Determining the influencing factors of a caesarean section birth on breastfeeding

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Abstract

Background. Although the Health and Social Care Information Centre (HSCIC) report that 26% of women in the UK currently give birth by caesarean section (CS), the subject of breastfeeding post CS is vastly understudied. In the latest UK infant-feeding survey (McAndrew et al, 2012), it was confirmed that although similar rates of breastfeeding initiation were found with women who gave birth vaginally or who underwent a CS, breastfeeding exclusivity was less common in the latter group, suggesting that an unknown factor was affecting breastfeeding exclusivity in this group of women.

Aim. The aim of this literature review was to explore how breastfeeding is affected by a CS birth, with the intention of formulating recommendations to improve rates of breastfeeding sustainment.

Methods. The research question: ‘What impact does a CS birth have on breastfeeding?’ was framed with the aid of the standardised search strategies: population, exposure, outcomes (PEO) and sample, phenomenon of interest, design, evaluation, research type (SPIDER). The research databases CINAHL, MEDLINE and ProQuest were strategically searched using a combination of search terms. CINAHL and MEDLINE produced 30 and 43 results, respectively, and ProQuest returned 340 papers. Eight papers were selected for inclusion following a review of the titles, abstracts and findings of the papers identified by the literature search and an additional paper was found through searching Google Scholar.

Findings. Pain is a significant barrier to breastfeeding success and women who reported higher levels of pain breastfed less often and were more prone to ceasing breastfeeding in favour of artificial milk supplementation. Blood loss also had a negative impact on women’s breastfeeding experiences. Lack of education and support were identified as key factors in breastfeeding cessation and poor support was associated with the introduction of artificial milk supplementation. Women who did not receive antenatal breastfeeding education breastfed for a shorter duration than those who did.

Conclusion. Breastfeeding post CS is negatively impacted by post-operative pain and a lack of support resulting in an increase in the uptake of artificial milk supplementation and lower breastfeeding rates at six months postpartum.

Recommendations. Further research into the impact of a CS birth on breastfeeding is needed in order to conclusively answer the research question. The acronym ‘PRESS’ (Prepare, Relieve, Educate, Stimulate, Success) was created to formally amalgamate the recommendations to improve breastfeeding rates. Improved education for both women and midwives was the most significant recommendation in terms of its perceived impact on breastfeeding continuation rates. More qualitative research would also be welcomed to understand women’s experiences of breastfeeding post CS and in particular for those women prone to CS because of a raised body mass index and those aged over 35.

Key words: Lactation, breastfeeding support, caesarean section, midwives, evidence-based midwifery

Background

In 2008, it was estimated that 1.4 million child deaths globally were a direct result of ‘sub-optimal breastfeeding’ where babies were not exclusively breastfed (Save the Children, 2013: 7). Furthermore, between 16% and 22% of newborn deaths could be prevented annually if all babies were breastfed within the first hour of life (NEOVITA Study Group, 2016; Save the Children, 2013). Caesarean section (CS) delivery impacts on breastfeeding exclusivity and delays initiation of breastfeeding (McAndrew et al, 2012). In the UK’s latest infant-feeding survey (McAndrew et al, 2012), it was confirmed that although similar rates of breastfeeding initiation were found when comparing women who gave birth vaginally to those who underwent a CS, exclusive breastfeeding was less common in the latter group.

The HSCIC (2015) reported that the CS rate rose by 0.7% in the latest period of study between 2013 and 2014, meaning around 26.2% of UK women currently give birth by CS. A rise in the birth rate of those over 40, levels of obesity and associated co-morbidities, including diabetes, are all said to be contributing factors to the escalation (Public Health England, 2016; HSCIC, 2015). The aim of this literature review was to explore the question: ‘What impact does a CS birth have on breastfeeding?’

Method

The review started in May 2015. The research question was framed with the aid of the standardised search strategies: population, exposure, outcomes (PEO) and sample, phenomenon of interest, design, evaluation, research type (SPIDER). The SPIDER strategy was employed in order to further the formulation of search term generation aiming to improve rigour.

The research databases CINAHL, MEDLINE and ProQuest were strategically searched using a carefully selected combination of search terms and the application of relevant limiters or exclusion criteria.
The literature search was limited to papers published after 2005 to ensure the research was clinically up to date. Breastfeeding is a global issue and, as such, it was imperative that the literature search did not dismiss international papers. Due to the impracticalities of translation, however, papers not written in the English language were excluded. Boolean operators and truncation were used to advance and maximise the search potential. CINAHL and MEDLINE produced 30 and 43 results, respectively, and ProQuest returned 340 primary research papers. Titles and abstracts were analysed for their relativity to the research aim and a shortlist of 33 papers was compiled. These were scrutinised further with the aid of inclusion and exclusion criteria (see Table 1).

Qualitative and quantitative research was welcomed within the literature review, however, research that lacked focus and strayed from the aims of this paper were excluded, along with secondary research papers. Following this process, a total of eight papers were selected. One further research paper (Albokhary and James, 2014) was found using Google Scholar and, having met the inclusion and exclusion criteria, it was included in the review. Of the final nine papers (see Table 2), three were of qualitative methodology and six were quantitative in nature. The qualitative research was critically analysed using the Critical Appraisal Skills Programme (CASP) (2013). The quantitative research was examined using an adapted version of ‘The Rees model for critiquing quantitative research’ (Glasper and Rees, 2013). During the appraisal process, themes naturally assembled through constant and contemporaneous comparison of the papers. Thematic development was aided through the use of colour coding and grouping. As a result of this in-depth process, three significant themes emerged:

- Post-operative pain
- Lack of support
- Artificial milk supplementation.

### Results

Breastfeeding initiation and maintenance rates were impacted by post-operative pain following a CS which, when combined with a lack of professional and personal support, resulted in increased rates of artificial milk supplementation in breastfeeding women.
Post-operative pain

Post-operative pain as a barrier to breastfeeding post CS was reported by all but one (Baxter, 2006) of the nine authors, illustrating that pain is a persistent inhibitor to breastfeeding in women who have undergone a CS.

Karlström et al’s (2007) study in Sweden reported that one-third of the 60 women sampled who had undergone a CS suggested that the pain caused by the wound inhibited breastfeeding to a ‘very large extent’ (Karlström et al, 2007: 434). Furthermore, women who experienced birth complications were more likely to cease breastfeeding as a result of post-operative pain (Brown and Jordan, 2013).

Women in Karlström et al’s (2007) study reported incision pain post CS based on a 10-point visual analog scale (VAS). A VAS score of four or above was considered to be at a level where pain relief should be offered. It was found that women suffered high levels of pain post CS. A total of 83% of women who underwent an emergency CS and 74% of women who had an elective CS reported a VAS score of between four and 10.

Wound pain was reported to affect basic functioning post delivery: ‘It was so painful to lift and carry baby’ (Baxter, 2006: 292); ‘I hated breastfeeding because it hurt to try and sit up’ (Beck and Watson, 2008: 233). One woman described the pain to be ‘absolute agony’ and not something she could forget (Tully and Ball, 2014: 714-5). These experiences are backed up by the findings of Karlström et al (2007), who identified that 62% of women reported their ability to breastfeed their babies was hindered by post-operative pain. Brown and Jordan (2013) suggested that antenatal breastfeeding intention does not predict breastfeeding rates at discharge from hospital. In Tully and Ball’s (2014) study of 115 women, only 73% who had intended to breastfeed did so exclusively in the immediate postnatal period.

Women who had described an antenatal intention to breastfeed but fed their babies artificial milk from birth had low levels of commitment, which was compounded by maternal tiredness and incision pain post CS (Tully and Ball, 2014). Brown and Jordan (2013) studied the relationship between the classification of delivery, complicated or uncomplicated, and the reasons for women discontinuing breastfeeding. Perceived difficulty, post-operative pain and pressure from others were reported to be the greatest influence on women’s decisions to forego breastfeeding in favour of using artificial milk. This is backed up by findings of McGrath and Phillips (2009), where pain and pressure from others were

Table 2. Final nine papers

<table>
<thead>
<tr>
<th>Title and author</th>
<th>Method</th>
<th>Location</th>
<th>Sample size</th>
<th>Year of publication</th>
</tr>
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<tbody>
<tr>
<td>Maternal accounts of their breastfeeding intent and early challenges after caesarean childbirth (Tully and Ball, 2014).</td>
<td>Qualitative/ interview</td>
<td>UK</td>
<td>75+40</td>
<td>2014</td>
</tr>
<tr>
<td>Does caesarean section have an impact on the successful initiation of breastfeeding in Saudi Arabia? (Albokhary and James, 2014).</td>
<td>Quantitative/ questionnaire</td>
<td>Saudi Arabia</td>
<td>60</td>
<td>2014</td>
</tr>
<tr>
<td>Elective caesarean delivery: does it have a negative effect on breastfeeding? (Zanardo et al, 2010).</td>
<td>Quantitative/ telephone questionnaire</td>
<td>Italy</td>
<td>2137</td>
<td>2010</td>
</tr>
<tr>
<td>The breast or the bottle? Women’s infant-feeding choices in a subsequent birth after a previous caesarean section (McGrath and Phillips, 2009).</td>
<td>Qualitative/ interview</td>
<td>Australia</td>
<td>20</td>
<td>2009</td>
</tr>
<tr>
<td>Post-operative pain after caesarean birth affects breastfeeding and infant care (Karlström et al, 2007).</td>
<td>Quantitative/ questionnaire</td>
<td>Sweden</td>
<td>60</td>
<td>2007</td>
</tr>
<tr>
<td>Women’s experience of infant feeding following birth by caesarean section (Baxter, 2006).</td>
<td>Quantitative/ questionnaire</td>
<td>UK</td>
<td>289</td>
<td>2006</td>
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common reasons cited for breastfeeding cessation.

Woods et al (2012) studied the relationship between types of patient-controlled pain relief and women’s pain post CS, as well as its effect on breastfeeding frequency and initiation in the US. No significant difference was found between the method of analgesia and the time to first breastfeed, however, a negative correlation was found between average total pain score and number of breastfeeding sessions.

Lack of support
Lack of support, as well as lack of preparation, for CS delivery was found to affect women’s perceptions of their ability to cope with the pain experienced; this then fundamentally affected their breastfeeding (Woods et al, 2012; Karlström et al, 2007). Much of the evidence from the research studied implied that a lack of support was a common denominator in women who had ceased or struggled to breastfeed (Tully and Ball, 2014; Brown and Jordan, 2013; Baxter, 2006).

Research by Zanardo et al (2010) found that timely support during the immediate postnatal period is integral to women’s breastfeeding success. Baxter (2006) reported that 6% of 289 participants in her study ceased breastfeeding following a CS because of poor help received on the postnatal ward. The help offered to women was described to be prone to ‘conflicting advice’ and ‘shift changes’ (Baxter, 2006: 292) which negatively impacted on the women’s ability to breastfeed.

Tully and Ball (2014) highlight the implications of no overnight visiting for women’s partners. Mothers in their study (Tully and Ball, 2014) struggled to breastfeed during the night because of a lack of help while also commenting that women were scared or hesitant to buzz for help from midwives. Women turned to artificial milk supplementation instead of pressing their buzzer for breastfeeding support in order better care for themselves (Tully and Ball, 2014).

This is supported by findings from McGrath and Phillips’ (2009), who found that artificial feeding was started to allow mothers a break to relieve tiredness.

Brown and Jordan (2013) found that while mothers who gave birth via CS did breastfeed for a ‘significantly shorter duration’ (Brown and Jordan, 2013: 833) than women following a vaginal birth, mothers who ceased breastfeeding for reasons of lack of support, breastfed for a longer period of time than those who terminated breastfeeding as a result of difficulty or pain. Additionally, Brown and Jordan (2013) found no significant difference between mothers who gave birth vaginally or via CS who reported lack of support.

Women in Beck and Watson’s (2008) study highlighted the importance of evidence-based teaching and support. Women in this study (Beck and Watson, 2008) recalled their resentment of hands-on teaching techniques that were adopted by staff caring for them, finding it to be a violation of their dignity.

One participant felt that her breasts no longer belonged to her because the support received involved healthcare workers ‘grabbing [her] breasts’ (Beck and Watson, 2008: 234) rather than opting for a hands-off technique and woman-centred approach. One participant recounted: ‘Why do it [breastfeed] when to learn and to do it invites assistance from health professionals, and if you even touch my body again, or touch me like that, I am going to kick you…’ (Beck and Watson, 2008: 234).

This illustrates the negative way breastfeeding support was seen by some women following a CS.

Nevertheless, not all women perceived postnatal breastfeeding support as negative. Women in McGrath and Phillips’ (2009) study recalled the help from midwives in relation to breastfeeding as supportive, while Baxter (2006) stated that 60% of 146 participants found support from staff to be sufficient; Tully and Ball (2014) also noted that most women considered midwives as supportive.

Artificial milk supplementation
The WHO recommends exclusive breastfeeding for the first six months of a baby’s life (WHO, 2016). Early introduction of artificial milk supplementation following a CS was reported by all nine authors. Baxter (2006) suggested that one reason for the high number (47%) of artificial feeds given to breastfeeding babies in their study was women’s perception of insufficient milk supply.

Mothers who had experienced a previous CS who subsequently underwent another gave the reason that mixed feeding was successful last time (Tully and Ball, 2014), while other breastfeeding mothers admitted to choosing artificial milk overnight in order to get more sleep (Tully and Ball, 2014).

CS delivery impacted on breastfeeding duration throughout the immediate six months postpartum. Women who underwent a CS delivery were less likely to exclusively breastfeed at seven days, three months and six months postpartum compared with those after a vaginal birth (Zanardo et al, 2010). In relation to breastfeeding rates in the postnatal period, when comparing method of CS delivery, elective or emergency, women who underwent an emergency CS were more likely to cease breastfeeding sooner than those who underwent a planned caesarean. These results are supported by the findings of Brown and Jordan (2013).

Much of the research illustrated the commonality of women not initiating breastfeeding within the timeframe of one hour postpartum, as recommended by WHO et al (2009). In their study of 60 women, Albokhary and James (2014) found that mothers who gave birth via CS were 93% more likely to not breastfeed in the first hour following birth than women who gave birth vaginally.

When comparing types of delivery, women who underwent a CS were 12 times more likely to suffer delayed initiation of breastfeeding over 24 hours postpartum (Albokhary and James, 2014). A total of 40% of the sample of 60 women who had undergone a CS did not initiate breastfeeding within 24 hours postpartum (Albokhary and James, 2014). Woods et al (2012) reported that the mean time from birth to initiation of breastfeeding in their total sample of 621
women was 249.3 minutes or 4.16 hours; some three hours over the WHO recommendations. Skin-to-skin contact is positively associated with breastfeeding success (Robiquet et al, 2016). In the research conducted by Albokhary and James (2014), the majority of babies were cared for in a separate healthy baby nursery away from their mothers. This is similar to the circumstances described in Zanardo et al’s (2010) study. In addition to this, mothers who had skin-to-skin contact following their deliveries did not have extended contact with their newborns (Albokhary and James, 2014). The longest period of skin-to-skin contact achieved was by 1% of the sample (Albokhary and James, 2014) who had between 11 and 15 minutes of contact – 45 minutes shorter than the time recommended by WHO et al (2009). CS delivery impeded women’s ability to experience immediate and prolonged periods of skin-to-skin contact with their newborn consequently leading to poor breastfeeding initiation rates and higher rates of artificial milk supplementation in this group of women (Albokhary and James, 2014).

Reasons for artificial milk supplementation post CS are not limited to the lack of skin-to-skin contact following birth. Tully and Ball (2014: 717) found that women ceased breastfeeding and supplemented feeds with artificial milk for a number of reasons: in an attempt at ‘satiating [the] infant’, as a result of a lack of support, to minimise wound pain involved with breastfeeding, and as a result of a lack of knowledge about colostrum and early infant satisfaction. This supported earlier research by McGrath and Phillips (2009), who found that breastfeeding mothers quickly turned to artificial feeding when obstacles occurred such as lack of support, lack of enjoyment, perceived pressure, post-operative pain, lack of sleep and if the baby was in the neonatal unit. Women post CS perceived newborns to be more settled on formula milk and ceased breastfeeding due to fears of an inadequate milk supply (Brown and Jordan, 2013).

A link between maternal perception of inadequate milk supply and the uptake of artificial milk was reported by several authors (McGrath and Phillips, 2009; Beck and Watson, 2008; Baxter, 2006). The perception of insufficient milk supply was the most commonly cited reason for breastfeeding cessation within 18 weeks of birth, with 29.2% of a group of 89 women agreeing (Baxter, 2006). In Beck and Watson’s (2008) study, women described traumatic birth experiences as having affected their milk supply or their perception thereof. Women who initially breastfed their babies but gave up when faced with difficulties described a sense of not having enough breastmilk for their babies (McGrath and Phillips, 2009).

Furthermore, participants in Tully and Ball’s (2014) study believed that they had an insufficient milk supply because they were unaware of normal nocturnal feeding habits and the importance of night-time breastfeeds. An association between frequent waking and poor milk supply was made by mothers who lacked sufficient knowledge on breastfeeding physiology and this impacted on breastfeeding rates.

Discussion

Following this systematic literature review, it is evident that no one single factor affects breastfeeding post CS. The combination of poorly medicated or unexpected post-operative pain and a lack of support from both professionals and partners overnight was found to be associated with artificial milk supplementation in breastfeeding women. Lack of breastfeeding physiology and newborn behaviour knowledge in relation to breastfeeding also contributed to women’s breastfeeding demise.

Pain was found to be associated with lower rates of breastfeeding initiation and continuation. Women’s experiences of breastfeeding were impacted by the pain they experienced post CS. Not only was it established that pain reduced women’s experiences of breastfeeding, but it also proved significant in its effect on breastfeeding duration through the quantitative research findings (Albokhary and James, 2014; Brown and Jordan, 2013; Woods et al, 2012; Zanardo et al, 2010; Karlström et al, 2007). Women who experienced more pain post CS reported less frequent breastfeeding sessions in the first 48 hours postpartum (Woods et al, 2012).
Although no other study looked specifically into breastfeeding frequency, increased breastfeeding sessions over a 24-hour period could be argued to be associated with breastfeeding success. If less pain was seen to be attributed to more breastfeeding sessions, then more pain can be positively associated with breastfeeding cessation. This idea is supported by the findings of Woods et al (2012) and Karlström et al (2007). These findings help to illustrate the importance of careful pain management post CS in order for breastfeeding rates to improve.

Artificial milk supplementation was a significant issue in many maternity hospitals within the study (Albokhary and James, 2014; Tully and Ball, 2014; Brown and Jordan, 2013; Zanardo et al, 2010; McGrath and Phillips, 2009; Baxter, 2006). This is backed up by results from the latest UK infant-feeding survey (McAndrew et al, 2012), which found that although initiation rates of breastfeeding were similar in women post CS to those who delivered vaginally, 24% of breastfeeding mothers who underwent a CS mixed their infants on discharge from hospital, compared with 16% of mothers who delivered vaginally (McAndrew et al, 2012). Inadequate knowledge on the physiology of lactation, a lack of skin-to-skin contact following CS births, as well as poor support for women to breastfeed during the first hour postpartum and beyond, was found to affect rates of artificial milk supplementation (Albokhary and James, 2014).

The definition and need for support varies from one breastfeeding woman to the next. Support is not limited to that offered by professionals, but also encompasses the partner’s role in breastfeeding support. Women in Tully and Ball’s (2014) study reported difficulty in breastfeeding overnight when partners were sent home. Improved support for women breastfeeding overnight needs to be considered to ensure that breastfeeding women make the decision to cease or forego a breastfeed in favour of artificial milk, following, and not instead of, receiving support.

The negative way that breastfeeding mothers viewed postnatal support from some health professionals in Beck and Watson’s (2008) study highlights the importance of the availability of support from well-trained professionals. Some women were hesitant to press their buzzer for help from healthcare professionals as a result of the care they received (Beck and Watson, 2008).

Recommendations
The following recommendations aim to improve the rates of exclusive breastfeeding in the first six months following CS, as recommended by the WHO (2016). Although it is evident from the findings that breastfeeding post CS is impacted in a multitude of ways, the recommendations fall under one principal category: education – for both midwives and parents.

Timely and appropriate support was found to be influential in women’s breastfeeding success (Tully and Ball, 2014; Brown and Jordan, 2013; Baxter, 2006). Women in Beck and Watson’s (2008) study were clear that hands-on support was not effective, left women traumatised and influenced higher rates of artificial milk supplementation. Annual mandatory training for midwives exemplifying evidence-based practice relating to support and techniques for women breastfeeding post CS is strongly recommended. Within this training, ‘hands-off’ techniques for assisting women struggling to breastfeed must be taught to midwives to ensure that women receive support that promotes learning and upholds women’s dignity and respect (NMC, 2015).

Early introduction of artificial milk following a CS was reported by all nine authors (Albokhary and James, 2014; Tully and Ball, 2014; Brown and Jordan, 2013; Woods et al, 2012; Zanardo et al, 2010; McGrath and Phillips, 2009; Beck and Watson, 2008; Karlström et al, 2007; Baxter, 2006). A lack of skin-to-skin contact and inadequate knowledge regarding the milk supply contributed to the high rate of artificial milk supplementation that was apparent in breastfeeding women. Targeted education for both women and healthcare professionals is recommended to improve these figures. Midwives must enable early skin-to-skin contact where clinically feasible following a CS and prompt support with breastfeeding must be available for all women. Furthermore, it is recommended that women are educated on the physiology of lactation and the importance of regular breast stimulation in the form of breastfeeds and hand expression where necessary. This will help to ensure adequate milk supply and improve breastfeeding rates following discharge from hospital.

Pain was found to be negatively associated with breastfeeding success. While pain isn’t completely avoidable.

Figure 2. Breakdown of ‘PRESS’ stages

<table>
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<tr>
<th>‘PRESS’ for success</th>
<th>‘PRESS’ for success</th>
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<tbody>
<tr>
<td>P Prepare women for a CS birth, including tailored antenatal education relating to breastfeeding post CS.</td>
<td></td>
</tr>
<tr>
<td>R Elevate pain post CS to improve breastfeeding initiation and maintenance rates.</td>
<td></td>
</tr>
<tr>
<td>E Educate women on the physiology of lactation and the importance of night-time breastfeeding. Promote effective pain management through educating midwives on the negative correlation between pain and number of breastfeeding sessions.</td>
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</tr>
<tr>
<td>S Stimulate – remind women of the importance of stimulating their breasts through regular breastfeeding sessions (including overnight) and the consequences of artificial milk supplementation on breastfeeding longevity.</td>
<td></td>
</tr>
<tr>
<td>S Success with exclusive breastfeeding of all infants until aged six months following a CS of mothers who wish to breastfeed.</td>
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post CS, improving awareness of the significant association between pain and breastfeeding demise would enable better support for women attempting to breastfeed. Midwives would benefit from being educated on the importance of good pain relief and its positive association with improved breastfeeding exclusivity and longevity through teaching sessions and improved guidelines.

With 26% of the childbearing population currently at risk of giving birth by CS (McAndrew et al, 2012), it would be beneficial if all women were educated antenatally on how a CS may affect breastfeeding. Additionally, it is recommended that this teaching should empower women to be mindful of alternative breastfeeding positions to relieve wound pain. Information relating to the consequences of artificial milk supplementation and lack of breast stimulation overnight should be taught to women so that they are aware of the influence these have on breastfeeding longevity. An informed choice or decision is something that all women should be afforded.

It could be argued that only once education has been provided can a woman be said to be basing her decision to ask for a bottle or for support with breastfeeding on informed choice. Figure 1 was created with the intention of simplifying the above recommendations. The acronym ‘PRESS’ (Prepare, Relieve, Educate, Stimulate, Success) (see Figure 2) was thought appropriate in that women on postnatal wards were found to be hesitant to press the buzzers to ask for help with breastfeeding (Tully and Ball, 2014).

Conclusion

While post-operative pain, lack of support and artificial milk supplementation have been shown to impact on a woman’s ability to breastfeeding post CS, it is unlikely that this review alone has conclusively answered the research question. Due to the size and nature of this review, a larger study is recommended to allow the impact of CS on breastfeeding to be more widely understood.

In addition to this, more qualitative research on women’s experiences of breastfeeding post CS would be encouraged, as it was found that there has been more quantitative than qualitative research into this subject. There is a well-established link between both obesity and increased maternal age and CS delivery (Public Health England, 2016; McAndrew et al, 2012) and views from these groups of women and their breastfeeding journey following a CS would add depth to our knowledge of the subject.

References


