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Without a Happy Mother, a Family Cannot Thrive – Professionals' Reasoning for Providing Breastfeeding Support: A Qualitative Study in the Netherlands

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Abstract

Women who want to breastfeed their child are not always able to do so as they desire. In the Netherlands, women experience differences in the adequacy of breastfeeding support between professionals. Although previous studies have investigated facilitators and barriers for breastfeeding support based on professionals' perspectives, an in-depth understanding of professionals' motivations is unclear. The present study uses cultural schema theory to obtain a better understanding of how individual values and beliefs about breastfeeding support together with personal experiences with breastfeeding support motivate professionals' reasoning for providing support to mothers. In-depth interviews were conducted with eight postnatal care workers in Groningen, a province in the Netherlands, in 2022.

Findings show that participants' reasoning for breastfeeding support is often aimed at protecting mother's wellbeing. Their reasoning depends on three components: the professional providing support, the mother receiving support, and the broader context. Furthermore, participants sometimes feel conflicted between their personal preferences and what they feel is best for mother's wellbeing. The findings suggest that professionals do not solely focus on the promotion of breastfeeding but that they primarily aim to protect or improve mother's wellbeing when reasoning about support. However, these aspects are not included in present Dutch breastfeeding guidelines.

Based on the findings, the Netherlands Organization for Applied Scientific Research (TNO) with representatives of the National Breastfeeding Council (LBR) – who jointly developed the Dutch national multidisciplinary breastfeeding guideline – are recommended to include contextual and psychosocial aspects of breastfeeding support when revising current guidelines.

Keywords: breastfeeding support, professionals, cultural schema theory, qualitative research

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List of Abbreviations

HH-QRC	Hutter-Hennink Qualitative Research Cycle
MCA	Maternity Care Assistant
WBC-N	Well-baby Clinic Nurse
WBC-P	Well-baby Clinic Physician

1 Introduction

1.1 Background

Women who want to breastfeed their child are not always able to so as they desire. Some women have difficulties starting breastfeeding, while others have difficulties continuing (Lanting & van Wouwe, 2007; Odom, Ruowei, Scanlon, Perrine, & Grummer-Strawn, 2013; Oosterhoff, Hutter, & Haisma, 2014). In the Netherlands, about one third of women who started breastfeeding stopped in the first month after birth. Of this group of women, one half stopped in the first week and the other half in week two or three after birth (Engelse & van Dommelen, 2018). This rapid decrease in breastfeeding shortly after birth may indicate a discrepancy between the desired breastfeeding duration and the actual duration (Lanting & van Wouwe, 2007). These decreasing breastfeeding rates are not unique for the Netherlands but similar in many other European countries (Theurich et al., 2019).

There are various reasons for mothers to not initiate or continue breastfeeding. First, to make breastfeeding successful, women are recommended to prepare themselves during pregnancy by inquiring information and knowledge about breastfeeding. However, women state that preparation during pregnancy is more often focused on childbirth than on breastfeeding (Oosterhoff et al., 2014). Therefore, women may not be well informed about breastfeeding, making initiation and continuation more difficult. Moreover, women experience a discrepancy between what professionals recommend before birth, and how professionals act after birth. Some women say that professionals recommend breastfeeding as the preferred type of feeding, but that once they seek help with issues related to breastfeeding, professionals tend to recommend formula as a solution (Holcomb, 2017). Thus, even if women decide to breastfeed their child once it is born, conflicting messages by professionals can make it difficult to continue breastfeeding. Other common breastfeeding issues that are important reasons for women to discontinue breastfeeding are pain while breastfeeding, the perception that they do not produce enough milk to feed their baby, insufficient growth of the baby, and difficulties combining breastfeeding with work (Lanting & van Wouwe, 2007; Odom et al., 2013; Oosterhoff et al., 2014).

Professional support may help mothers who desire to breastfeed to prevent undesired breastfeeding cessation by adequately addressing issues (Hannula, Kaunonen, & Tarkka, 2008; Keister, Roberts, & Werner, 2008; Odom et al., 2013; Theurich et al., 2019; van Dellen, Wisse, Mobach, & Dijkstra, 2019). For instance, pain during breastfeeding may be solved by using different latching techniques that can be taught by a professional (Kent et al., 2015). The Netherlands have national multidisciplinary guidelines that aim to promote breastfeeding (Engelse & van Dommelen, 2018; Nederlands Centrum Jeugdgezondheid, 2014; Theurich et al., 2019). However, women living in the Netherlands experience great differences in breastfeeding support between professionals (Oosterhoff, 2015). Differences between professionals may be due to individual factors that impact professionals' breastfeeding support for new mothers (Cook et al., 2021; Whelan & Kearney, 2015).

Examples of such individual factors of professional support have been found in studies conducted in other European and North-American countries (Brodribb, Fallon, Jackson, &

Hegney, 2008; McInnes & Chambers, 2008; Whelan & Kearney, 2015; Whelan, McEvoy, Eldin, & Kearney, 2011). According to these studies, professionals name practical factors – such as time and education –, and personal factors – such as attitudes towards breastfeeding – as potential facilitators and barriers for providing breastfeeding support. Lacking time and education seem straightforward barriers for providing adequate breastfeeding support and may be addressed by health organizations. In contrast, personal reasons may be less universal, depending on a variety of personal and professional experiences and attitudes towards breastfeeding. Moreover, motivation for providing breastfeeding support may be generated by more than practical and personal factors alone. For instance, breastfeeding is culturally defined (Oriá & Ob, 2010; Osman, El Zein, & Wick, 2009). Thus, motivation to provide breastfeeding support may also be shaped by a broader sociocultural context. Truly understanding the underlying mechanisms of what motivates professionals' reasoning to support with breastfeeding may be the first step to addressing these mechanisms.

To this date, there are no known published studies exploring professionals' motivations to provide breastfeeding support in the Netherlands. The present study will explore what motivates professionals to provide breastfeeding support, using cultural schema theory. Cultural schema theory is a cognitive-anthropological theory that may help understand how professionals' individual values and beliefs about breastfeeding and breastfeeding support and their personal experiences with breastfeeding and breastfeeding support motivate their reasoning to support with breastfeeding to mothers (D'Andrade, 1992).

1.2 Objective and research questions

The aim of this study is to obtain a better understanding of how individual values, beliefs, and personal experiences with breastfeeding and breastfeeding support of professionals motivate their reasoning to support with breastfeeding to mothers. Understanding these underlying mechanisms may help to improve current breastfeeding support offered by professionals in the Netherlands. Thus, the overall research question is: *'How do professionals' individual values, beliefs, and experiences with breastfeeding and breastfeeding support motivate their reasoning to support mothers with breastfeeding in the Netherlands?'*.

1.3 Societal relevance

Understanding what motivates professionals' reasoning to support mothers with breastfeeding may eventually help formulate policies that aim to address breastfeeding support more effectively in the first weeks after birth. Improving breastfeeding support for mothers is beneficial for mothers, their children, and society in general, because of two reasons. First, adequately helping women in the Netherlands to feed their babies as they desire, whether this is breastfeeding, formula feeding, or a combination, may improve mothers' psychosocial wellbeing. Women can experience feelings of guilt and insecurity about the way they feed their baby (Holcomb, 2017). Addressing issues that women experience with feeding their child adequality may reduce such feelings of guilt and insecurity and hopefully contribute to their wellbeing. Second, helping women who want to continue breastfeeding as they desire, may be beneficial for public health in general. In the Netherlands, the share of women breastfeeding

their babies at birth is decreasing, with 80% of women initiating breastfeeding in 2015 compared to 69% of women in 2018 (Engelse & van Dommelen, 2018; Peeters, Lanting, & van Wouwe, 2015). Breastfeeding has numerous public health benefits for both mother and child, such as reduced risk of childhood obesity and reduced risk of maternal cancers (Binns, Lee, & Low, 2016; de Beer et al., 2015). Therefore, helping women to continue breastfeeding as they desire may support their own health and indirectly affect public health.

1.4 Thesis structure

In the following chapters, the theoretical background (chapter 2), the methods (chapter 3), the findings (chapter 4), and the discussion and conclusion (chapter 5) will be described. Chapter 2 will elaborate on cultural schema theory and the literature review. Chapter 3 will describe the study approach, study population and context, how participants were recruited, and how data was collected and analyzed. Chapter 4 will present the findings from the interviews. And finally, chapter 5 will discuss and conclude the findings, the strengths and limitations of the present study, and the implications and recommendations.

2 Theoretical framework

2.1 Cultural Schema theory and literature review

The present study uses cognitive-anthropological cultural schema theory. The theory helps to get an in-depth understanding of how personal experiences together with sociocultural context motivates professionals' reasoning to support with breastfeeding. A schema is *"a simplified interpretative framework used to understand events"* (D'Andrade, 1992, p. 48). Schemas can, among other things, consist of values and beliefs, personal experiences and emotions. How certain events are interpreted by an individual is shaped by broader cultural values and beliefs in interaction with their personal experiences. Cultural values and beliefs are shared by a group, while experiences are more personal. Schemas are dynamic and change constantly over time because they are shaped by cultural and psychological processes that are exposed by lifelong cultural input and personal experiences. There is a continuous internal psychological interaction between values and beliefs and personal experiences when interpreting events (D'Andrade, 1992). The interpretation of such events may lead to certain human actions, depending on motivational goals (D'Andrade, 1992). For instance, two professionals may have similar individual schemas. But if one professional prioritizes to care for the mother's wellbeing while the other focusses on the feeding and health of the baby, then this may lead to different types of actions. In this section, I will further elaborate on individual values and beliefs together with personal experiences.

Motivational force and conflicting schemas

Cultural schema theory assumes that schemas have a certain hierarchy and that the hierarchical structure influences the amount of motivational force a schema has. In descending order of the hierarchy, there are high-, middle-, and low-level schemas. High-level schemas are linked to more universal goals – such as financial security or wellbeing – and have the highest motivational force. Middle-level schemas sometimes need higher-level schemas to generate goals but can also generate their own goals. In contrast, low-level schemas can only generate goals if these lower-level schemas interact with higher-level schemas (D'Andrade 1992 in: de Haas, 2017). For example, providing breastfeeding support as a low-level schema does not generate reasoning for support. But if providing breastfeeding support is linked to a higher-level schema, such reducing stress for a mother to improve her wellbeing, then together this may generate a professional's reasoning for support.

How schemas are internally linked matters for the motivational force, leading to certain reasonings for breastfeeding support. For example, in the present study, a high-level schema of a professional could be mother's health. If a professional feels that breastfeeding contributes to the mother's health, this will lead to another reasoning for support compared to a professional who thinks that formula feeding and breastfeeding are equally good for the baby, but that breastfeeding can cause more stress in the mother compared to formula feeding. These two professionals, with the same higher-level schema, have different middle- lower-level schemas, resulting in different reasonings for providing breastfeeding support. Furthermore, schemas can be conflicting (de Haas & Hutter, 2019). For example, professionals could reason that formula feeding would be better for a mother because it reduces stress and improves the mother's wellbeing. But this reasoning could conflict with the notion that breastfeeding is the

best type of infant feeding, as is indicated by guidelines or learned via education provided by the organization. How professionals cope with these conflicts may depend on their individual strategies (de Haas, 2017).

Individual values and beliefs

How professionals motivate their reasoning for breastfeeding support may depend on their individual values and beliefs. In this thesis, values are defined as *"an enduring belief that a specific mode of conduct or end-state of existence is personally or socially preferable to an opposite or converse mode of conduct or end-state of existence"* (Rokeach, 1973, p. 5). Beliefs are thus concepts that people assume to be true, based on their emotions rather than objective facts. Values follow from these beliefs and motivate people's reasoning for behavior (S. H. Schwartz, 2006). For example, professionals could *value* breastfeeding over formula feeding based on the *belief* that breastfeeding is better – e.g., healthier for the baby or mother, good for attachment between mother and child – than formula feeding. Values can differ in their motivational force and can thus be a schema at each level of the hierarchy (D'Andrade, 1992; S. H. Schwartz, 2006). For example, professionals could both value a healthy mother and a breastfed baby but, if necessary, could value a healthy mother over a breastfed baby. As with other schemas, values and beliefs can change over time because the sociocultural context on which preferences are based constantly change (S. H. Schwartz, 2006).

Previous studies found that different values and beliefs at the personal, social, and cultural level facilitate or hamper professionals to support women with breastfeeding. On a personal level, professionals experience that personal attitudes can be a facilitator or barrier when providing breastfeeding support. Attitudes can relate to professionals' preferred type of feeding or their attitudes towards parents (Baker, Evans, Fielden, & Arnott, 2021). Having negative attitudes towards breastfeeding and lacking confidence in a mother to proceed breastfeeding hampers adequate breastfeeding support. Moreover, a discrepancy in attitudes towards breastfeeding between mother and professionals was named as barrier to provide breastfeeding support (McInnes & Chambers, 2008). Not only having positive or negative attitudes matters, but also how professionals view breastfeeding in general. In some studies, professionals appeared to speak of breastfeeding in a medical manner (McInnes & Chambers, 2008), or referred to the medicalization of breastfeeding and obstetrics in general as factors that influence breastfeeding support (Whelan & Kearney, 2015). When looking at breastfeeding medically, professionals tend to primarily focus on the growth of the baby or the objective milk intake as indicators of how successful breastfeeding is, rather than considering the wellbeing of both mother and baby more holistically. This can be a barrier if mothers seek help because they experience breastfeeding negatively due to stress, regardless of how well the baby drinks and grows. From a medical perspective, formula can be experienced as the safer option because both mothers and professionals know exactly how much milk the infant drinks (Whelan & Kearney, 2015). In contrast, professionals named a holistic view, where the focus is not only on medical aspects of breastfeeding but also on psychosocial factors related to breastfeeding, as a facilitator for providing breastfeeding support (McInnes & Chambers, 2008; Whelan & Kearney, 2015). Furthermore, attitudes could conflict with what professionals experience on the social and cultural level. For example, professionals who had positive attitudes towards breastfeeding, sometimes felt that marketing of formula and their personal

breastfeeding experiences conflict with these attitudes, negatively affecting the support they provided with breastfeeding (Baker et al., 2021).

In numerous studies, professionals also mentioned factors at the occupational or organizational level as facilitators and barriers for providing breastfeeding support. Professionals who valued training and new developments as an important part of their job, were more motivated to invest in breastfeeding support training (Anstey et al., 2018; Whelan & Kearney, 2015). However, investing in breastfeeding support training was not always possible due to increasing work pressure or the lack of training opportunities (Anstey et al., 2018; Baker et al., 2021; Llorente-Pulido, Custodio, López-Giménez, & Otero-García, 2021; McInnes & Chambers, 2008; Swerts, Westhof, Lemiengre, & Bogaerts, 2019; Whelan & Kearney, 2015) In other studies, professionals named conflicting information about breastfeeding as a barrier for providing breastfeeding support (Anstey et al., 2018; Llorente-Pulido et al., 2021; Whelan & Kearney, 2015). Furthermore, the presence of guidelines was mentioned as a facilitator of providing adequate breastfeeding support (Anstey et al., 2018; Burns, Duursma, & Triandafilidis, 2020; McInnes & Chambers, 2008; Whelan & Kearney, 2015). However, adherence to guidelines may depend on if and how these guidelines are communicated, whether they accommodate for contextual differences, and whether they are in line with professionals' personal values (Pilbeam et al., 2022). Other occupational factors that were mentioned in the reviewed studies were having access to information and knowledge about breastfeeding, and organizational coordination (Anstey et al., 2018; Burns et al., 2020; McInnes & Chambers, 2008; Whelan & Kearney, 2015).

At the cultural societal level, professionals named general attitudes towards breastfeeding in society and the marketing of formula as important facilitators or barriers for breastfeeding support. Working in a society that is not breastfeeding oriented may make it more difficult to address issues that women experience regarding feeding in public, or the opportunities women have to combine breastfeeding with work (Anstey et al., 2018; Baker et al., 2021). This could cause a conflict between what professionals believe and want to advice women and what they believe is achievable in day-to-day life. For example, the Netherlands has mixed breastfeeding friendly policies. Mothers are expected to return to work only three months after birth (Theurich et al., 2019). And although there are Dutch laws that allow women to express milk or feed their baby during working hours during the first nine months after birth, not all organizations adopt and apply these laws (e.g., Hentges & Pilot, 2021).

Personal experiences

Next to individual values and beliefs, professionals' motivations for providing breastfeeding support may also be generated by their personal breastfeeding experience, by personal experiences of receiving breastfeeding support, and by personal experiences with providing support. Previous studies found that professionals who had personal breastfeeding experiences felt more confident in providing support with breastfeeding compared to professionals who did not have such experiences (Baker et al., 2021; Whelan & Kearney, 2015). However, there may be differences in views on breastfeeding among professionals who have personal breastfeeding experiences, simply because they have had very different breastfeeding experiences, varying from very positive to very negative experiences (Baker et al., 2021; Whelan & Kearney, 2015). Also, past experiences with providing breastfeeding support may motivate professionals' reasoning for breastfeeding support (Furber & Thomson, 2008). For instance, professionals

who have a lot of experience with providing breastfeeding support have acquired more knowledge about what works and what not when helping women compared to professionals who have little experience (Bäckström, Wahn, & Ekström, 2010). Last, experiences with receiving support themselves may function as a guide for professionals on how to, or how not to, provide support.

2.2 Conceptual model and expectations

Based on cultural schema theory and the literature review, it is expected that individual values and beliefs about breastfeeding and breastfeeding support, interacting with personal experiences with breastfeeding and breastfeeding support, shape the motivations of professionals for providing breastfeeding support. Furthermore, it is expected that the motivational force of a schema depends on the perceived importance of certain values, beliefs, and personal experiences. Last, it is expected that if schemas are conflicting, professionals will describe strategies for coping with these conflicting schemas. Figure 1 shows a deductive conceptual model, summarizing the expectations. It shows that the interaction between the individual schemas 'values', 'beliefs', and 'experiences' are embedded in a wider sociocultural context. Professionals' reasoning for breastfeeding support is shaped by the interaction between these three schemas and depends on the motivational force of a schema.

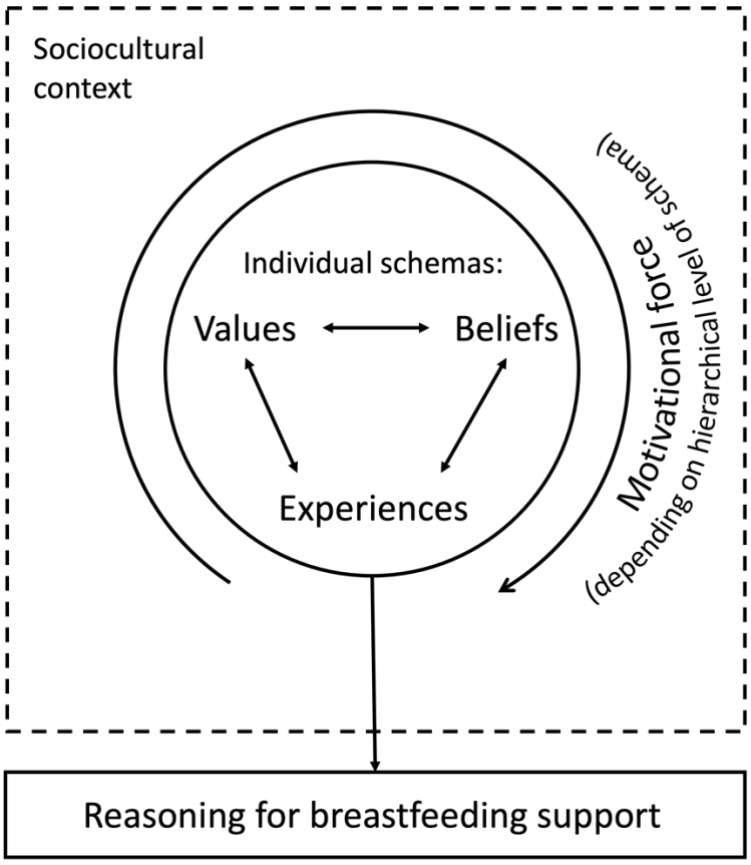

Figure 1. Deductive conceptual model

3 Methods

3.1 Study approach

Interpretive paradigm and qualitative research methods

In social science research, including the field of demography, the positivist paradigm is the most dominant paradigm. Positivism assumes that reality can be observed and measured objectively, without any influence of the researcher on the study process. Conducting research within the paradigm of positivism means that measurable hypotheses are derived from theory. These hypotheses are then statistically tested using empirical data. The positivist paradigm has received numerous critique in social research, because it neglects the human aspects of both researchers and participants (Hennink, Hutter, & Bailey, 2020).

As a response to the positivist paradigm, the interpretive paradigm emerged within social sciences. Interpretivism acknowledges the human features and influences of both researchers and participants in the research process. Moreover, the interpretive paradigm assumes that reality is not objectively measurable, but that reality is socially constructed by people. Social constructivism of reality considers that reality is based on individuals' historical, cultural, social, and personal contexts as well as their own personal experiences and perceptions. The interpretative paradigm can be best explained by showing the difference between *Verstehen* from the emic perspective versus *understanding* from the etic perspective. From the emic perspective, researchers aim to develop an insiders' perspective, by understanding insiders' opinions and beliefs. In contrast, from the etic perspective, researchers try to understand events based on their own points of view, and their own opinions and beliefs. The emic perspective is closely linked to Verstehen, whereas the etic perspective is linked to understanding. Qualitative research is commonly conducted within the interpretive paradigm, from the emic perspective, and aimed to achieve Verstehen (Hennink et al., 2020).

The present study was conducted primarily from the interpretive paradigm with adopting some aspects of the positivist paradigm. On the one hand, conducting research within the interpretive paradigm is most appropriate for this study because it allows to get an in-depth understanding of professionals' motivations, by collecting data about experiences and perspectives of professionals regarding breastfeeding support from their own point of view, using their own words, and within their own sociocultural context. On the other hand, aspects from the positivist paradigm, such as the use of theory and the formulation of expectations and a conceptual model, helps to create coherence and guides the researcher throughout the research process (Hennink et al., 2020).

More specifically, semi-structured in-depth interviews were conducted. In-depth interviews facilitates getting insight into mechanisms, such as schemas, that motivate reasoning for breastfeeding support (Hennink et al., 2020). The interviews were semi-structured because it allowed to collect information both deductively, based on the literature and conceptual model, and inductively. Moreover, using a semi-structured interview guide gives participants more agency in deciding which topics and in what order they are discussed. Semi-structured interviewing gives a more conversational experience to the interviewee, helping the interviewee feel more comfortable to share their experiences and views. The next paragraph

will elaborate on the research process and the role of deductive and inductive reasoning and the data collection.

The Hutter-Hennink Qualitative Research Cycle

This study was conducted based on the Hutter-Hennink Qualitative Research Cycle (HH-QRC). Figure 2 gives a schematic summary of the HH-QRC. The HH-QRC is a qualitative research framework that integrates elements of the positivist and interpretive paradigm (Hennink et al., 2020). The integration of the positivist and interpretive paradigm means that this research is conducted both deductively as inductively. Deductive reasoning means that the study is guided by theory, that is in line with the positivist paradigm. In contrast, inductive reasoning encompasses the process of theory building based on data, that is more in line with the interpretive paradigm (Hyde, 2000). The HH-QRC acknowledges that inductive and deductive reasoning are interlinked, because a researcher always has preset ideas and assumptions about reality, guided by a theoretical lens (Hennink et al., 2020). The HH-QRC is a cyclical framework that makes it possible to go back and forth between different stages of the research process. This allows to deductively go through the design, ethnographic, and analytic cycle, while also going back and forth within and between these cycles based on inductive findings and new insights (Hennink et al., 2020).

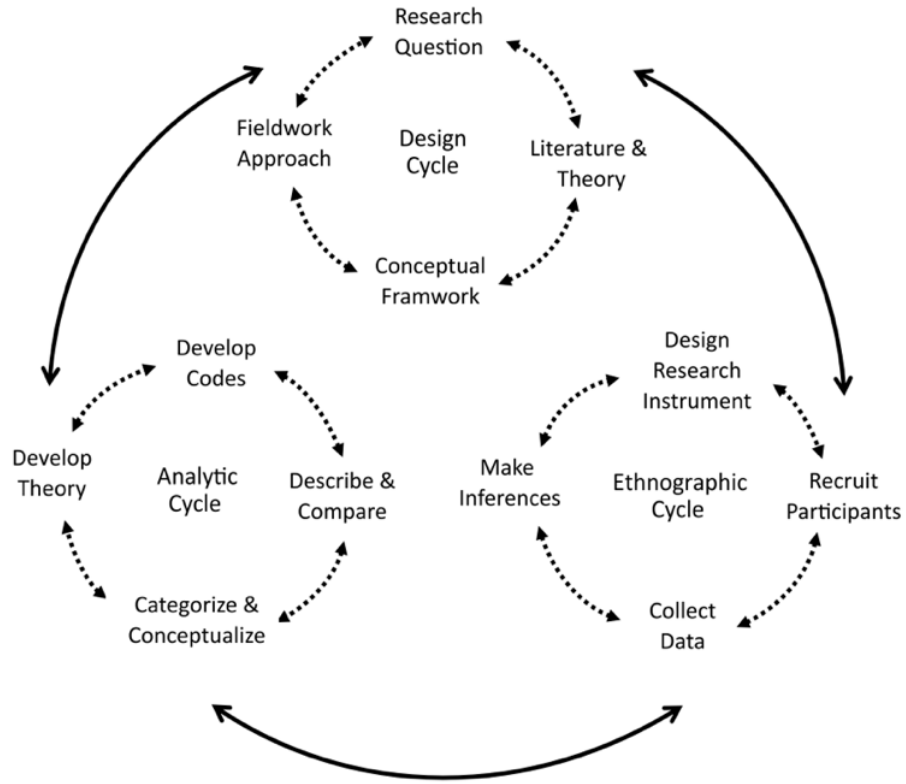

Figure 2. The Hutter-Hennink Qualitative Research Cycle (Hennink et al., 2020, p. 322)

3.2 Study population and context

Because breastfeeding cessation in the Netherlands is largest in the first month, the present study focused on professionals who are mainly involved in this period: maternity care assistants and professionals working at well-baby clinics. The Netherlands has a unique maternity and childcare system. During the first eight to ten days after birth, mothers and their babies receive postpartum care at home that is for a large part covered by all Dutch insurances (Laureij et al., 2021). During this week, a maternity care assistant visits the home to monitor and care for the mother and baby, teaches the young parents how to care for their baby, and provides some domestic help. This is often also seen as an important moment for mothers to get support with breastfeeding their baby (Laureij et al., 2021; Wiegers, 2006). After this first week, parents are informed that they can make free use of well-baby clinics, or in Dutch 'consultatiebureau'. This is a national governmental public health organization that organizes the national vaccination program, offers to weigh the baby, take other measurements, and monitors the child's development. Parents can make use of this service for free until their baby reaches the age of four. Often, nurses working in well-baby clinics visit families at home two weeks after birth. The first visit to the well-baby clinic by parents and their babies is around four weeks after birth (Rijksoverheid, 2022). The present study included maternity care assistants and nurses and physicians working in well-baby clinics, hereafter combinedly indicated as professionals.

There are also other professionals that could provide breastfeeding support in the first weeks after birth, but it was decided to not include these professionals because of several reasons. First, Board-Certified Lactation Consultants working in the Netherlands were not included because they are not covered by basic insurance. A consult can be expensive, and are therefore not accessible for all women living in the Netherlands (van Paassen et al., 2016). Especially women with lower financial means, that are more likely to stop breastfeeding (Thulier & Mercer, 2009), depend their professional help mostly on maternity care assistants and well-baby clinic professionals. Moreover, Board Certified Lactation Consultants are extensively trained in providing breastfeeding support and their primary job is supporting families with breastfeeding (van Paassen et al., 2016). This makes Board Certified Lactation Consultants substantially different compared to a maternity care assistant or well-baby clinic professional, who received far less training and have many other tasks. Second, it was decided to not include nurses working at maternity wards in the hospital. Not all women who give birth can go home and receive maternity care at home. Some women stay in the hospital because of their own health, their baby's health, or both. Women in this situation may face many different challenges that may directly or indirectly affect the successfulness of breastfeeding. Therefore, professionals working with hospitalized mothers and babies may face very different challenges compared to professionals working with mothers and babies who are at home.

The present study was conducted in the province Groningen, which is the most Northern province in the Netherlands. Groningen is an interesting area because of two reasons. First, the overall socioeconomic status in the region is lower than in other regions in the Netherlands. Women with lower socioeconomic status less often breastfeed and have fewer financial resources to get specialized help from a lactation consultant if necessary (Ruijsbroek, Wijga, Kerkhof, Koppelman, & Smit, 2011; van Paassen et al., 2016). Therefore, aiming to improve

free or low-cost postnatal breastfeeding support may be particularly helpful for this region. Moreover, because of the lower socioeconomic status, nutrition-related diseases, such as obesity, are more prevalent in Groningen compared to other regions in the Netherlands (RIVM, 2020). Breastfeeding is associated with fewer nutrition-related diseases in later life (de Beer et al., 2015; Yan, Liu, Zhu, Huang, & Wang, 2014). Therefore, improving breastfeeding circumstances may be helpful for women and children living in Groningen. However, the impact of this study on nutrition-related diseases is likely to be negligible.

3.3 Participant recruitment

Participants were recruited in several ways. Appendix A shows the flyer used when recruiting participants. First, I contacted self-employed maternity assistants directly via e-mail. Maternity care assistants working in larger organizations were more difficult to reach, because I could not contact them directly. Thus, I e-mailed general e-mail addresses provided on these organizations' websites. Second, I visited all eight well-baby clinics in the city of Groningen at least once. During some visits I only saw the secretarial assistant, who I briefly informed and gave multiple flyers. I asked if they could spread the flyers among the nurses and physicians working in the clinic. During other visits I was able to directly talk to a nurse, who were generally very interested and willing to share my flyer among colleagues. After a couple of weeks of recruiting, I received an e-mail by a pediatric physician working in one of the well-baby clinics who wanted to assess my research before sharing it with all well-baby clinics. This assessment was approved, whereafter they shared my information directly to all nurses and physicians in Groningen via e-mail. Furthermore, after I conducted my pilot interview with a Board-Certified Lactation Consultant, she also shared my e-mail with lactation consultants working in well-baby clinics, who then in turn e-mailed other professionals working in these clinics. Lastly, I shared my flyer via LinkedIn twice, a social media platform for professionals to connect and network.

In the end, eight professionals responded in several ways: one maternity care assistant working in a larger organization and two self-employed maternity care assistants replied directly to my e-mail, one maternity care assistant filled in my Google Form based on the flyer shared on LinkedIn, one well-baby clinic nurse gave me her e-mail address when I visited her clinic, one well-baby clinic nurse filled in my Google Form after being informed by a co-worker, and one well-baby clinic nurse and a physician e-mailed me after reading the e-mail spread by a co-worker that included my information and flyer.

Participant characteristics

Table 1 gives an overview of some basic characteristics of the participants in this study. In total, four maternity care assistants with pseudonyms Margreet, Lisa, Anne, and Fleur, participated in the study. Their working experience varied from about 5 to 36 years. There is some uncertainty about Lisa's number of years of working experience, because she indicated that she is self-employed for about three to four years after working for a couple of months for a larger organization. Furthermore, three well-baby clinic nurses participated in the study, with pseudonyms Marije, Rinske, and Hanneke, who had working experience varying from 7 to 31 years. Rinske, who has a total of 15 years working experience, worked at the pediatric ward in a hospital for ten years, where she also worked with newborn babies and new mothers.

Hanneke, who has a total of 31 years working experience, worked ten years in obstetrics and gynecology before she started working as a well-baby clinic nurse. Last, one well-baby clinic physician, with pseudonym Esther, participated and had a little under one year of working experience. What is noticeable is that all participants are women.

Table 1. Overview of participants' pseudonyms, years of working experience, occupation, and type of organization or neighborhood.

#	Pseudonym	Gender	Years of working experience	Occupation	Type of organization or neighborhood*	Personal breastfeeding experience
1	Margreet	Female	36	Maternity care assistant	Small organization	No
2	Lisa	Female	±5	Maternity care assistant	Self-employed	Yes
3	Anne	Female	6	Maternity care assistant	Self-employed	Yes
4	Marije	Female	7	Well-baby clinic nurse	Suburb with very mixed SES	No
5	Fleur	Female	14	Maternity care assistant	Self-employed	Yes
6	Rinske	Female	15	Well-baby clinic nurse	Urban area with middle/low SES	Yes
7	Hanneke	Female	31	Well-baby clinic nurse	Small town with mixed SES	Yes
8	Esther	Female	<1	Well-baby clinic physician	Small town with middle/low SES	Yes

* Type of organization for maternity care assistant and type of neighborhood (location and socioeconomic context) for well-baby clinic professionals.

Selection bias

It is important to note that there was selection bias when recruiting participants. Because professionals were invited via e-mail and because participation required some effort as in-depth interviews are time consuming, professionals with an interest in the topic primarily responded to my call for participants. For example, almost all professionals working in the well-baby clinics did an extra schooling to become a breastfeeding coach, which is not a mandatory schooling of their profession. Moreover, self-employed maternity care assistants indicated that their population of clients were more likely to breastfeed their child compared to families that receive maternity care from larger organizations. They reasoned that parents who want a self-employed maternity care assistant are overall more into "natural parenting", a parenting style that focusses primarily on the child's natural physical and emotional needs. These parents usually breastfeed on demand, cosleep with their child, and carry their children extensively on the body with a carrier (Schön & Silvén, 2007).

The selection bias, where professionals with an interest in breastfeeding mainly replied, could have been prevented by changing the wording on the flyer and in the e-mails. The focus

of the flyer and e-mails was on professionals' experiences with breastfeeding support. Changing this wording into support with feeding, thus including formula feeding too, could sound more appealing to professionals who are less interested in or experienced with providing breastfeeding support. Including this group of professionals would have been very interesting, as a difference in motivations between professionals may have been more pronounced.

3.4 Data collection

Data was collected using semi-structured in-depth interviews. In-depth interviews are an appropriate method *"when seeking information on individual, personal experiences from people about a specific issue or topic"* (Hennink et al., p. 117, 2020). This method is typically used when identifying, among other things, people's motivations for certain behaviors, their feelings and emotions, and their beliefs and perceptions. In-depth interviews allowed to get insight into how schemas *motivate* professionals' reasoning for providing breastfeeding support. Semi-structured means that the interview guide follows a typical structure, with an introduction, some opening questions to build rapport, key questions containing topics – derived from theory and the literature review –, and closing questions (Hennink et al., 2020).

The decision for the use of a semi-structured guide was based on two reasons. First, it allowed to ask all participants about the same topics deductively derived from theory and literature. Second, not completely structuring the interview allowed the participants to have more agency in suggesting new topics and in what order the topics were discussed. This ensured that they shared what they thought was important, rather than having to prompt for what I thought was important. Table 2 shows the operationalization of the interview guide. Appendix B shows the final interview guide in Dutch.

Furthermore, different types of probing questions were used during the interview. Some were formulated in the interview guide; others were not formulated beforehand but used during the interview depending on what the participant shared. Topical probes were formulated based on the theoretical framework to ensure an in-depth understanding of what the participant shared during the interview. Moreover, motivational probing was used during the interview to encourage participants to share their views. There are different types of motivational probing, such as reflective, silent, and expansive probing. Reflective probing refers to the interviewer summarizing what is said to ensure that they have understood the interviewee correctly. This type of probing was not included in the guide but was used during the interview. Silent probing refers to the interviewer staying silent for a couple of seconds to give the interviewee the opportunity to continue sharing their views. Again, silent probes were not indicated in the guide, but sometimes silence was used during the interviews to encourage participants to continue their story. Expansive probing refers to the interviewer asking about examples to acquire more information (Hennink et al., 2020). Such probes were included in the interview guide. In table 2 the type of probe per probing question is indicated.

All interviews were audio recorded with permission by the participants and then transcribed verbatim as preparation for data analysis. Before conducting the interviews, a pilot interview was conducted with a Board-Certified Lactation Consultant. The decision was made to test the interview guide with a lactation consultant because she could give additional information and feedback based on her lactation consultant expertise. Based on the pilot

interview, the wording of some of the questions were changed to make them easier to understand. The lactation consultant was also asked whether she thought if the interview guide should be adapted to the type of professional who was interviewed, but she said that the questions were general enough that they would be appropriate for both maternity care assistants and well-baby clinic professionals.

Table 2. Conceptualization of the interview guide from theory and literature.

Function	**Questions and probes**
Introductory questions	
Building rapport	Could you tell me something about your current job?
	a. How did you get here?
	b. What does your working day look like?
Building rapport	Could you tell me something about your professional past?
	a. Education
	b. Professional experience
Building rapport	Could you describe yourself as a professional?
Building rapport	a. What characterizes you?
Motivation/personal goals	
Topical probe	b. What motivates you? / What made you want to work as a XX?
Expansive probe	c. How does this manifest itself in your job?
Individual values and beliefs about breastfeeding	
Key question	What comes up when you think about breastfeeding?
Topical probe	a. Why does this come up? What do you associate with breastfeeding?
Topical probe	b. What role plays the context of mother's home situation?
Topical probe	c. What do you think about formula feeding?
Topical probe	d. Have your views on infant feeding changed over the course of time? If so, in what way? And why?
Personal experiences with breastfeeding	
Key question	Could you tell me something about any personal experience with breastfeeding? *This could be a personal breastfeeding experience, or from a partner or someone else within you family or close social circle.*
Topical probe	a. Could you tell me how this has affected you as a professional?
Expansive probe	b. And how does this experience manifest itself in your job?
Individual values and beliefs about breastfeeding support	
Key question	What comes up when you think about breastfeeding support?
Expansive probe	a. Why does this come up?
Topical probe	b. Has this changed over the course of time? If so, in what way? And why?
Key question	Could you tell me something about your role as a professional when helping and supporting women with breastfeeding?
Key question	What characteristics do you feel are important for a professional when they help and support women with breastfeeding?
Expansive probe	a. Why do you think these characteristics are important?
Professional experiences with breastfeeding support and occupational context	
Key question	Could you tell me something about your professional experiences with breastfeeding support?
Expansive probe	a. Examples?
Topical probe	b. Barriers and facilitators of breastfeeding support?
Topical probe	c. Role of guidelines
Topical probe	d. Role of training/education
Key question	How do other professionals in your profession think about breastfeeding?

Table 2. (continued).

Function	Questions and probes
Professional experiences with breastfeeding support and occupational context	
Expansive probe	a. How do you notice this in your profession?
Key question	How do other professionals in your profession think about help and support with breastfeeding?
Expansive probe	a. How do you notice this in your profession?
Sociocultural context	
Key question	How do you think people in the Netherlands think about breastfeeding?
Expansive probe	a. Why?
Topical probe	b. How do you notice this in your job?
Key question	How do people in your close social environment think about breastfeeding?
Expansive probe	a. Why?
Closing questions	
Closing the interview	What do you think about the way professional help and support with breastfeeding is organized in the Netherlands? a. Why? b. Is there something you would like to see differently?
Closing the interview	What would you like to tell other professionals who help and support women with breastfeeding?
Closing the interview	Is there something that we have not discussed during the interview, but that you would like to share with me?

Reflection on the interviews and positionality

When planning the interviews, I asked all participants where they would like to be interviewed, at a location of their choice, at the university, or online if an in-person meeting was not possible. Six interviews were conducted at the faculty of Spatial Sciences at the University of Groningen, one at the office of a well-baby clinic nurse and one online. All in-person interviews were conducted in a private, quiet setting, where no other people could listen or intervene. The duration of the in-person interviews varied from one hour to two hours and 15 minutes. In contrast, the interview conducted online was less private because the interviewee had to share her office with a co-worker. Although her co-worker could not hear me, she could hear my participant talking. Moreover, she was on a time limit, resulting in an interview of an hour. Although all key topics were discussed during the interview, the reliability of this interview could be questioned. For example, when asking the participant about how she would characterize herself as a professional, she laughed and said that she looked at her co-worker. This gave me the impression that she felt a little uncomfortable to reflect on herself in that way while her co-worker could hear her.

In qualitative research, positionality and subjectivity of the researcher can influence how the participant responds, thus indirectly influencing the quality of the data collected during the interviews. Positionality means the way you portray yourself as researcher. The researcher's gender, appearance and attitude will influence the way participants perceive the researcher. Subjectivity means that the researcher's own characteristics, such as background or perceptions, influence the research (Hennink et al., 2020). It is thus important for a researcher to think about and reflect on how they will present themselves, how participants might react to their presence, and what their own impressions are of the participants (Hennink et al., 2020).

I have faced some challenges related to my positionality and subjectivity when interviewing the professionals, while also enjoying some advantages that came with my own experiences and background. What is first and foremost important to note is that I am not only a student, but also a young mother who was still breastfeeding her eleven-month baby at the start of the interviews. I stopped breastfeeding around the third interview. In most interviews my own experience came up directly because interviewees saw a photo of my child on my phone or because we talked about children before the start of the interview. Often, the participants were positively surprised, saying they expected a younger student, and I felt it helped building rapport. In other interviews, this was not discussed at all, or only after the interview. For example, in the online interview it did not come up at all. Being a mother with breastfeeding experiences had both advantages and disadvantages. First, it made it easier to talk about breastfeeding and easier to understand terminology that these professionals were using. For example, before having breastfed myself, I had no idea about all possible complications that could come with breastfeeding. Now, as a woman who has breastfed their child, it was easier to probe when professionals were talking about breastfeeding and the support they provided. On the other hand, not only during the interviews, but during the whole research process, I had to keep in mind that my own experiences should not influence the whole process too much. During the interviews, I had to make sure to keep an open mind and to not project my own experiences on the perceptions and experiences of these professionals. Next to being a mother, I also have a background in nursing and caregiving. Having these professional experiences sometimes made it easier to understand some of the occupational experiences these professionals had. To me, it felt easier to level with the professionals and to probe. Last, it was sometimes challenging to decide what I wanted to share about my own personal experiences with postnatal care and breastfeeding when the participants asked about these experiences. For example, some professionals asked me about my own experiences with maternity care givers or breastfeeding support. On the one hand, these professionals shared in-depth information about their own, sometimes quite private, experiences. Thus, keeping a distance by withholding my own personal experiences felt unfair. At the same time, I wanted to keep a professional distance. During almost every interview, there was constant balancing between what I did and did not want to share with the participants. For example, at one point, one of the participants shared a story about my own midwife. After the interview, she asked who my maternity care assistant and midwife were. As I did not want to make her feel uncomfortable, I decided not to share the name of my midwife. Another example that occurred often, was professionals asking me about my own experiences with breastfeeding or maternity care before the start of the interview. I then told the participant that I wanted to share my own experiences, but only after the interview because I did not want my own experiences to influence her when sharing her personal and professional experiences.

3.5 Data analysis

Before coding and analyzing the data in Atlas.ti version 22, seven interviews were transcribed manually using F4, a transcribing program, and one interview was transcribed using an automatic transcribing software developed by the Radboud University. This transcribing software ensures privacy because it has no commercial interest and deletes audios and

transcripts completely from its servers once the researcher deletes these files from the software. The decision to try the software was made because manually transcribing is very time-consuming. However, the software was not very accurate and editing the automatically transcribed interviews was at least as time consuming as manually transcribing the interviews. Therefore, it was decided to manually transcribe the remaining interviews instead of using the software.

Reflexive Thematic Analysis

In the present study, thematic analysis was used to analyze the data. Thematic analysis can simply be described as *"[…] a method for identifying, analyzing, and reporting patterns (themes) within data"* (Braun & Clarke, 2006, p. 79). Thematic analysis is a flexible approach that allows for both theory-and-data driven qualitative research. Some of the main advantages of thematic analysis are its flexibility, that it is easy to understand for people with little qualitative research experience, that it can help generate insights that were not anticipated for, and that it helps to give a systematic overview of key features within complex and large data sets. Although thematic analysis is a very flexible approach – allowing for a variety of analytical options – Braun and Clarke (2006) provided guidelines and criteria that helps qualitative researchers to conduct good thematic analysis. Roughly, the six main steps of thematic analysis are: (1) familiarizing yourself with the data, (2) coding the transcripts, (3) generating initial themes, (4) developing and reviewing themes, (5) refining, defining, and naming themes, and (6) writing up (Braun & Clarke, 2006, 2022).

One of the many different approaches to thematic analysis is *reflexive* thematic analysis. In reflexive thematic analysis, the researcher acknowledges their own influence on the research process, by reflecting on their position throughout all the steps of thematic analysis (Braun & Clarke, 2022). The ten core assumptions of reflexive thematic analysis are: (1) the subjectivity of the researcher is a tool and not a bias, (2) interpretation of the data cannot be objectively good or bad, but rather weaker or stronger, (3), a researcher can code the data alone, or through collaboration. However, collaboration does not mean to verify consensus, but to get a deeper understanding of the data, (4) coding is strong if it is both a result of engagement as well as giving the process some distance, by taking a break, (5) themes are based on meanings or shared ideas, not just a summary of the data, (6) themes cannot be identified ahead of the process, they build on the codes, (7) themes are actively produced by the researcher, they do not passively emerge from the data, (8) the analysis is always based on theoretical assumptions that need to be acknowledged, (9) understanding researchers' own perspectives is key to good qualitative research, and (10) creativity is key in data analysis (Braun & Clarke, 2022).

I decided to use reflexive thematic analysis because of two main reasons. First, the possibility to code and analyze the data both deductively as inductively is in line with the HH-QRC as described in section 3.1. Moreover, I am not very familiar with mainly inductive coding and starting the coding process by just coding what I read was very overwhelming. Deductive coding felt more comfortable and helped me to start the coding process and get a feeling of the data. However, the possibility of inductive coding helped me to get insight into themes and mechanisms that I did not anticipate for. Second, reflexive thematic analysis has a large emphasis on reflecting on own assumptions and subjectivity. Because this topic is close to my own heart and because I have personal experiences with the topic, it is important to stay reflective when coding and analyzing the data. My own experience can be a valuable tool

because I may see information that others without these experiences may not see. However, to prevent a biased view, I should stay conscious of my own subjectivity and the role of my own experiences and views while analyzing the interviews.

Reflection on the data analysis process

At the start of the coding process, I began coding with very broad codes, for instance 'attitudes towards breastfeeding', 'attitudes towards formula feeding', 'occupational context', 'organizational context', 'barriers' and 'facilitators' – deductively derived from theory and the literature review. Very soon I began to formulate subcodes to make my broad codes more specific. For example, subcodes of 'attitudes towards breastfeeding' would be 'healthy for the baby' or 'good for attachment', and subcodes for 'organizational context' would be 'breastfeeding seen as important', 'focus on natural parenting' or 'professional has autonomy'. This is where the inductive and deductive coding began to blur, because some of these codes were in line with what was found in the literature review, whereas other codes were formulated based on the data. After a while I got an impression of how participants' values and beliefs about breastfeeding and breastfeeding support together with their professional and personal experiences motivate their reasoning for breastfeeding support. I summarized these schemas with common terms and added a large list of quotes to my findings chapter, to get a deeper understanding of the different ways participants discussed these concepts. Writing the findings was a very iterative process, in which I constantly switched between reading and coding transcripts, adding quotes to my chapter, scraping quotes, and writing the findings. For example, while writing about the beliefs regarding attachment, I read through the transcripts again and browsed through the codes related to attachment to check if this was discussed in other manners than I had written about in the findings chapter. I tried to capture an overall idea about breastfeeding, while also aiming to discuss the differences between participants (Hennink et al., 2020). This meant that I constantly questioned myself: is this what I think is important? Why do I think this is important? And is this shared by more participants or are there differences?

I wanted to get a deeper understanding of participants' motivated reasoning for support, rather than a summary of schemas. During the coding, reading, and writing process, I looked for conflicting schemas as I had expected beforehand that this would occur. There were two overarching conflicts that became apparent while going through all the data. With these overarching conflicts in the back of my mind, I browsed the codes and transcripts again to check how these conflicts were discussed and how participants deal with these conflicts. Furthermore, during a meeting with my supervisor, we had already talked about possible findings and how to structure them. She shared with me an idea from her own research using cultural schema theory, looking at motivated reasoning for providing sexuality education in Uganda. In her theoretical framework she reasoned that a teacher's message also depended on an interaction between three factors: the provider, the receiver, and the overall context (de Haas, 2017). I kept this idea constantly in mind going through all the data and realized that this was relevant for my findings too.

3.6 Ethical considerations and data management

Before the start of the study, the research was approved by the Research Ethics Committee (REC) of the Faculty of Spatial Sciences at the University of Groningen. The application form and letter of approval are added in appendix C. In this application form I extensively considered all possible ethical issues. Among other things, the safety of participants and myself, informed consent and the confidentiality of the participants were considered. To ensure informed consent, I sent an information letter and letter of consent, as shown in appendices D and E, to all participants a couple of days before the interview. At the start of the interview, I asked the participants if they had read the letters and if they had any questions. Thereafter, we signed the letters of consent together, making sure that we both had a signed copy. Next to all ethical considerations, I designed a data management plan before the start of participant recruitment and data collection. Table 3 shows this data management plan.

Table 3. Data management plan.

What data will be collected?	Where will it be stored and how will it be secured?	What will be done with the data after the research project is finished?
Phase 1: participant recruitment		
Participant's name, e-mail address, telephone number	In Google forms, made from my university of Groningen account that is protected with a two-way verification: a personal password and an authenticator code that I can only access through my phone which is also secured with a personal password.	After participant recruitment is finished, I will delete the Google Forms and all data that is collected through these forms.
Participant's name, e-mail address	On my University of Groningen e-mail account that is protected with a two-way verification: a personal password and an authenticator code that I can only access through my phone which is also secured with a personal password.	After I finished my thesis project, I will delete the e-mail correspondence with my participants.
Participant's name, e-mail address	I will summarize all information about (potential) participants in a secured Excel sheet that I can only access through a password on my iCloud, which is also protected with a personal password. I will do this because it helps me to keep up to date who I have contacted already, who has replied to my e-mail(s) and who has and has not agreed to participate in my study.	After I have finished my thesis project, I will delete the password protected Excel sheet.
Participant's name, e-mail address, signature	A couple of days before the interview, I will send the participant's an information sheet and letter of consent. The participant must sign the letter of consent with their personal signature. Moreover, if the participant wishes to receive a copy of the transcript of the interview, they can note their e-mail address on the letter of consent. The signed letters of consent will be	After 5 years, the signed letters of consent will be destroyed.

Table 3. (continued).

What data will be collected?	Where will it be stored and how will it be secured?	What will be done with the data after the research project is finished?
Phase 1: participant recruitment		
	stored in my supervisor's office that is secured with a lock, only accessible by her.	
Phase 2: the interview		
Participant's occupation and personal experiences, values, and beliefs regarding breastfeeding and breastfeeding support.	With permission, I will audio record the whole interview. I will upload the recording to my laptop immediately after the interview at the location where the interview took place. If I have access to the internet, I will upload the recording to the UWP of the University of Groningen. If I do not have access to the internet, I will save the recording to a secured folder on my computer. Once home, I will move the recording to the X-drive of the University of Groningen which is secured via a password and double authenticator code that I can only access through my phone which is also secured with a personal password.	The audio record will be destroyed once the master thesis is finished.
Participant's occupation and personal experiences, values, and beliefs regarding breastfeeding and breastfeeding support.	I will transcribe the audio record verbatim. The transcript will be anonymized as much as possible. There may be identifiable content (e.g., description of a personal situation). Therefore, the transcript will also be stored on the X-drive of the University of Groningen which is secured via a password and double authenticator code that I can only access through my phone which is also secured with a personal password.	If eventually my thesis will be published in a scientific journal, the transcript will be saved securely. I will store the audio and transcripts on the university Y-drive of my thesis supervisor.
Phase 3: data analysis		
No additional data but the interview transcript	I will do all analyses in the Atlas.ti program that is installed in the secured environment of the University of Groningen. This environment is secured with my personal password and an authenticator code that I can only access through my phone which is also secured with a personal password.	If eventually my thesis will be published in a scientific journal, the transcript will be saved securely on the Y-drive of the faculty that can be accessed by my thesis supervisor.

4 Findings

4.1 Schemas regarding individual values and beliefs about breastfeeding support

Participants' schemas regarding individual values and beliefs were often based on schooling and professional experience, and to a much lesser extend on guidelines. Participants mentioned that they often learned by doing, as will be further explained in section 4.2. Three main schemas on individual values and beliefs about breastfeeding support became clear from the interviews: 'attachment', 'mother's wellbeing, and 'trust and confidence'.

Attachment

All participants felt that an important part of breastfeeding is how it positively affects the attachment between mother and child. Most of the time, attachment was viewed as the emotional bonding between the mother and child. Participants mentioned that breastfeeding helps mothers to recognize the baby's different signals, for instance for being tired or hungry. According to some professionals that participated in this study, recognizing these signals helps mothers to respond adequately to the baby's needs, therefore improving the bond between mother and baby. This perception was often based on schooling and working experience:

> "Because of the training […] you get a lot of information about that, that is just very good for the attachment (between mother and child), say breastfeeding. And I also see it in my, well, seven years of experience as a pediatric nurse among the hundreds of mothers I've seen who breastfed, I also see that it promotes bonding very much. I notice that breastfed babies are calmer. Much less crying, because mothers are more likely to respond to the baby's signals with breastfeeding than with formula."
> - Marije, WBC-N

Not much was said by participants about feeding and attachment between a father or non-feeding mother and baby. When talking about attachment, participants focused mainly on bonding between a mother and child. If participants mentioned the other, non-feeding, parent, they often said that their support to a breastfeeding mother is important to make breastfeeding successful. One participant who did mention bonding between the other parent and baby, said that they can bond with their babies in different ways, mainly by spending time with the baby:

> "Fathers also find it a pity that they cannot give a bottle, that they think: oh I miss that bonding moment. But you can make sure that father, well he then has an important role in changing diapers and clothes, and you involve him (father) very much with that."
> - Marije WBC-N

That breastfeeding and attachment was often linked to the bonding between the feeding mother and baby could be because participants often viewed attachment quite literal. Participants mentioned that breastfeeding physically attaches the baby to the mother as they were connected during pregnancy via the umbilical cord. By some, breastfeeding was viewed as the fourth trimester of pregnancy. As Margreet mentions:

> "A child who is breastfed is simply attached to that mother, however you look at it. And then I think, yes, it's also lived and grown in the belly for nine months. And it's just important that that continues. And with breastfeeding, that just happens automatically."
> - Margreet, MCA

However, participants also felt that attachment can be negatively affected by breastfeeding if breastfeeding enhances feelings of stress in the mother. If this were the case, participants felt that formula feeding, or a combination between formula feeding and breastfeeding, can be a good way to improve attachment between a mother and child:

> "Bonding is also very important the first weeks. So, yes, when a mother looks at their child (and thinks) "Oh my, I have to feed you again and I'm dreading it and it doesn't feel right at all". This is of course also very disruptive for the attachment."
> - Rinske, WBC-N

Almost all participants felt that feeding on demand is very important for attachment, and more often linked to breastfeeding than formula or bottle feeding:

> "I think that with breastfeeding, you're just more likely to listen to your baby, by, by giving what the baby needs, or if you don't know what it wants just to start feeding it. That it creates more calmness compared to just bottle feed every three hours and letting your baby cry in between: 'But it was just fed, he can only be fed again in three hours, so we just leave it (the baby)'".
> - Anne, MCA

Some participants thought that attachment cannot be equally achieved with formula feeding compared to breastfeeding. For instance, Lisa felt that parents who bottle feed usually do not pay as much attention to their baby compared to mothers who breastfeed:

> "But then I think to myself: how nice is it for the baby that you're skin-to-skin with your mother during a feeding, you can smell your mother, you can feel her, her warmth and everything. Personally, I think that that's much more pleasant for a baby compared to what usually happens with bottle feeding. Then a child is often placed in front of them (the parent), the bottle is put in the baby's mouth, and it is simply not looked at, or worse."
> - Lisa, MCA

In contrast, some participants felt that attachment can be equally achieved with breastfeeding and formula feeding, if parents are equally responsive to their child, but that this is less often the case for parents who use formula. For example, Anne mentioned that feeding on demand can also be achieved with formula feeding. However, she felt the type of parents who usually decide to formula feed their baby are people who want structure, which is the opposite of feeding on demand:

> "Because you can give formula, you can give it on demand, but often that part is the reason why people choose formula, because that whole on demand feeding, they don't want to, they want that regularity, so that's why they choose for formula."
> - Anne, MCA

Fleur had similar views as Anne:

> "Yes, well, it's mainly, sometimes people who bottle-feed, formula-feed, that they do want some kind of, well, rhythm."
> - Fleur, MCA

During the interviews it appeared that participants believed that people who breastfeed often do other things that are good for attachment too, such as carrying the baby and skin-to-skin contact:

> "[…] mothers are more likely to respond to the baby's signals with breastfeeding than with formula. Because there's much more skin-to-skin contact, breastfeeding mothers also often carry the baby in a sling. So, you have that attachment even more."
> - Marije, WBC-N

Thus, the participants seemed to motivate their reasoning for the type of support by wanting to help mothers to bond with their child. In their reasoning, participants often focus on attachment between mother and baby, and to a much lesser extend on attachment between baby and the other parent. For some participants, attachment is best achieved through breastfeeding. For others, it is sometimes better to formula feed, as this reduces stress for the mother and improving her feelings towards her baby. Some participants seemed to have strong associations with the type of person that breastfeeds or formula-feeds. By these participants, formula is associated with structure, feeding at set times, and more physical distance between mother and child. Breastfeeding is associated with feeding on demand, skin-to-skin contact, carrying – the so-called natural parenting. This gives the impression that some participants also shape their ideas about the type of parent they care for based on these parents' feeding behaviors. Regardless of their ideas about attachment and feeding, participants seemed to always keep in mind mothers' wellbeing when they reason about the support they provide, as will be shown in the next subsection.

Mother's wellbeing

Most participants felt that how they support mothers with breastfeeding depends on what is best for a mother's wellbeing. This could either mean basing support on what a mother expresses as her wishes and needs, or on what participants themselves observe and perceive as being best for mother's wellbeing.

Almost all participants felt that an important part of their job was to make a mother happy, as this improves other aspects: the baby's wellbeing, the whole family's wellbeing, and mothers' overall health. Some participants were also driven by their personal feelings, as a happy and content mother gives them joy. Other participants said that they can only help a mother if support is based on her wishes, as forcing their own opinions will never work if a

mother is not motivated. Altogether, this meant that if a mother wishes to breastfeed, the participant will do everything to help a mother succeed:

> "I always look for what a mother wants. […] I don't want them all necessarily to breastfeed. I also understand very well that sometimes it just isn't working, or it is not pleasant, or isn't going well. But it is nice to look at: if they still want to but there are barriers, to look at how you can remove those barriers so that it becomes easier for them."
> - Esther, WBC-P

This also meant that participants would do their best to support a mother who wishes to stop breastfeeding, even if they feel like continuing would be an option for the mother. Participants all said that in this or any other case, they would never share their personal preferences with a mother. For example, Hanneke shared during the interviews that she felt that a lot of mothers stop breastfeeding if they experience any, in her eyes normal, challenges. She felt that with the right support, these women could successfully continue breastfeeding. However, she also recognizes that an unhappy, exhausted mother outweighs her personal preference for breastfeeding:

> "Anyway, a woman should not fall apart by it (breastfeeding). Breastfeeding is, I always say that breastfeeding is better than formula feeding. If you put breastfeeding here and formula feeding there, then breastfeeding has advantages. Anyway, it is also a mother who has to give it, but if a mother crushes, then she is of course not much of use to an entire family system. […] If a mother can only breastfeed but is tired and grumpy all day long, I don't think that outweighs the benefits of the milk itself."
> - Hanneke, WBC-N

Securing a mother's well-being is not always based on what a mother tells the professional, but also on what a professional observes. Participants felt that if a mother is persistent to make breastfeeding successful, but they observe a mother who is really struggling and getting more stressed, they would start a conversation with the mother:

> "But if at a certain point you see that a mother also suffers from this, then I am also someone who starts the conversation with: what is your limit? What feels good to you? And [thinks]. I'm not saying you must stop. But: think about it carefully, what do you want, how far do you want to go, when do you still feel good about it? […] So if you can take the load off a bit with that (the conversation), then it can also have a positive influence on it. That maybe temporarily a bottle or something else can sometimes take the pressure off and well, that it, that it goes better afterwards."
> - Rinske, WBC-N

Participants also reasoned that they sometimes differ from breastfeeding guidelines if this is better for mother and baby, and thus serves their needs. For example, Anne shared that there are rules that state that professionals must advise a parent to express milk using a breast pump

or supplement breastfeeding with formula if the baby loses too much weight. But Anne felt that introducing a breast pump is not always in the best interest for the mother and the baby. In these cases, she would ignore the guidelines and base her advice on her own working experience and beliefs in breastfeeding being a natural and self-regulating process:

> "I experience pumping as something, as a kind of burglar in a certain process. Which is sometimes necessary. But if everything goes well, but the baby is just at eight percent (weight loss), I'd rather wait another day. Because a lot can happen in one day. And often it is just that turning point where you see that the next day the baby has grown. And then you have not caused twenty-four hours of unrest by bringing in a breast pump. Because the moment you start doing that, it will become much more restless for that woman and that baby."
> - Anne, MCA

This relates to another reoccurring motivation for participants' reasoning for breastfeeding support: creating a calm environment. Linked to what Anne mentions, most participants felt that keeping a calm environment is best for both mother and baby. Participants reasoned that a calm environment reduces feelings of stress, improving the milk production, and overall breastfeeding experience. In a sense, participants felt like gatekeepers to mother's and baby's wellbeing, where they felt like it is their responsibility to guard mother and baby from stressors. For some participants this meant that their support was rather strict, almost protecting the mother and baby, especially for maternity care assistants who often meet other family members as well:

> "So, a sister comes in with a present and she's blaring over a mother. So, sometimes [laughs] it's also a bit of keeping calm and guarding. I had that in this one family, because at one point there was a mother, a grandmother, a sister, and the radio was on, and the breastfeeding was not going well, and the woman also had pain when feeding. […] That sister was there. But that baby just wouldn't drink. It was very restless. And then I intervene. Then I say: I'm going to turn off the radio now, it should be a bit quiet here. That scares everyone [laughs]. But later I heard that they were very happy with that. And then, it is important to me how mother and baby are doing."
> - Margreet, MCA

Although most participants felt that breastfeeding is usually complicated and challenging at the start, they reasoned that if they saw a mother disproportionately struggling – whether it was mentally or psychologically – introducing formula could bring a lot of peace to not only the mother and baby, but the whole family system:

> "Well, sometimes you can also choose to say: well, you know, you can also […] a part breastfeeding and a part formula. That is also very beautiful. If a child just structurally gets too little nutrition, with all the advice we have given, and it just remains restless. Yes, then I think, give it a go. And if you have a happy baby. Whole system okay. And

sometimes breastfeeding does start again."

- Hanneke, WBC-N

Thus, when providing breastfeeding support, participants seem to aim for what is best for a mother's wellbeing. This notion of what is best could either be based on what a mother tells or asks, or on what a participant observes and perceives as being best for a mother's wellbeing – regardless of participants' personal feeding preference. For some, their reasoning for how to support a mother was not only aimed at securing a mother's wellbeing but also aimed at securing the well-being of the whole family system.

Trust and confidence

Another belief that was shared by most professionals that participated in the study is the importance of trust and confidence when providing support. Participants' support was motivated by trust and confidence in several ways. First, participants felt that their own degree of confidence in the natural process of breastfeeding guided their reasoning for support. This was especially important and explicitly mentioned by the three self-employed maternity care assistants. They shared that they have a lot of trust in the natural process of breastfeeding, giving them the confidence to sometimes disregard breastfeeding guidelines and just wait for nature to do its work:

"If breastfeeding isn't going well in the first few days, then I really don't act right away because the list says: baby has lost more than 10 percent, or is it more than 7 percent, for that matter, that I immediately start supplementary feeding. I have a lot of trust in the body and that it is natural that it (milk production) has not immediately started from day one. And that virtually every woman is physically capable of breastfeeding."

- Lisa, MCA

Moreover, participants felt that a large part of their support is based on giving the mother confidence. This could mean giving the mother the confidence and tools to trust in the breastfeeding process reducing feelings of insecurity and having a more positive breastfeeding experience. For example, participants mentioned that for a lot of mothers, feeling insecure about their own milk production is a reason to stop breastfeeding. They indicated that helping mothers to gain confidence by teaching them other signs that show that a baby is getting enough milk, may reduce feelings of insecurity and help them continue breastfeeding:

"Yes, I think with breastfeeding a lot really comes down to self-assurance and confidence. And being able to let go of: oh but I don't know how much my baby is getting. But I can tell it's happy after feeding it. That it, that it grows, and you will see that in the long run, of course, at the well-baby clinic. That if all that works, that it is precisely the bit of trust that is important."

- Anne, MCA

According to some participants, it also meant that support in general should never make parents insecure. Participants felt that if support is focused on what a parent is doing wrong or giving parents the feeling that they are not doing the right thing, this might influence the relationship

between the parent receiving support and the professional providing support. Thus here, support should rather focus on building confidence, trust, and keeping rapport rather than making parents insecure:

> "And above all, don't say that parents are doing a bad job, or that they're doing it all wrong, or that you make them feel like they're failing, or that they are... Because then they will become completely defensive, and they will no longer be open to help at all."
> - Marije, WBC-N

4.2 Schemas regarding personal experiences with breastfeeding support

During the interviews, two main schemas became apparent that were linked to personal experiences with breastfeeding, experiences of significant others with breastfeeding, personal experiences with receiving breastfeeding support, and participants' own experiences with providing support. First, participants' reasoning for providing support was related to sympathizing with mothers based on own or significant others' experiences with breastfeeding or breastfeeding support. This schema is summarized as 'sympathizing' and was discussed in several ways. Second, participants shared how professional experiences with providing support motivate their reasoning for support, where each professional and personal experience seems to reinforce their knowledge and judgment. This is summarized as 'cumulative learning'.

Sympathizing

When asking about personal or significant others' experiences with breastfeeding, two participants felt that they did not take this into account at all when providing professional support. Participants who did feel that their personal experiences with breastfeeding reflected on them as a professional discussed this in different ways. Some participants said that it was easy for them to sympathize with a mother as they had experienced issues that most mothers face too. For these participants, their own experience could motivate women to continue breastfeeding because they are able to oversee the long-term process of breastfeeding, even beyond the period they provide support, such as the maternity week:

> "So yes, if a woman says: I'm in pain, or I have a really painful let-down reflex, then I know exactly what she's talking about because I've felt it too. I can still feel it, every now and then. […] So yes, I can relate well with mothers in terms of breastfeeding. What they like about it, what they don't like about it. And I've had most of the problems myself. So, I also know it gets better. Even with that very bad experience, I also had very nice experiences fortunately."
> - Lisa, MCA

Sympathy could also mean that participants wished their own positive experiences to others as well, as Fleur explains after I asked her about what motivates her to help a mother with breastfeeding:

> "I have also breastfed, and then you notice that it is just very nice, at least I found it very nice myself. That you see how your child is growing. And that it grows bigger because of your milk. That's just something really beautiful."
> - Fleur, MCA

On the other hand, sympathy could mean that participants want to prevent mothers from having a negative experience that they themselves have experienced. For example, Anne had bad breastfeeding experiences with her first child. Moreover, she had negative experiences with receiving support with breastfeeding from professionals. After having her first child, she became a maternity care assistant. Because her own experience with receiving breastfeeding support had been negative, she was really motivated to help other mothers to have a positive breastfeeding experience and maternity week:

> "I think that motivates me the most. I really think that... Yes. I try to give people a maternity week like I would have liked it myself, I think, yes."
> - Anne, MCA

Cumulative learning

Participants' experiences with providing support seemed to be an important source when providing support. Some felt that guidelines become less and less important when gaining working experience, as they learn how to handle different types of situations by doing. In the beginning of their careers, almost all questions asked by parents are new to them. Therefore, participants ask other professionals for help or look up information in guidelines or other sources. After a while, these experiences help participants to not have to ask or look up everything, because they have done so in the past:

> "Then you say: well, I don't know that right now, but I'm going to find out for you. Then I read into the literature, or I ask colleagues what advice to give. And we have protocols at the [organization] about breastfeeding. I'll go through those. And then I can answer to mother, or to parents. And every, every couple of years you get so many
>
> of the same questions that at some point you just, yes, you learn more and more by just figuring it out."
> - Marije, WBC-N

Other participants shared that they learned by observing other professionals who they have consulted when mothers face problems that they themselves cannot help with. If possible, they would use this information to help other mothers in the future instead of having to consult other professionals:

> "If you ask a lactation consultant to come by and she will help and guide you, I can also learn a lot from that. I also think that's very nice. That I think: oh yes, handy like that, that (breastfeeding) position like that. So, I'll remember that."
> - Fleur, MCA

One participant, Marije, also learned from significant others' experiences that even if mothers want to breastfeed, they have different preferences of how to breastfeed their child, as she noticed with her two sisters-in-law. One of her sisters was very open to help and open about breastfeeding in general, by also feeding in public, while the other withdrew herself often when there were visitors and was less open to help from others. Marije said that she learned to respect those boundaries:

> "So, I took that from that (experience), that you should respect mothers. That you can't just say: I'm going to watch how your feeding is going. But that you really ask: are you okay with that? That you just really consider whether mothers would like that or not."
> - Marije, WBC-N

For some participants, experience over time also changed their personal views on breastfeeding. These participants felt that before they had any experience with breastfeeding, they had romanticized it, whereas after personal and professional experiences they learnt that breastfeeding can be a struggle:

> "So, my own experience and all the questions asked by parents. Yes, that it's not, that it's not always that easy. In the past I used to think: okay, breastfeeding is the most beautiful thing there is, it's fun, it's just working out well […] But it is not always so easy, or painless, or obvious, or possible."
> - Esther, WBC-P

During the interviews, participants spoke differently about schooling, showing differences in the eagerness or the feeling of urgency to learn about breastfeeding. Although all professionals that participated in this study felt that gaining and exchanging knowledge about breastfeeding is an important part of their job to provide adequate breastfeeding support, some participants were more eager to learn than others. For example, Marije and Rinske, both well-baby clinic nurses, had followed an additional breastfeeding schooling to become a breastfeeding coach. Marije was also very motivated to keep up to date with the newest breastfeeding knowledge and insights, and sometimes read articles about breastfeeding in her own time.

4.3 Conflicting schemas between participant's feeding preferences and mother's wellbeing

The interviews showed that most participants aim to improve mothers' wellbeing when providing breastfeeding support. This higher-level goal sometimes conflicts with participants' notion that breastfeeding is the preferred type of feeding: although participants feel that breastfeeding is the preferred type of feeding, they also experience that breastfeeding is not always best for the mother. For example, all participants felt that breastfeeding is good for the attachment between mother and baby, and that breastfeeding is the healthiest for an infant because it contains antibodies and all-important nutrients. But participants also felt that breastfeeding is not always best for the mother because of various reasons. For instance, breastfeeding itself could cause stress and pain, mothers could feel forced by others to breastfeed while they themselves are not motivated, or there could be mental or physical factors

that compromise breastfeeding. Lisa shared her internal conflict between what she wished for a mother and the mother's own wishes:

> "And when a woman is very firm (about breastfeeding), I sometimes think: oh my god please, choose for yourself. Then it's such a struggle. But I have to try [thinking], I say that sometimes. Especially if medically a child loses weight quickly. Then I just have a fact that I can use for my argument. But I try to keep my own feelings out of it as much as possible. But sometimes I see someone struggling so I think: I just wish you some rest. And temporary supplementation (with formula) does not necessarily mean that you will destroy an entire breastfeeding period."
> - Lisa, MCA

Participants felt that there is a difference between mothers who are struggling with breastfeeding and mothers that are showing serious mental problems – such as depression, anxiety, extreme insomnia – or mothers that seem physically incapable to breastfeed. Most participants felt that breastfeeding is always a struggle at the start, because mothers have to learn how to breastfeed, a child has to learn how to drink, and the milk production is not yet regulated. Participants seem to internally consider their support based on if mothers experience regular struggles or more serious problems that occur. This also depends on how the mother experiences these struggles. For example, Hanneke felt that this also depends on a mother's expectations about breastfeeding:

> "And one mother says: yes, he will wake up at night, I find that very annoying, how can I change that? And I want to sleep through those nights, and. And then, the next one is a mother with a child of six, seven months and she says: yes, he comes twice a night, no, I don't think that's a problem at all, no, no, I think that's nice. […] She thinks: it's just the way it is and it's probably just fine. She doesn't make a problem of that,
>
> while another mother does make it a problem because she wants to have the child in a regular scheme."
> - Hanneke, WBC-N

Participants have different strategies to deal with this conflicting schema, but the overall motivation was to always aim for what is best for a mother and to not force participants' own ideas to the mother. This could, for example, mean to ask or propose a mother what is better for her if they see that a mother is struggling:

> Then I'm not going to say: come on, just keep going! That also depends a bit on the situation of the woman. Are they really weak physically? Or mentally? Then you have to make choices for them. Or at least propose choices.
> - Fleur, MCA

Some participants mentioned that not only a mother's wellbeing is most important, but the baby's and family's wellbeing too. However, these participants often indicated that the wellbeing of a baby and the whole family starts with a happy and healthy mother. In other words, without a happy mother, a family cannot thrive. Therefore, support related to breastfeeding was mostly aimed at the mother, rather than other family members.

4.4 Additional insight: the interaction between professional, mother, and context

When trying to connect schemas and get insight into conflicting schemas, I got a deepened, more latent understanding of what participants shared with me during the interviews. Inspired by de Haas (2017), I found that professionals' reasoning for breastfeeding support is complex and depends on the interaction between three components: the professional providing support, the mother receiving support, and the broader – occupational, organizational, and family – context. Figure 3 gives a schematic summary of this interactional component. As described in this chapter, what motivates professionals reasoning for providing support depends on individual schemas and the motivational force of these schemas – thus, how important they are to them. How professionals apply or select particular schemas when providing support depends on the mother receiving this support together with the context in which their support takes place.

The *professional providing support* has individual schemas on breastfeeding and breastfeeding support, formed by personal and professional experiences, that in itself motivates a professionals' reasoning for support. Moreover, professionals work in a certain *context,* that can also shape reasoning for support. For example, most maternity care assistants who participated in my study shared that families sometimes viewed them as being part of the family during the maternity week. This shapes the way she approaches a mother or the type of language she uses when providing support. In contrast, two well-baby clinic nurses in my study mentioned that they sometimes face the challenge of having a negative reputation as a well-baby clinic professional. They felt they are sometimes viewed as outsiders, and messages can come across as patronizing to parents. These feelings shape if and how professionals formulate support. Furthermore, family context also matters when providing support. Participants shared that if a family also faces other challenges, such as poverty or relational problems, supporting these challenges may have a bigger priority than breastfeeding. This also illustrates that participants aim to improve or guard a mother and her family's wellbeing. Last, participants also motivate their reasoning for support depending on the *mother receiving support.* For instance, if and how participants shape their support is based on how willing a mother is to receive support, the type of support she requires, but also on how the professional views the mother. As showed in section 4.1, participants' higher goal is to protect or improve a mother's wellbeing. This can either be based on what a mother asks of the professional, but also on what a professional observes, and thinks is best for the mother.

Thus, participants motivate their reasoning on three components that interact: their individual schemas, the context they work in – their occupational role, their organization, and the family context of the mother –, and the mother receiving support. If participants experience a conflict between their personal feeding preferences and the higher-level goal of protecting or

improving a mother's wellbeing, they aim to resolve this conflict by outweighing the positives and the negatives to align with the higher-level goal.

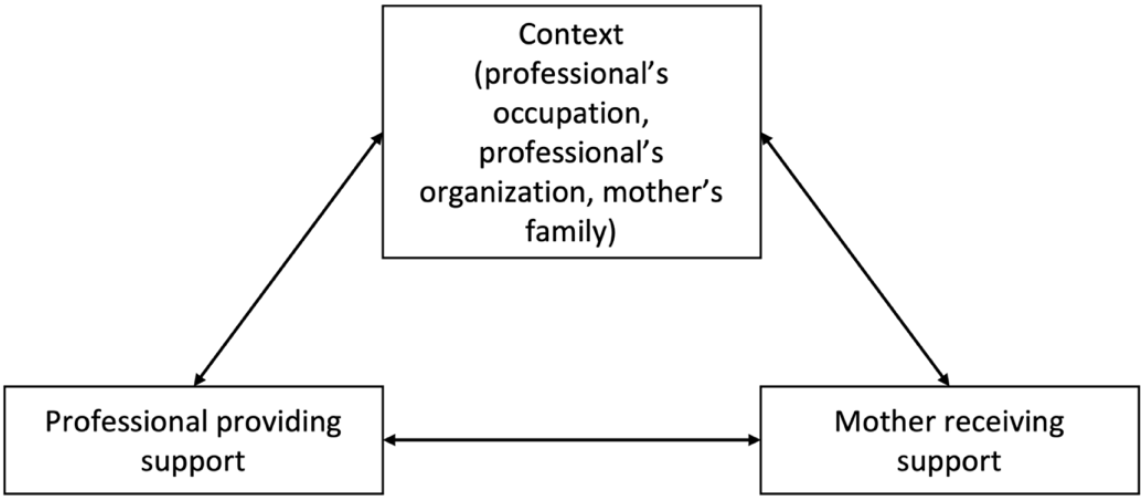

Figure 3. Additional inductive model, inspired by de Haas (2017).

5 Discussion and conclusion

5.1 Discussion

The present study aimed to obtain a better understanding of how individual values, beliefs, and personal experiences with breastfeeding and breastfeeding support of professionals motivate their reasoning to support mothers with breastfeeding. Cultural Schema theory was used to get insight into what motivates professionals' reasoning for support. According to this theory, schemas – cognitive frameworks to interpret and understand events – can occur at the lower, middle, or higher hierarchical level, depending on their motivational force. To answer the research question, in-depth interviews were conducted with four maternity care assistants and four well-baby clinic professionals. Based on the theory and literature review, it was expected that (1) individual values and beliefs about breastfeeding and breastfeeding support, interacting with personal experiences with breastfeeding and breastfeeding support, shape the motivations of professionals for providing breastfeeding support, (2) that the motivational force of a schema depends on the perceived importance of certain values, beliefs, and personal experiences, and (3) that if schemas are conflicting, professionals will describe strategies for coping with these conflicting schemas.

Three overall themes related to individual values and beliefs about providing breastfeeding support were discussed by the participants during the interviews: (1) the importance of attachment between mother and baby, (2) mother's wellbeing, and (3) having trust and confidence in themselves as professionals together with helping mothers to have confidence in the bodily ability to breastfeed when providing support. First, the participants felt that attachment between mother and baby is important when reasoning about breastfeeding support. Participants felt that breastfeeding is best for attachment between mother and child, unless breastfeeding causes any form of distress. This finding was not anticipated based on the literature review and gives new insights into how professionals consider attachment between mother and child when providing support with infant feeding – whether this is formula- or breastfeeding. Second, mother's wellbeing was considered important by the participants when reasoning about breastfeeding support. This links to findings from previous studies, where professionals felt that focusing on psychosocial factors that affect breastfeeding helps providing adequate support to mothers (McInnes & Chambers, 2008; Whelan & Kearney, 2015). However, the present study showed that participants not only considered psychosocial factors that affect breastfeeding when providing support, but that professionals base their infant feeding recommendations – whether this is breastfeeding or formula feeding – on what they feel is best for a mother's wellbeing. Third, the participants felt that support should never be aimed at making a parent insecure and should focus on improving mothers' trust and confidence in themselves and in feeding their child. This links to previous research where professionals felt that having confidence in a mother facilitates adequate breastfeeding support (Baker et al., 2021). However, findings from this study show that participants also view mothers' confidence in their own bodily ability to breastfeed as an important way to support women with breastfeeding.

What became apparent from these three themes is that participants seemed mostly motivated by protecting or improving mothers' wellbeing when providing support. In other

words, participants seemed to consider mothers' wellbeing as the higher-level goal and not breastfeeding itself. For example, if breastfeeding caused distress for a mother, participants reasoned that breastfeeding would not be the best for a mother– and indirectly not for the baby and the family system. In this case, participants reasoned that support should be aimed at protecting mother's wellbeing rather than the solely promotion of breastfeeding. This finding is in line with the expectation that the motivational force of professionals' reasoning for providing breastfeeding support depends on how important values and beliefs regarding breastfeeding support are to professionals. However, the present study gives additional insight in the hierarchy of professionals' goals, showing that mothers' wellbeing has the highest motivational force.

Furthermore, the findings showed that the personal experiences that were discussed during the interviews can be summarized in two themes: (1) sympathizing and (2) cumulative learning. In line with the expectations, participants felt that personal experiences with breastfeeding and receiving support made it easier for them to sympathize with mothers, especially if these experiences had a significant impact on how they viewed support should be provided. Furthermore, participants who felt that schooling and gaining knowledge was important put more effort into gaining such knowledge. This links to previous studies where professionals who valued training and viewed acquiring knowledge as an important part of their job, were more motivated to invest in training (Anstey et al., 2018; Whelan & Kearney, 2015). However, the present study gave some additional understanding of how schooling and gaining knowledge motivates participants' reasoning, as professionals indicated that schooling and knowledge gave them confidence in how skilled they felt to provide support. Furthermore, it was anticipated that professionals would be motivated by previous experiences of providing support, by both the literature as by Cultural Schema theory. According to the theory, schemas are dynamic and change over time as they are shaped by psychological and cultural processes that are exposed by lifelong learning (D'Andrade, 1992). And according to the literature, professionals felt that having more working experience facilitates providing support (Bäckström et al., 2010; Furber & Thomson, 2008).

The present study also found that participants are guided by previous experiences and seem to learn cumulatively. When talking about guidelines, participants felt that guidelines do not play a big role when providing support – especially if participants felt they were experienced with providing support. Participants even felt that deferring from guidelines was sometimes necessary to provide adequate support, depending on their experience. Although previous studies found that professionals felt that having guidelines facilitates adequate support (Anstey et al., 2018; Burns et al., 2020; McInnes & Chambers, 2008; Whelan & Kearney, 2015), it might be that if guidelines are present, they do not accommodate for contextual differences necessary for providing adequate support (Pilbeam et al., 2022). This relates to the additional finding of this study, where participants reasoning was shown to be contextual as it involves the interaction between the professional providing support, the context they work in, and the mother receiving support. In other words, professionals adapt their motivation to provide support based on the specific mother and the context in that moment.

Last, in line with the expectation, the findings showed that participants could feel internally conflicted between their motivations to protect or improve a mother's wellbeing and promoting breastfeeding. For instance, their personal preference for breastfeeding could

conflict with what they felt is best for mother's wellbeing. If such conflict occurred, professionals reasoned that they would always aim at what they thought was best for mother's wellbeing, as wellbeing was viewed as the higher-level goal to achieve. Professionals based their ideas about what is best for a mother's wellbeing on both was said by a mother, what they themselves observed, and on their own values and beliefs of what wellbeing entails. This is in line with previous studies that found that professionals could feel conflicted between what a professional desired for a mother versus what they thought was achievable (Anstey et al., 2018; Baker et al., 2021). However, the present study gave new insight into how professionals cope with this conflict. For example, the introduction of formula feeding was named by participants as a coping strategy to reduce breastfeeding related stress and improve mother's wellbeing.

5.2 Conclusion

This study aimed to answer the research question: *'How do professionals' individual values, beliefs, and experiences with breastfeeding and breastfeeding support motivate their reasoning to support mothers with breastfeeding in the Netherlands?'*. First, three main themes related to participants' individual values and beliefs about breastfeeding support were found that motivate their reasoning: the importance of attachment between mother and baby, the importance of protecting or improving mothers' wellbeing, and the importance of giving mothers confidence in the bodily ability to breastfeed. Second, two main themes related to personal and professional experiences with breastfeeding support were found that motivate participants' reasoning for breastfeeding support: the ability to sympathize with mothers and the role of life-long learning. Based on the findings it is concluded that motivations of professionals' reasoning for providing breastfeeding support is often aimed at protecting or improving mothers' wellbeing and not just the promotion of breastfeeding. In other words, participants seemed to consider mothers' wellbeing as the higher-level goal and not breastfeeding itself. Moreover, participants' support is contextual as their reasoning is based on the interaction between three components: the professional providing support, the context they work in, and the mother receiving support.

5.3 Strengths and limitations

The present study has several strengths and limitations. A strength of this study is the use of Cultural Schema theory. An advantage of using this theory is that it helped grasp underlying, more latent motivations for professionals' reasoning. The theory helped to obtain a deeper understanding of motivations that were not always directly mentioned by professionals – or that they were sometimes even aware of – but became apparent when analyzing the interviews. This latent information is based on my own interpretations of what was said during the interviews. There may be other interpretation of the data. However, Reflexive Thematic Analysis was used as analyzing methods, where a large emphasis lies on reflecting on the role of the researcher and using their experience and subjectivity as a tool. To make analysis stronger, future researchers would be recommended to code and analyze the data through collaboration, to get a richer understanding of the data.

Another strength of this study was the use of semi-structured in-depth interviews. Semi-structuring the interviews allowed me to ensure that I asked about topics relevant for my

research question and theoretical framework on which my research was based. At the same time, it left room for professionals to discuss what they felt was important to share with me. This allowed me to collect information that I did not anticipate beforehand. However, conducting in-depth interviews and analyzing these interviews is also very time consuming. Together with the difficulty to find professionals willing to participate in my study and the scope of this master thesis, this resulted in a small sample size. Having a small sample size in qualitative research may make it more difficult to reach saturation. Saturation is reached if extra data collection does not give additional insights (Hennink et al., 2020). I do not expect that I have reached saturation because my study sample was both small and may not reflect the perspectives of other professionals, because the professionals who participated in my study were predominantly breastfeeding oriented. Moreover, three out of four maternity care assistants were freelancers with a very pro-breastfeeding and natural parenting clientele. It would be interesting to see what motivates professionals with different personal ideas and experiences with breastfeeding or who work in larger organizations. Moreover, it would be interesting to see if other internal conflicts arise for these professionals. However, professionals who are less breastfeeding oriented might also aim to improve or protect mothers' wellbeing. To further study this, it is recommended to include more professionals, who work in different types of organizations or with different types of clients. This may give a more complete and saturated impression of what motivates professionals at large.

5.4 Implications and recommendations

The findings suggest that professionals do not solely aim at the promotion of breastfeeding when providing support but that they primarily aim to protect or improve mothers' wellbeing when reasoning about breastfeeding support. In their reasoning, professionals consider their own schemas, the context they work in, and the mother receiving support. Although more recent guidelines of the World Health Organization for the counseling of breastfeeding mothers recommends a more holistic view and enabling environment when supporting women, Dutch national guidelines for breastfeeding support do not yet consider contextual and psychosocial aspects (Nederlands Centrum Jeugdgezondheid, 2014; World Health Organization, 2018). Neglecting these aspects might compromise the adequacy of support provided by Dutch professionals. Moreover, adherence to guidelines also depends on the facilitation of guidelines for contextual differences (Pilbeam et al., 2022). While professionals who participated in this study felt that schooling, knowledge, and experience have a more significant role in their reasoning for support than guidelines, adequate guidelines are important because schooling is often based on these guidelines. Moreover, guidelines set the standard for professionals, meaning that they carry out professional norms about how breastfeeding support should be provided. Based on the findings and more recent recommendations by the WHO (World Health Organization, 2018) the Netherlands Organization for Applied Scientific Research (TNO) with representatives of the National Breastfeeding Council (LBR) – who jointly developed the Dutch national multidisciplinary breastfeeding guideline – are recommended to include contextual and psychosocial aspects of breastfeeding support when revising current guidelines.

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Appendix A: Flyer for participant recruitment

GEZOCHT KRAAMZORG en CONSULTATIEBUREAU MEDEWERKERS

Voor een onderzoek naar **professionele hulp** en **begeleiding** bij **borstvoeding**

- Bent u werkzaam in de kraamzorg of als verpleegkundige of arts bij het consultatiebureau?
- Adviseert, helpt of begeleidt u vrouwen bij het geven van borstvoeding?
- Dan ben ik benieuwd naar uw ervaringen en kom ik graag een interview bij u afnemen. Dit duurt ±60 minuten.
- U krijgt van mij na afronding van het onderzoek een overzicht van de resultaten.

SCAN DE QR CODE

met uw telefoon voor meer informatie en aanmelding of stuur een e-mail naar:
d.r.de.jong.1@student.rug.nl

rijksuniversiteit groningen

Contactinformatie
Dorien de Jong
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Appendix B: Final interview guide in Dutch

Interviewschema: Professionele Begeleiding bij Borstvoeding.

Ik wil je allereerst hartelijke bedanken voor je deelname aan mijn afstudeeronderzoek. Zoals ik al heb verteld ben ik Dorien de Jong en ik doe de masteropleiding Population Studies (Demografie) aan de Rijksuniversiteit Groningen. Dit afstudeeronderzoek is de laatste stap om af te studeren.

Mijn afstudeeronderzoek gaat over professionele begeleiding bij borstvoeding. Tijdens dit interview vraag ik je naar je persoonlijke kijk op professionele hulp bij borstvoeding en op borstvoeding in het algemeen. Daarnaast ben ik ook benieuwd naar ervaringen met het bieden van professionele hulp bij borstvoeding en eventuele eigen ervaringen of ervaringen in uw directe omgeving met het geven van borstvoeding. Het interview duurt ongeveer 60 minuten maar het kan ook wat korter of langer duren afhankelijk van wat hoeveel je vertelt. Ik begin met wat algemenere vragen om jou als professional wat beter te leren kennen en ga daarna specifieker in op borstvoeding en professionele begeleiding bij borstvoeding.

Voel je vrij om alles dat je met mij over dit onderwerp wil delen te delen. En ik wil ook benoemen dat je er altijd voor mag kiezen om een vraag niet te beantwoorden. Ook mag je op elk moment gedurende het interview besluiten om te stoppen met het interview of aangeven dat je graag een pauze wilt nemen.

De inhoud van dit interview zal ik vertrouwelijk verwerken en bewaren, zoals beschreven in de informatiebrief en op het toestemmingsformulier die je hebt getekend. Heb je naar aanleiding van deze brieven nog vragen? *[Antwoord afwachten en eventuele vragen beantwoorden]*

Zoals ik in de brieven beschreef zal ik het interview opnemen. Bij het tekenen van het toestemmingsformulier heb je toestemming gegeven voor geluidsopname van het interview. Vind je het nog steeds goed dat ik het interview opneem? *[Antwoord afwachten]*

Heb je voor we beginnen nog vragen?

Achtergrondinformatie
Interviewnummer:
Leeftijd:
Gender:
Opleiding:
Huidige functie:

Introductievragen.

1. Zou je mij wat over je huidige werk willen vertellen?
    a. Hoe ben je hier terecht gekomen?
    b. Hoe ziet een werkdag eruit?
2. Zou je mij wat over je professionele verleden willen vertellen?
    a. Opleiding
    b. Werkervaring

3. Hoe zou je jezelf als professional beschrijven?
    a. Wat karakteriseert jou?
    b. Wat motiveert jou? / Wat maakte dat je als XX bent gaan werken?
    c. Hoe uit zich dit in je werk?

Persoonlijke waarden en overtuigingen m.b.t. borstvoeding in het algemeen.

4. Wat komt er in je op als je denkt aan borstvoeding?
    a. Waarom komt dit in je op? Wat associeer jij met borstvoeding?
    b. Welke rol speelt de thuissituatie van een moeder?
    c. Wat zijn je gedachten over kunstvoeding?
    d. Zijn je ideeën over het voeden van baby's in de loop van de tijd veranderd? Zo ja, hoe dan? En waarom?

Persoonlijke ervaringen met borstvoeding.

5. Zou je wat willen vertellen over je eventuele persoonlijke ervaringen met borstvoeding? *Dit kan een eigen borstvoedingservaring zijn, van je partner of binnen het gezin, of in je directe omgeving.*
    e. Zou je kunnen vertellen hoe dit invloed heeft gehad op jou als professional?
    f. Hoe uit zich dit in je werk?

Persoonlijke waarden en overtuigingen m.b.t. professionele begeleiding bij borstvoeding.

6. Wat komt er in je op als je denkt aan professionele begeleiding bij borstvoeding?
    a. Waarom komt dit in je op?
    b. Is dit in de loop van de tijd veranderd? Zo ja, op welke manier? En hoe komt dit?
7. Zou je wat over jouw rol als professional kunnen vertellen wanneer je vrouwen helpt en begeleidt bij het geven van borstvoeding?
8. Welke eigenschappen zijn belangrijk voor een professional wanneer hij of zij vrouwen begeleidt bij borstvoeding?
    a. Waarom denk je dat deze eigenschappen belangrijk zijn?

Professionele ervaringen met het begeleiden bij borstvoeding en beroepscontext.

9. Zou je wat willen vertellen over je professionele ervaringen met het begeleiden van vrouwen bij het geven van borstvoeding?
    a. Voorbeelden?
    b. Wat beperkt of bevorderd jou in het bieden van begeleiding?
    c. Richtlijnen
    d. Training/opleiding
10. Hoe wordt er binnen jouw beroepsgroep over borstvoeding gedacht?
    a. Waaraan merk je dit in het beoefenen van je beroep?
11. Hoe wordt er binnen jouw beroepsgroep tegen professionele hulp en begeleiding bij borstvoeding aangekeken?
    a. Waaraan merk je dit in het beoefenen van je beroep?

Sociaal culturele context.

12. Hoe wordt er in jouw privé omgeving over borstvoeding gedacht?
    a. Waarom denk je dit?
13. Hoe denk je dat mensen in Nederland over borstvoeding denken?
    a. Waarom denk je dit?
    b. Hoe zie je dit terug in je werk?

Afsluitende vragen

14. Hoe denk je over de wijze waarop professionele hulp en begeleiding bij borstvoeding is vormgegeven in Nederland?
    a. Waarom denk je dat?
    b. Is er iets dat je graag anders zou zien?
15. Wat zou je andere professionals die vrouwen hulp bieden bij borstvoeding mee willen geven?
16. Is er iets dat we niet hebben besproken tijdens het interview, maar dat je wel met mij zou willen delen?

Appendix C: Application and letter of approval Research Ethics Committee

Chapter 1: Ethics check-list for research projects

1.1 Consent

	Yes	No	Not certain
(a) Will the research project involve participants who are in any way vulnerable or who may be incapacitated to give informed consent as to their participation or participants age 18 or below, or belonging to sensitive groups who are unable to give informed consent (i.e. people with learning disabilities)? (a*s general guidance, research participants under the age of 18 may be considered vulnerable)*		X	
(b) Will participants be enlisted in the project without their knowledge and/or consent? (e.g. via covert observation of people in public places)		X	
(c) Some studies require the co-operation of a gatekeeper for initial access to groups or more individuals to be recruited. For instance one municipality employee sending out a survey to other employees, a self-help organization helping to reach members of different self-help groups, a nurse reaching out to residents of retirement homes. If you use a gatekeeper please reflect on this ethically. In the case of recruitment through a gatekeeper, consent should still be given by each of the group members. But the use of a gatekeeper may lead to the situation where people do not feel free to give their consent, as there may be group-pressure or strong power relations. Does your study involve a gatekeeper around which there may be ethical issues?	X		

1.2 Research Design/Methodology

	Yes	No	Not certain
Are there any significant concerns regarding the design of the research project? For example: *(based on a.o. Lee, R & Renzetti, C, Researching Sensitive Topics, 1993:6)*			
(a) Where research intrudes into the private sphere or delves into some deeply personal experience			X
(b) Where the study is concerned with deviance or social control		X	
(c) Where the study impinges on the vested interests of powerful persons or the exercise of coercion or domination		X	
(d) Where the research deals with things that are sacred to those being studied that they do not wish profaned			X
(e) Where the research deals with personal data and links personal behavior and spatial data.	X		
(f) If the proposed research project relates to the provision of social or human services, is it feasible and/or appropriate that service users (or service user representatives) should be in some way involved?		X	

(g) Could the study induce negative consequences beyond minimal risks?[3]		X	

1.3 Financial Incentives

	Yes	No	Not certain
(a) Will there be any payments planned/carried out to researchers and/or participants that may have an impact on data collection and/or data analysis?		X	
(b) Will financial inducements (other than reasonable expenses and compensation for time) be offered to participants?		X	

1.4 Confidentiality

	Yes	No	Not certain
(a) Will research involve the sharing of data or confidential information beyond the initial consent given?		X	
(b) Will you collect personal data, as defined in article 4.1 by the European General Data Protection Regulation (GDPR)?	X		
(c) Will the research involve recruiting and/or interviewing respondents over the internet or other visual/vocal methods whereby respondents may be identified?	X		
(d) Will the research involve administrative or secure data that requires permission from the appropriate authorities before use?		X	

1.5 Multi-performer and multi-sited projects

	Yes	No	Not certain
Will the research take place in other countries than the Netherlands?		X	

1.6 Risk to researchers

	Yes	No	Not certain
Are there any doubts or concerns regarding your own safety and /or wellbeing of any of your fellow colleagues during the research period?			X

Decide if you have to complete the full questionnaire

[3] The concept of minimal risk is taken from the research ethics framework of the ESRC (pages 21 to 26): "Risk is often defined by reference to the potential physical or psychological harm, discomfort or stress to human participants that a research project might generate. This is especially pertinent in the context of health-related research. But, in addition, social science raises a wider range of risks that needs to be considered by RECs. These include risk to a subject's personal social standing, privacy, personal values and beliefs, their links to family and the wider community, and their position within occupational settings, as well as the adverse effects of revealing information that relates to illegal, sexual or deviant behaviour. Research which carries no physical risk can be disruptive and damaging to research subjects either as individuals or as whole communities or categories of people, such as those with HIV infection."

If, after careful consideration and completing the ethics checklist above you have answered all questions with No (whether you are a student, PhD researcher or junior/senior researcher at the faculty), then you do not need to complete the form below. No ethical approval is required.

If you have answered Yes or Not certain to any one question in the checklist, you will need to fill in the full ethics report.

Chapter 2: Full Ethics report

Part A: General information about your project

Please complete the following checklist and provide general information about your research project. The checklist is designed to identify the nature of any ethical issues raised by your project. This checklist must be completed before potential participants are invited to partake in your project.

A1 Applicant Details

Name of involved researcher(s): * *Principal Researcher who is responsible for/coordinating the project*	Dorien de Jong
Status (delete as appropriate):	Graduate Student
E-mail address:	d.r.de.jong.1@student.rug.nl
Contact address:	IJsselstraat 53, 9725 GC, Groningen
Telephone number:	0648366158

A2 Additional Details for master thesis research

Supervisor	Dr. Billie de Haas
Supervisor's email address:	b.de.haas@rug.nl

A3 Project Details

Title of the project and brief abstract: (150-200 words – please outline your research project in non-technical language intelligible to a wider audience, the purpose of your project and your methods)

Postnatal Care Workers' Personal and Cultural Values and Beliefs about Breastfeeding Support: A Qualitative Study in the Netherlands.

Background: In the Netherlands, breastfeeding rates at birth have decreased from 80% in 2015 to 69% in 2018. Moreover, in 2018, the largest group of women stopped breastfeeding in the first month (-22%). Breastfeeding initiation and cessation are influenced by adequate professional help and support. Although the Netherlands have national multidisciplinary breastfeeding guidelines, women experience great differences in breastfeeding information and support provided by Dutch health professionals.

Previous studies investigated facilitators and barriers that influence if and how mothers are professionally supported with breastfeeding. Professionals mentioned attitudes towards breastfeeding, social norms, and personal experiences as important factors. However, these studies did not thoroughly investigate these mechanisms. Studying these underlying mechanisms more thoroughly may help understand if and how differences in breastfeeding support between professionals occur.
Objective: Using Cultural Schema Theory, I will explore how personal and cultural values and beliefs about breastfeeding support motivates postnatal care workers to provide help and support with breastfeeding to (new) mothers.
Design: I will conduct semi-structured qualitative interviews with postnatal care workers to gain in-depth information about underlying cultural and personal considerations about breastfeeding (support).
Participants: Postnatal care workers in the Netherlands who have breastfeeding help and support roles during the first weeks after birth: maternity care assistants and nurses and physicians working in well-baby clinics.

Part B: research details and ethical considerations

B1 Research aims

Please provide *brief* (no more than 500 words) details in non-technical language the project's aims, the scientific background of the project and the methods that will be used. This summary should contain sufficient information to acquaint REC with the principal features of the research proposal.

In the Netherlands, the share of women breastfeeding their baby's at birth have decreased from 80% in 2015 to 69% in 2018 (Engelse & van Dommelen, 2018; Peeters et al., 2015). In 2018, the largest group of women stopped breastfeeding in the first month after birth (-22%), with 11% stopping in the first week and 11% stopping in week two or three (Engelse & van Dommelen, 2018). These low breastfeeding rates in the Netherlands are similar to many other European countries (Theurich et al., 2019). This trend may be of concern because breastfeeding has numerous benefits for both mother and child (World Health Organization, 2021). Moreover, there seems to be a large group of women in the Netherlands that have the intention to breastfeed at birth but decide not to continue breastfeeding.
Previous studies showed that providing professional help and support promotes breastfeeding initiation and prevents breastfeeding cessation (Hannula et al., 2008; Keister et al., 2008; Odom et al., 2013; Theurich et al., 2019; van Dellen et al., 2019). Although the Netherlands have national multidisciplinary guidelines that aim to promote breastfeeding, the percentage of women breastfeeding exclusively remains low (Engelse & van Dommelen, 2018; Nederlands Centrum Jeugdgezondheid, 2014; Theurich et al., 2019). One reason for this may be that there are differences in the way health professionals apply these guidelines, as great differences in breastfeeding support between professionals are experienced by women living in the Netherlands (Oosterhoff, 2015).
Studies conducted in other European and North-American countries found that professionals name various facilitators and barriers that impact the way they support women with breastfeeding, such as practical factors (e.g., time, education) or personal factors (e.g., attitudes towards breastfeeding) (Brodribb et al., 2008; McInnes & Chambers, 2008; Whelan & Kearney, 2015; Whelan et al., 2011). Practical factors such

as lack of time and education may be more easily to understand while personal reasons are less universal and may thus also be more complicated to fully understand. Truly understanding the underlying mechanisms of how values, beliefs, and experiences motivate professionals to provide breastfeeding help and support may be the first step to addressing these mechanisms,

To this date, there are no known published qualitative studies exploring postnatal care workers' personal and cultural values and beliefs about breastfeeding (support) in the Netherlands. Therefore, this proposed study aims obtain a better understanding of how personal experiences, ideas, values, and beliefs about breastfeeding of postnatal care workers motivate their help and support with breastfeeding to (new) mothers. The study focusses on those health professionals who are most crucial in the first month after birth in the Netherlands: maternity care assistants and nurses and physicians working in well-baby clinics. I will use semi-structured in-depth interviews to collect the data. In-depth interviews allow us to get insight into mechanisms (e.g., cultural schemas) that lead to certain behaviors (e.g., breastfeeding support) (Hennink et al., 2020).

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B2 Research methodology

How will data be collected and analysed during the project?

Depending on the participants' preference, the interviews can take place in two ways: (1) in person and (2) via an online video call. In both cases I will record the interview using an audio recorder that is not connected to the internet only (thus a stand-alone device, not a recording app on my smartphone or laptop). After audio collection I will transcribe the recorded interview verbatim. I will pseudonymize the audio by excluding names, names of organizations, or other identifiable information. I will then analyze these transcripts using the program Atlas.ti.

What concerns have been taken into account with regard to the preparation and design of the research project? If agencies, communities or individuals are to be directly affected by the research (e.g. participants, service users, vulnerable communities or relations), what means have you devised to ensure that any harm or distress is minimized and/or that the research is sensitive to the particular needs and perspectives of those so affected?

I will recruit participants in several ways. (1) I will visit well-baby clinics to inform their front-desk/assistant about my research and I will ask if they can give my flyer to the nurses and physicians working there, (2) I will e-mail maternity care organizations and ask them if they can send my flyer and email to their maternity care assistants, and (3) I will post my flyer on LinkedIn. I am thus using gatekeepers when recruiting participants. Gatekeepers might have their own interests and motivations to recruit their colleagues or participants might not want gatekeepers to know they're participating. Therefore, I am making sure that potential participants can only sign up for my research by personally emailing me. Moreover, I am not informing any gatekeepers about who is and who is not participating in my research.

Before the start of the interview, I will send the participants an information sheet and letter of consent to inform them about the content of the study, their rights as participants, information about what it means to participate in the study and information about how data is stored and used. At the start of the interview, I will make sure that the participant has read the information and understands the information. I will remind them of their rights and once again ask them if I can audio record the interview.

The most concern is with the storage of the recorded audio because this could get lost or stolen when traveling after an interview. The audio may contain information that is identifiable. I will upload the recording to my laptop immediately after the interview at the participant's place. If I have access to the internet, I will upload the recording to the UWP of the University of Groningen. If I do not have access to the internet, I will save the recording to a secured folder on my computer. Once home, I will move the recording to the X-disk of the University of Groningen which is secured via a password and double authenticator code that I can only access through my phone which is also secured with a personal password. I will take these precautions because of my laptop does get stolen or gets lost, it will not be easily accessible because it will be protected with at least two passwords on my personal laptop or with two passwords and an authenticator if I upload it to the X-disk of the university immediately. I will delete all audio recordings once I have finished my thesis.

The transcript will be anonymized as much as possible. There may be identifiable content (e.g., description of a personal situation). Therefore, the transcript will also be stored on the X-disk of the University of Groningen.

How has the methodology addressed ways in which sensitive information, data or sources will be handled? (e.g. personal data, data protection, tracking of people)

I will collect data via in-depth interviews. This method can result in the collection of very personal data. Therefore, I will ensure that the interview is conducted in an environment where other people cannot hear or interrupt us and where the participant feels

comfortable. I will let the participant pick a location that they feel comfortable with, like their own home or office. Moreover, I will make sure that the data is safely stored, as I have described in other parts of this application. Also, when processing all the data I will make sure that it is not identifiable, by using pseudonyms.

In case the participant did not feel comfortable with me or has questions related to me that they want to share with another person from the University of Groningen, I will refer to the contact details of the ethics committee on the information sheet. I will remind the participant of this at the beginning and the end of the interview.

B3 Research participants

Who do you identify as the participants in the project? Are other people who are not participants likely to be directly impacted by the project?

I invite maternity care assistants (in Dutch: 'kraamzorg medewerkers') and nurses and physicians working in well-baby clinics (in Dutch: 'consultatiebureaus') to participate in my study. These professionals might discuss matters related to other persons (e.g., co-workers) or the organization they work for in general. These persons or organizations are therefore indirectly also involved in the study. I will make sure that the people indirectly involved in the study are not harmed. I will do this by storing the data safely, by pseudonymizing the data and making sure that it is not identifiable. Moreover, I will not share who participates in the study with the organizations or other persons.

What arrangements have been made to preserve confidentiality for the participants or those potentially affected?

I will anonymize these persons and organizations by leaving out their names by using pseudonyms and by leaving out other information that could identify them in my transcripts.

Are there any specific risks to research the participants or third parties?

Participants may discuss issues related to the organization they work for. If the organizations learn about these issues raised by a certain participant, then this may harm the professional position of the participant. These issues could also become known to the public, which may harm the image of the participant or the organization. I will minimize this risk by storing the data safely, by pseudonymizing the data and making sure that it is not identifiable. Moreover, I will not share who participates in the study with the organizations or other persons.

Please explain the mechanisms in place to ensure the confidentiality of private information, and compliance with data protection law.

I will not collect any private information like addresses. However, I will collect participants' names, e-mail addresses and telephone numbers during the application process. This is collected via a Google Forms that I can only enter through my University of Groningen account that is protected with a personal password and authenticator code. I will only use this information so I can contact the participant, send them the information sheet/letter of consent, and make the appointment for the interview. Participants can also provide their e-mail address if they wish to have a copy of the transcript. They will share their email on paper with me. I will store these papers in my supervisor's office, because that office has a lock and is only accessible to her.

I will not collect any private information like addresses. However, I will collect participants' names, e-mail addresses and telephone numbers during the application process. This will be done in two ways.
If participants find my study via de flyer (at well-baby clinics or LinkedIn), they care sign-up in two ways: by emailing me or via a Google Forms that they can find via the QR code on my flyer. If participants sign-up via e-mail, I will collect their e-mail addresses. I am using my student e-mail account of the University of Groningen, that is protected via a personal password and authenticator code. The Google Forms is also made with my student account and therefore also protected with a personal password and authenticator code. On the Google Forms I also ask

potential participants to fill in their e-mail address so I can call them. I will only use this information so I can contact the participant, send them the information sheet/letter of consent, and make the appointment for the interview.
I recruit maternity care assistants also by directly sending organizations/individual maternity care assistants an e-mail via my student account at the University of Groningen. As I mentioned above, this account is protected via a personal password and authenticator code.

Once participants agreed to participate in my study I will send them an information letter and letter of consent via e-mail. I will ask them to sign the letter of consent. In case participants want a copy of the transcript, they can also indicate that on the letter of consent and fill in their e-mail address so I can send them the transcript. Because the letter of consent also collects private information like name and e-mail address, I will store these signed letters in my supervisor's office. That office has a lock and is only accessible to her.

During the interview I will also collect private information. With permission I will audio record this interview. The audio recordings will be stored in a password secured folder on the X-drive of my student account at the University of Groningen, which is protected via a personal password and authenticator code.

B4 Informed consent

1. Will participants be asked to give informed consent in writing and will they be asked to confirm that they have received and read the information about the study? If not, why not?

Please attach a draft information sheet and/or consent form in the annex. Refer to the standard forms provided by REC.

The participants will receive an information letter and letter of consent. I have attached my drafts to my email.

2. Has the study been discussed or are there plans to discuss the study with those likely to be involved (including potential participants or those who may represent their views)?

I have not discussed the study with potential participants or those who may represent their views. However, I have asked the opinions of mothers about the study. Some of these mothers were my friends, others were anonymous mothers via online fora. I have informed them briefly about my study and asked them which professionals they consulted when they had questions about breastfeeding and in what period (first week/month/or later) after birth professionals were most relevant. This, together with studies and data that I found about breastfeeding initiation and cessation, made me decide to study the first month and thus focus on maternity assistants and nurses and physicians working in well-baby clinics.

3. Will insights gathered from one individual or group be shared with others who are likely to be involved, including potential participants or those who may have other views?

No.

4. Has information (written and verbal) about the study been prepared in an appropriate form and language for potential participants? At what point in the study will this information be offered? *(please check with the Project Information Sheet)*

Yes, I have written my flyer, the Google form, the information letter and the letter of consent in a language that is understandable for the general public, by not using methodological terms or other difficult words. This information is offered in different stages of recruitment, application, and participation.
Recruitment: there will be limited information about the study on the flyer (see attachment), but I will link with a QR code to a Google form made on my university account where I provide more information (similar to the information sheet) and where participants can enroll.
Application: when participants sign up to participate in the interview, I will contact them and send them the information letter and letter of consent using my university email account.
Participation: at the start of the interview, I will discuss the information letter and letter of consent, make sure the participant understood everything, make sure the participant signed the

letter of consent and inform the participant once more about their rights and ask them if I can record the interview. I will make sure that they sign two copies of each, one for them and one for me.

5. What provision has been made to respond to queries and problems raised by participants during the course of the study?

On the information sheet I provide my e-mail address and state that if participants have any questions or requests, they can contact me via email. I will also tell the participants that they can get a copy of the transcribed interview so they can make revisions or delete parts of the interview.

If my research is approved by the ethics committee, I will add this to the information letter. I will also add the contact information of the ethics committee to my information sheet in case the participant wants to contact someone else but me. This might be the case if the participant has any concerns about me or the way I conduct the research.

B5 Ethical questions arising from the provision of incentives

Do you offer any incentives to participants? If yes, what could be the potential ethical issues arising from this?

No.

B6 Dissemination

Will the results of the study be offered to those participants or other parties involved who may wish to receive them? If so, what steps have been taken to minimize any discomfort or misrepresentation that may result at the dissemination stage.

I will tell my participants that they can receive a copy of the transcript of their own interview, so they can delete or revise content of their own interview. When I am done with my thesis, they can also receive a copy of my thesis if they want to. Moreover, I will make a summary of the most important results and present them nicely and understandable. I will send this overview to my participants if they are interested.

B7 Risk to researchers

Are there any risks to researchers? If so, please provide details.

I am allowing the participants to interview them at a location of their choice. This may make it easier to organize a moment to interview them. But this may be risky to me. Therefore, I will ensure my safety as much as possible by:
Trying to schedule the interview with my participants during the day.
Giving my supervisor access to the information about the participant and the location of the interview.
Letting my partner know when I am interviewing someone and what time I expect to be back.
Giving my supervisor's contact details to my partner, so he can contact her in case anything happens.

Part C: Self-reflection

After completing the full ethics questionnaire part A and B faculty members and staff should reflect themselves if the research design appropriately addresses ethical issues and whether checks and balances are in place. The table on the following page should be filled in by the researcher to reflect whether a full ethical clearance by two REC members is required or not. PhD researchers have to submit their completed questionnaire to their promotor or co-promotor in the first instance. Every completed questionnaire and self-certification will be sent to the REC for documentation.

C1 Self-reflection questions

Self-reflection questions	Yes	No
Significant ethical issues are raised by the research, including research characterised by one or more of the following features:		
Research is conducted without their full and informed consent at the time the study is carried out or when the data is gathered, which involves the use of confidential information or which be considered (?)		x
Research involving more than minimal risk of harm to participants, such as:		
i. research involving vulnerable groups		X
ii. research involving personally intrusive or ethically sensitive topics		X
iii. research involving groups where permission of a gatekeeper is normally required for initial access to members	X	
2) The researcher wants to seek the advice of the Research Ethics Committee.		X
3) External obligations (for instance, funder requirements, data access requirements) require it.		X
4) Research undertaken by a student or member of staff who has not received appropriate training or has insufficient experience in research methods and research ethics. Comment by student: I want to indicate that I am a master student. I had two courses on qualitative research methods on bachelor and master level. I have experience as a research assistant at the UMCG with interviewing, transcribing, coding, and analyzing in-depth interviews. Moreover, I have had a couple of lectures about research ethics and data protection. Although I have some experience, I am still learning.	X	
5) Other reason(s) (please provide):		X
6) If you are a student, please indicate whether you checked the self-reflection with your supervisor.	X	
Summary of any ethical issues identified and the measure and safeguards that have be taken and set in place: The main ethical issues are ensuring confidentiality and protecting the collected data by storing them securely. I will anonymize transcripts as much as possible by leaving out personal details and I will secure data via double-paswords on the X-disk of the university of Groningen which is protected via a personal password and double authenticator code that I can only aquire via my personal phone that also has a personal password.		
Name: Dorien de Jong		
Researcher signature:		


Date: 4 April 2022

C2 Outcome of the self-reflection

On the basis of this self-reflection, I indicate that [tick in the relevant box]:

I have identified no important ethical issues or questions which have not been accurately tackled. *In this case, the full ethical report will be checked by one REC member.* *→ You can go ahead with your research.*	X
I have identified important ethical issues or questions for which I seek advice or review by the REC. *In this case, fill in the following table. Two REC members will check the full ethical report.* *→ Please wait with pursuing your research until you have consent from the REC.*	

The ethical approval is given for the entire research project. Any significant change in the question, design or conduct over the course of the research should be notified to the Research Ethics Committee through the Secretary.

Part D: Final approval by the Research Ethics Committee

REC will review your application and present their comments. Applications needing review must reach the secretariat at least 2 months before fieldwork commences. The REC aims to respond within 2 weeks, but this cannot be guaranteed. The REC will always respond within 6 weeks. The Principal Researcher will be sent a notification of the review. The committee may take one of the following decisions:
approved
approved in principle (with feedback and recommendations from REC)
deferred for re-submission
not approved

You will receive a formal decision following the format on the next page. In most cases email or other informal correspondence will precede this formal decision.

Research Ethics Committee review request number 20XX-.....	
Approved The application is ethically satisfactory and needs no amendment or correction.	
Approved in Principle The application is essentially ethically sound, however the researcher needs to make some minor amendments before it can be approved.	X
Deferred The Committee could not reach a decision and will contact the Principal Researcher to seek further clarification.	
Not Approved The application is ethically seriously flawed and requires major revisions before it can be considered for approval.	

In cases of b), c) and d) the principal researcher will receive observations and questions from REC.

In case of b), c) and d) the Committee decides to follow the next steps or ask for the following: 1)
Received appropriate answers from the Principal Researcher on 12 April 2022..... Signature..... 

university of groningen / faculty of spatial sciences / research ethics committee

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Handled by
Jeannet Brondsema

Date
20 April 2022

Our reference

Subject
Ethics committee

Dear Dorien,

The Research Ethics Committee of the Faculty of Spatial Sciences, University of Groningen, The Netherlands, has assessed your request concerning your research, entitled: "Postnatal Care Workers' Personal and Cultural Values and Beliefs about Breastfeeding Support: A Qualitative Study in the Netherlands."

We found that you have taken good care of the ethical aspects of the research. We, therefore, grant you ethical clearance for this project. We wish you all the best in pursuing this interesting research.

Please do not hesitate to contact us, should you have any further queries.

Kind regards,
On behalf of the Ethics committee

Hinke Haisma
Chair

Appendix D: Information letter in Dutch

Deelnemers informatiebrief

Een Afstudeeronderzoek naar Professionele Begeleiding bij Borstvoeding.

Groningen,

Beste deelnemer,

Allereerst hartelijk dank voor het tonen van interesse in dit onderzoek. Mijn naam is Dorien de Jong, ik ben masterstudent Population Studies aan de Rijksuniversiteit Groningen. Ik wil mijn afstudeerscriptie schrijven over ervaringen van professionals met het begeleiden van vrouwen bij borstvoeding. In deze brief zal ik u meer informatie geven over het doel van mijn afstudeeronderzoek en wat uw deelname betekent, zodat u een overwogen keuze kunt maken om deel te nemen.

Wat is het doel van dit afstudeeronderzoek?
Uit een landelijk rapport van het Nederlands Centrum Jeugdgezondheid is gebleken dat een grote groep vrouwen stopt met borstvoeding geven in de eerste maand na de geboorte. Onderzoek laat verder zien dat professionele hulp en begeleiding eraan kan bijdragen dat vrouwen die dat graag willen succesvol borstvoeding geven. Maar tegelijk geven vrouwen ook aan dat er grote verschillen zijn in de wijze waarop professionals hen helpen bij vragen met betrekking tot borstvoeding. Met mijn onderzoek wil ik in kaart brengen hoe professionals zelf tegen professionele begeleiding bij borstvoeding aankijken en vanuit welke ervaringen, waarden, en overtuigingen met betrekking tot borstvoeding zij vrouwen begeleiden. Dit wil ik onderzoeken door interviews af te nemen bij kraamzorgmedewerkers en verpleegkundigen en artsen werkzaam bij het consultatiebureau.

Wat betekent uw deelname?
Het liefst kom ik naar u toe op een door u gekozen locatie, maar het is ook mogelijk om het interview online te doen. Het interview duurt ongeveer 60 minuten. Tijdens het interview stel ik u open vragen, maar wil u vooral zelf uw verhaal laten doen. Met uw toestemming neem ik het interview op. Het interview zal vervolgens uitgeschreven worden, waarbij ik uw persoonlijke gegevens anoniem maak. Deze geanonimiseerde teksten zal ik vervolgens gebruiken voor de rest van mijn onderzoek. De teksten zullen door mijzelf en mijn begeleider gelezen worden. Anonieme quotes uit de interviews worden gebruikt in mijn scriptie en een eventuele wetenschappelijke publicatie.

Vertrouwelijkheid en uw rechten als deelnemer.

- Het interview wordt met een geluidsrecorder opgenomen en ik zal eventueel aantekeningen maken gedurende het interview. De geluidsopname maakt het voor mij mogelijk om het

interview woord voor woord uit te schrijven. Het uitgeschreven interview en eventuele notities gebruik ik voor de rest van het onderzoek.

- U mag ten alle tijden vragen of ik wil stoppen met het opnemen van het interview, u mag ervoor kiezen om bepaalde vragen niet te beantwoorden en u mag ten alle tijden stoppen met deelname aan dit onderzoek.
- Indien gewenst kan ik u een kopie sturen van het uitgeschreven interview. U heeft dan de mogelijkheid het interview door te lezen en aan te geven dat u bepaalde delen anders geformuleerd wilt hebben of helemaal wilt verwijderen. Als u dit aan mij doorgeeft zal ik dit aanpassen of verwijderen.
- De informatie zal vertrouwelijk bewaard worden, in een met wachtwoord beveiligde map op een met een wachtwoord beveiligde computer van de universiteit.
- De informatie zal primair gebruikt worden voor mijn afstudeeronderzoek, deze zal na afronding toegankelijk zijn via de bibliotheek voor studenten en werknemers van de Rijksuniversiteit Groningen.
- De informatie zal misschien ook gebruikt worden voor (wetenschappelijke) artikelen, boeken, gepubliceerd en ongepubliceerd werk en presentaties.
- De informatie die u verstrekt zal ik zo verwerken dat het niet identificeerbaar is. Dat betekent dat ik uw naam, namen van andere personen, organisaties of locaties die u benoemt in het interview weglaat.

Als participant heeft u het recht om:

- deelname te weigeren;
- een specifieke vraag niet te beantwoorden;
- op elk moment te verzoeken of de geluidsrecorder gestopt mag worden;
- het interview op elk moment te beëindigen;
- u terug te trekken uit het onderzoek tot het moment dat het onderzoek wordt gepubliceerd;
- vragen te stellen over het onderzoek op elk moment van uw deelname; en
- te verzoeken om (een deel) van de verzamelde informatie te verwijderen en niet te gebruiken in rapportage van dit onderzoek.

Ik wil u nogmaals bedanken voor uw tijd en uw interesse in mijn afstudeeronderzoek. Als u vragen heeft dan mag u via e-mail contact met mij opnemen: **d.r.de.jong.1@student.rug.nl**

Dit onderzoek is goedgekeurd door de ethische commissie van de faculteit Ruimtelijke Wetenschappen. Als u vragen of opmerkingen heeft waarvoor u iemand anders dan mij wilt raadplegen, dan kunt u contact opnemen met het secretariaat van de Ethische Commissie, Jeannet Brondsema: j.t.brondsema@rug.nl.

Hartelijke bedankt,

Dorien de Jong
Masterstudent Population Studies
Rijksuniversiteit Groningen

Appendix E: Letter of consent in Dutch

Toestemmingsformulier voor deelname aan afstudeeronderzoek
In het afstudeeronderzoek: Professionele begeleiding bij borstvoeding
Titel: Postnatal Care Workers' motivations about Breastfeeding Support
Ondertitel: A Qualitative Study in the Netherlands

Met dit afstudeeronderzoek wil de onderzoeker professionele support bij borstvoeding in kaart brengen. De onderzoeker wil bekijken hoe ervaringen, waarden en overtuigingen professionals motiveert om vrouwen te helpen en te begeleiden bij het geven van borstvoeding.

Met dit formulier verklaar ik dat:

- ik de informatiebrief over dit onderzoek heb gelezen en de inhoud begrijp,
- ik de mogelijkheid heb gehad om vragen te stellen aan de onderzoeker over deze studie en ik tevreden ben met de antwoorden die ik heb gekregen,
- ik begrijp dat deelname aan dit onderzoek vrijwillig is en dat ik op elk moment mag besluiten om te stoppen tot het moment dat dit onderzoek eventueel wordt gepubliceerd, en ik mag weigeren antwoord te geven op elke individuele vraag die gesteld wordt in dit onderzoek,
- ik begrijp dat mijn deelname aan dit onderzoek vertrouwelijk is. Zonder mijn goedkeuring mag geen enkel materiaal dat mij kan identificeren gebruikt worden in rapporten of artikelen die voortvloeien uit dit onderzoek,
- ik begrijp dat de informatie die verzameld wordt ook gebruikt kan worden in (wetenschappelijke) artikelen, boeken, gepubliceerd en ongepubliceerd werk en presentaties,
- ik begrijp dat alle informatie die ik verstrek vertrouwelijk wordt bewaard, in een met wachtwoord beveiligde map op een met een wachtwoord beveiligde computer op de universiteit.

Graag het juiste antwoord omcirkelen:

Ik geef toestemming voor geluidsopname van het interview JA / NEE

Ik begrijp dat ik anoniem zal blijven gedurende dit onderzoek JA / NEE

"Ik geef toestemming om deel te nemen aan dit individuele interview en bevestig dat ik een kopie van het toestemmingformulier en de informatiebrief heb ontvangen"

Handtekening van de participant:_____Datum: _____

Graag uw e-mailadres invullen als u een kopie van uw uitgeschreven interview wilt ontvangen zodat u de mogelijkheid heeft om aanpassingen door te geven.

E-mail: _____

"Als onderzoeker zal ik mij houden aan de voorwaarden die ik in de informatiebrief en op dit toestemmingsformulier heb beschreven en ik zorg ervoor dat er geen schade wordt toegebracht aan een deelnemer tijdens dit onderzoek"

Handtekening van de onderzoeker:_____Datum: _____