienced different support networks.

Current action needed support breastfeeding beyond infancy

Breastmilk is thought to be the most perfectly adapted nutritional source and personalised medicine a child can receive. A moderate global increase in breastfeeding rates can prevent an estimated 823,000 child deaths and 20,000 breast cancer deaths worldwide every year (Victoria *et al* 2016). However, fourteen years following the launch of the *Global Strategy for Infant and Young Child Feeding* (WHO UNICEF 2003, 2007) two publications from the Lancet Series demonstrated that the world has a long way to go in its efforts to support and protect a woman's rights to breastfeed to the recommended age (Victoria *et al* 2016, Rollins *et al* 2016). Indeed, in a UK context, 34% of infants are breastfed when they are born and only 1% continue to breastfeed to six months (McAndrew *et al* 2012, Victoria *et al* 2016). UNICEF's (2016) *'Protecting Health and Saving Lives: Call to Action'* highlights, that the UK, in particular, needs to tackle multifactorial determinants of continued breastfeeding, such as social attitudes and values, woman's employment conditions, legal and policy directives and availability of health care services. This indicates that interventions need to be delivered across a variety of settings and at different stages of a woman's breastfeeding journey in order to have any significant impact on enabling them to breastfeed for longer.

Current context of England's healthcare services to support continued breastfeeding

Public Health England (PHE 2016, 2018b) make a strong case for local healthcare commissioners to invest in breastfeeding health services. Breastfeeding is also identified as one of the targeted impact areas when delivering the national early intervention public health nursing universal service (PHE, 2018). However, specific services for supporting continued breastfeeding vary across different areas of the UK. Additionally, reports of recent government cuts to funding has resulted in some ongoing breastfeeding groups in England being shut down (Institute of Health Visiting 2018). Instead PHE offers ongoing advice via an automated instant response service on Facebook Messenger, Amazon Alexa or Google Assistant called *Start4Life Breastfeeding Friend* (PHE 2019a, 2019b). In some areas, health services train local mothers to become peer to peer volunteer supporters which has proven successful for continued support (Ingram 2013, Thomson, Balaam and Hymers 2015, Thomson *at al* 2011, Grant *et al* 2017). These services could be key in supporting the continuation of breastfeeding (Renfrew 2014). However, most current interventions focus on the initiation of breastfeeding rather than continuation which has much more disparity. Therefore, for those women breastfeeding beyond one-year healthcare support is extremely limited. Separate to health services and widely available across the UK is the *La Leche League* (LLL, 2019); an international charity where trained volunteer leaders provide local support via meetings, help forums, phone calls and social media. Additionally, the *Breastfeeding Network* (2019) are another registered charity providing ongoing support across the UK with trained volunteers. These services are crucial in light of the lack of healthcare. However, breastfeeding women may still need to access health services and need specific health care not necessarily related to their breastfeeding practices. We have sought to understand the experiences of breastfeeding women who have accessed healthcare services and engaged in alternative support networks with a child beyond twelve months.

Methods

This realist qualitative study was approved the University of Derby's ethics committee. We recruited 24 mothers (aged between 27 - 48) who were currently breastfeeding or had recent experience of breastfeeding at least one child over the age of twelve months. Local face to face breastfeeding groups were targeted by advertising on their social media page. To enable for the majority of the interviews to be conducted face to face the sample was limited to Derbyshire. The majority of the mothers interviewed were white and a higher proportion were well educated (58% of the women had a post graduate degree, 21% had an undergraduate degree, 17% had been to collage and 4% had left education after high school). This sample represents the largest ethnic group of this area, however, it also reflects research which reports that white British mothers with a higher maternal age and level of education are more likely to breastfeed for longer (Godbout *et al* 2016, Santorelli *et al* 2013, Dyson *et al* 2010, Mangrio, Persson and Bramhagen 2017). Most of the mothers had more than one child and had gone on to breastfeed subsequent children longer than their first. Two mothers were tandem feeding (breastfeeding multiple children) at the time of interview. The mean breastfeeding duration was 2 years.

After giving full, informed consent the women took part in a semi-structured interview facilitated by one of us (Jessica Jackson, author one). We invited them to discuss their breastfeeding journey. The interviews took place, face to face, either within the mother's home or in a private room at the University. One interview took place over the telephone. There were a number of interviews where the mother's child was present. To reduce the risk of bias during data collection the semi-structured questionnaire was prepared objectively by validating it to a non-respondent, with similar characteristics, and changes were made where appropriate. The mothers were first asked about their breastfeeding experiences in the early infancy period. They were then asked to

give specific focus to breastfeeding beyond infancy. The schedule included a list of questions in relation to accessing support services and support networks; significant other, wider family, professional, peers, online or face to face and public. Prompt questions included phrases such as: *Do you have any other examples? Please could you tell me more about this?* All interviews took place between April and June 2018 and lasted between 52 and 27 minutes. It was unfortunate that the shortest interview was cut short because of the mother having to attend to the needs of her child. We transcribed each interview verbatim after it had taken place and this enabled us to systematically review the quality and volume of the data as it was collected. When data saturation was reached, and no new information was being shared in the interviews, data collection stopped (Fusch & Ness, 2015). All the transcribed interviews formed a data corpus which we then systematically analysed using a thematic approach. This is an established qualitative method which enables patterned responses which represent "something important about the data" (Braun & Clarke, 2006 p. 82) to be identified. We separately used the six stages of thematic analysis outlined by Braun and Clarke (2006) to independently identify themes. The analytic process was informed by a theoretical approach which involved a focused reading of the data in order to create codes which mapped onto specific areas of interest (Boyatzis, 1998). NVivo was used to collate extracts from the interviews into codes, establish their validity and then group codes into themes. We then met to discuss the themes we identified, and it was noted that we were largely in agreement. This gave confidence in the thematic structure and so extracts which best represented themes were selected for analysis using a realist framework. This approach assumes that language reflects meaning and experience (Braun & Clarke, 2006).

We recognise that researchers cannot adopt "a value free, neutral, uninvolved approach" (Mies 1993, p. 67) and so it was important to explore what our roles had in shaping data collection and

analysis (Toerien, 2004). We each had different roles and values that brought different perspectives to the research. Jessica (author one) is a nurse researcher with a background in public health nursing. As such we considered what Vail (2001) terms an 'insider' - someone knowledgeable about breastfeeding. This position can lead to a loss of analytic distance as issues raised during interviews could have been taken for granted by Jessica as well as the women being interviewed (Lee, 2005). To help address this Jenny (author two), who is a Psychologist and has not actively engaged with this community in the past, assisted with the analysis. Both our own experiences of breastfeeding led us to this research area but Jenny's lack of active involvement with the breastfeeding community positioned her in what Vail (2001) terms an 'outsider'. We believed that this status enabled Jenny to approach the analysis with a level of naivety which could then be comparable to Jessica's more 'insider' stance.

Results

The following analysis explores the issues these women faced on their breastfeeding journey and the role that alternative services played in supporting their feeding practices. More specifically, the analysis first attends to positive encouragement that the women received from healthcare professionals and the public when they started their breastfeeding journey. Attention then turns to the challenges that the women faced from medical professionals, members of the public and friends and family as the women made the transition to breastfeeding an infant. Finally, the analysis examines the role that specialised support groups and social media played in normalising the women's feeding choices and offering emotional support. The stigma that women faced when feeding an older child and the specific role the public health nursing services had in advising the women were also significant issues and are addressed elsewhere (authors, 2019).

Starting the breastfeeding journey

During pregnancy the women became well informed of the benefits of breastfeeding and they entered into motherhood with a desire to exclusively breastfeed. When their baby arrived a minority of women reported issues surrounding the support they received. However, there was a consensus that midwives and health visitors went above and beyond to offer support.

They were great, they were amazing because I think when it is your first. I don't know what it was like for you but they kept coming to visit (Claire).

This support was central in enabling the women to establish breastfeeding and helped them work through health related breastfeeding difficulties such as mastitis. During infancy the women's breastfeeding was well received by doctors too.

They were on about his hydration levels, and I said to them, well I am still breastfeeding him, and the doctor did say to me, well that's amazing (Sharon).

Here Sharon recounts a time when she sought medical advice for her son who had scarlet fever. Sharon's disclosure of her breastfeeding practice in the consultation highlights some important issues. First, it demonstrates that Sharon felt comfortable in sharing her breastfeeding practice and understood that it was medically relevant. This knowledge about the medical benefits of breastfeeding was shared by the other mothers. Within the interviews these benefits were linked to the mother's role in protecting her child from illness and enabling them to thrive. The doctor's response to Sharon's breastfeeding practice validates her knowledge and use of the word *amazing* presents this practice as something that she should be proud of but also not the norm.

Emotional support and acceptance were also experienced by the women as they fed in public.

I remember a really elderly guy actually, a really elderly guy who, erm, I'd been covering up and he said oh, and he walked past and went oh, he's on the good stuff, or something like that, it was a really nice positive thing (Abbie).

Encouragement from strangers, kind words and gestures went a long way in supporting the women's breastfeeding practices. Many of the women reported that they were initially concerned about breastfeeding in public because it involved exposing their bodies and therefore could attract negative reactions or comments. This led to many of the women leaving the house prepared for confrontation and armed with responses that could be used to defend breastfeeding in a public space. A minority of women did have bad experiences, in which they were asked to move out of view, but many were taken aback by the kindness and support offered by the public. This helped to foster a sense of pride and achievement.

I have had quite a few comments where people have come over or walked past more than come over and said its lovely to see or it's just sort of nice to see mums feeding and all things like that. I felt proud. (Ella).

This section of the analysis has explored the support women received when breastfeeding an infant. Positive reactions from healthcare professionals and members of the public helped the women feel comfortable in their breastfeeding practice and feel good about breastfeeding their baby. Therefore, practical and emotional support were key in helping women at the start of their breastfeeding journey. The next section of the analysis explores changes which occurred as the women continued breastfeeding.

Making the transition

When initiating breastfeeding the women did not have a fixed end point in mind. Therefore, breastfeeding beyond infancy was not a conscious decision, it was something that developed organically. As the women experienced the benefits of breastfeeding in relation to health, bonding and parenting they moved towards natural term breastfeeding in which weaning was led by their child. The women felt happy in their decision but as their breastfeeding continued, support dwindled.

No one can object to new-born breastfeeding because that is their only food source but I think people feel differently when they can eat or drink other things (Amy).

Within the interviews there was a strong sense that a woman's right to breastfeed a baby was protected and therefore unquestionable. However, once their baby reached the age of six months attitudes towards breastfeeding changed and the practice was viewed as abnormal. This change was strongly tied to societal expectations around weaning and based on the assumption that breastfeeding only offered nutritional benefits. The women started to experience judgemental glances from strangers when feeding in public and their breastfeeding practices were challenged more directly by friends and family.

She's like, "You don't want him to be four and asking for milk," and it's just like, "Why not?" It's like the older they get you become like a closet breastfeeder' (Maggie).

Maggie's confidence in her practice and her ability to defend her breastfeeding practice was echoed by the other women. However, the women also spoke about the strength and resilience needed to feed an older child in public because of the stigma surrounding this practice. Feeding mostly took place in the home, in part this was due to the role breastfeeding played in reconnecting mother and

child at the end of the day or to help settle the child to sleep, but there was also a strong sense that feeding in public was not acceptable.

A group I took James to a lot was seedlings and I think I saw maybe one child who was a bigger child have a bit of a feed once (Emma).

Judgement was also passed in parent and baby spaces and women rarely fed older children. This led to marginalisation and the women started to feel as though they were the only ones breastfeeding beyond infancy. Crucially, at a time when women were facing judgment, General Practitioners (GP) and other healthcare professionals also became less supportive.

I suffered with vertigo at the beginning of the year and this doctor said to take these tablets you need to stop breastfeeding and it's about time you need to stop breastfeeding anyway but I didn't (Catherine).

When seeking medical help the women found that GPs were not willing to take their breastfeeding practices into account when deciding the best course of treatment. Within Catherine's consultation an unequal power dynamic was established in which she was simply expected to follow doctor's orders and stop breastfeeding in line with medical advice. However, Catherine alongside the other women interviewed were well educated in relation to breastfeeding and therefore they had the confidence to continue feeding despite being told not to. The women faced similar issues when visiting the GP with their sick children.

She had diarrhoea, and he was trying to tell me that she needed squash or water and I said well surely she'll get the antibodies she needs from the breast milk and he said 'well, that only lasts for the first few weeks'. Ugh. Face bomb. I didn't even bother. I was just like, I'm not, there's no, ugh (Valerie).

During these interactions the GPs were seen as ill-informed and risk adverse. Consequently, the women questioned their advice and competence. As evidenced above this closed lines of communication as Valerie felt it was useless entering into a dialogue with a medical professional who knew less than her. Other women such as Megan '*wouldn't volunteer to my GP that I was breastfeeding*' because of the judgement and advice that would be offered. This signified a growing level of mistrust between the women, their GP and other healthcare professionals which had the potential to negatively impact upon healthcare.

*'he *dentist* was like because you're going to brush her teeth then you're giving her (breast) milk, which is sugary, and that's going to cause cavities'. And I was like, no that can't be right because otherwise our ancestors' teeth must have fallen out' (Zoe).*

The perceived lack of knowledge, understanding and support from healthcare professionals led to direct confrontation or resulted in the women remaining silent but not following medical advice given in appointments because of what Megan described as a *'a lack of faith'*.

This theme has examined the ways in which women felt more isolated and alone in their breastfeeding practices as they continued in their breastfeeding journey. The final theme investigates how the women used different forms of support to help them continue breastfeeding.

The importance of specialised support

Judgement and feelings of being alone led the women to seek out advice and support from voluntary services such as La Leche League (2019).

I went to La Leche League and the first or second meeting there was a lady there who was tandem feeding and I think the old one she was feeding was 3 or 4 and I was like oh my goodness I didn't

know that you could feed for that long and I didn't know that you could tandem feed and she was like my hero (Gail).

La Leche League meetings offered women the space to meet up with other like-minded mothers who were attuned to their breastfeeding practices. In contrast to general breastfeeding groups or other parent and baby spaces older children were breastfed openly in these meetings and issues such as tandem feeding were addressed. Consequently, the women were able to feel part of a community and receive specialised support that was not forthcoming from public health nurses and healthcare practitioners. Attending meetings also helped to address the stigma around breastfeeding beyond infancy by normalising this practice.

It's completely normal, completely natural, and I think having seen people feeding children that were eighteen months, two years, it made me realise it's not weird, its completely normal. It had a major influence (Katy).

Meetings enabled the women to feel less marginalised. This in turn gave them more confidence in their breastfeeding and offered reassurance that they were not engaging in an unhealthy practice. For the women interviewed, seeing positive breastfeeding role models was an empowering experience and being part of these groups enabled them to support other women in their feeding practice.

Elsie always asks for boob when we're there, which is fine, and I do feel it has helped two other mums to continue breastfeeding past a year, because they have had pressure from their families to say, 'they're getting older, maybe time to stop', but you know what, carry on, it's fine, do what you want, it's your body (Valerie)

Valerie illustrates the supportive environment of the meeting space and the role it can play in directly addressing stigma and pressure to stop feeding. As such face to face meetings served several important functions from offering support, empowerment, and practical information from likeminded women.

The women also spoke about the relevance of closed groups set up on social media specifically for women breastfeeding beyond infancy.

There's a really good group I'm part of, Breastfeeding Babies and Beyond, I think it is, and they're from all over the world, and there's thousands of us and you can post anything and you'll get a response pretty much straight away (Sarah).

The international membership of the support group was particularly important for the women interviewed. It further normalised breastfeeding beyond infancy as the women could connect with other women across the world and hear about their experiences. Also, it was a way these women could feel that they were not alone because there was usually someone awake and online who could offer support and advice immediately. This enabled the women to access support when they needed it rather than be tied to specific face to face meeting groups that may not fit in with their busy schedules. Asynchronous communication and women posting images of themselves breastfeeding their older children served as a useful bank of information that could be accessed and scrolled through when the women needed it.

I like the one, the older babies, 'cos it is nice to see like the older, like the 5-year olds still being breastfed, and they're still like completely normal functioning children (Laura).

Significantly, normalisation in the images and stories shared on the site extended to the children themselves. Social stigma surrounding breastfeeding beyond infancy often centres on the

practice creating an unhealthy relationship between mother and child which is psychologically damaging. Images within the online groups directly countered this and offered reassurance that breastfeeding beyond infancy would have no adverse or long-standing effects on the child. The groups also extended the emotional support that they had experienced when feeding a baby.

Sometimes just getting that wow, I'm impressed with you, 'cos you know like sometimes your friends don't really say it like, so it's nice sometimes to get that positive like, yeah, you've done really well to tandem feed for three years or for fifteen months or whatever (Laura).

Positive and congratulatory comments in relation to social media posts the women made reinforced their breastfeeding practices and reconceptualised it as something to be proud of rather than ashamed about. This helped to maintain the motivation to continue in their practice and view it as an achievement. As well as offering social support the group also served as a place where the women could access practical advice and support that was not given by healthcare providers.

Sometimes people will come out with some facts and things that I've not heard before and they're offered like advice like we used to, at one point, with, like nipple tweaking (Zoe).

People are talking about weaning, self-weaning when they're having other babies, you know, how that works and I find that really helpful and supportive (Catherine).

This practical advice enabled the women to address issues surrounding breastfeeding etiquette, fertility and feeding through pregnancy from a community of well-informed mothers who were able to offer empathy and draw directly upon their experience to offer useful solutions. This often led to the online community being viewed as experts who were able to offer better medical advice than doctors and other healthcare practitioners.

There are so many instances where they've said 'I'm having an MRI, so I can't breastfeed for this long', actually you can breastfeed after it, or 'I've got to have the dye and I can't breastfeed afterwards' and there's no evidence to say that. So everybody gets directed to The Breastfeeding Network, which has factsheets and says 'no, you can' (Valerie)

The group was also seen as a space in which women could post questions about medical procedures and medication. The responses posted by other mothers often questioned the medical advice given by GPs and provided an evidence base to support the advice they offered. On the one hand this further fed into the mistrust between the women and healthcare providers by questioning healthcare providers competence. However, it also provided a knowledge base that could be used by the women in consultations to bring about a more equal power relationship and encourage healthcare providers to engage in a more open dialogue.

Discussion

These results have highlighted that for the women interviewed, finding information and support in the early stages of breastfeeding was crucial but relatively easy. This reflects the current services which are available targeting woman during the prenatal and antenatal period due to a government drive to increase initiation (PHE 2016). These findings are encouraging and they point towards the importance of early intervention and the need for further funding in this area. However, in order to support breastfeeding to the age of two years and beyond, as is recommended, further support is needed. These women encountered different issues as their breastfeeding journey continued, they felt stigmatized as their breastfeeding practices were challenged and deemed inappropriate. This resulted in the women feeling part of a minority, forced out of public spaces or segregated from general mother and baby groups. Crucially, at this time they also felt unsupported by

healthcare professionals and the advice offered by GPs and dentists was viewed as inaccurate. This negatively impacted upon the women and their trust in healthcare providers.

The experiences shared by these women raises two central issues surrounding the importance of support and offers insight into the ways in which policy can be shaped to offer much needed specialized support for women who breastfeed beyond infancy. The first issue centred on peer support. Within the interviews the women spoke about the value of La Leche League meetings. These meetings offered a space in which they could see older children being fed and openly feed their child without fear of judgement. This had a powerful effect in normalizing breastfeeding of an older child and providing positive role models. It enabled the women to feel part of a supportive community rather than a minority thus affirming the continued need and relevance of peer support for women who breastfeed beyond infancy (Thomson, Crossland and Dykes 2011, Thomas, Balaam and Hymers 2015). However, a limitation of La Leche League meetings is that they are held at a fixed time and place. Many of the women had returned to work and so attendance at the meetings was not always possible. Returning to work is a challenging time as many women do not receive information about their breastfeeding options (Weber, Janson and Nolan 2011). Therefore, specialist support is especially needed at this time. For the women interviewed, closed groups on social media offered the flexible and responsive support needed to continue with their breastfeeding practices. As with the La Leche League meetings the women found emotional and practical support in these groups. However, these groups also served another important function surrounding healthcare advice. At a time when the women felt judgement from their healthcare providers and questioned their competence their favored source of information was from specialized social media groups. The women were able to access medical information by being pointed towards useful and informative organizations such as the Breastfeeding Network. They

were also able to access practical information concerning issues surrounding nipple tweaking that were unaddressed by public health nurses. On the one hand this experience was empowering for the women and it ensured that concerns were met. However, it also opens up the possibility for women to access and share unreliable sources of information or result in women failing to seek and access medical advice and treatment when it is needed.

The women's reliance upon social media indicates that further research is needed in this area. It has been noted that social media can positively influence health behaviors and the sharing of health messages (Park *et al* 2016, Kite *et al* 2016, Woolley and Peterson 2012). It can also be a means of increasing accessibility and availability of health information for academics and health professionals and provide a way of engaging with the public and patients (Moorhead *et al* 2013; Ryan, 2013). As such social media could provide a useful way for healthcare providers to reach out to women who breastfeed beyond infancy through providing support and relevant information. Such exchanges could also go some way to tackling the mistrust towards healthcare practitioners that women can feel when breastfeeding an older child and help to develop a more positive and open relationship between women and healthcare providers.

Implications for practice

In order to re-address the imbalance of trust the women conveyed within this study, practitioners need to recognize their personal breastfeeding views and ensure these are not impacting on their advice. The advice they offer should be evidence-based and non-judgmental and therefore education for all healthcare practitioners in regards to natural term breastfeeding would be beneficial. Breastfeeding beyond infancy should be encouraged. Interventions which support breastfeeding mothers need to be designed to address issues that arise at all stages of a women's breastfeeding journey. These women require flexible and responsive spaces to obtain support and

advice, particularly for those returning to work. Digital platforms were able to offer this and therefore, more investigation is needed into how these platforms can be utilized by healthcare practitioners as an effective means of offering specialist interventions which can enable more mothers to breastfeed for longer.

Conclusion

This study builds on the knowledge that interventions at a variety of levels are crucial to support the initiation and continuation of breastfeeding. There are a number of limitations to this study which affects the transferability of these findings. Recruitment was limited to Derbyshire and therefore limits the demographics. This sample is also typical of those who are known to be more successful at breastfeeding and therefore cannot consider additional needs non-white, younger woman breastfeeding beyond infancy may have. These mothers were also, at the time of recruitment, 'following' a local breastfeeding support group on social media. Therefore, this recruitments method would have missed participants not already affiliated to a local group or accessing online support. This should be considered when conducting further research within this subject area. However, findings presented here offer a strong case for support to be specialized and tailored to the different needs that emerge as a woman progresses through her breastfeeding journey. There needs to be more of a focus on addressing social stigma, fostering a sense of community and pride and also developing positive relationships with healthcare providers. A combination of specialized charities and online international breastfeeding groups are central to enabling women to find that support which is missing from their local environments. These spaces enabled the women to build their own trusting community of emotional and informative support. The mothers themselves also became passionate about supporting others, demonstrating the effects of peer to peer support. These findings have implications for worldwide health and

social care and public health as well as for the UK. Professionals and academics should regularly engage with this community. Working together globally can tackle discrimination, promote normalization, and share best practices or high-quality research.

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