AN EXPLORATION OF HOW THIRD SECTOR BREASTFEEDING SUPPORT ORGANISATIONS HAVE DEVELOPED THEIR SERVICES FOR DELIVERY IN AREAS OF SOCIO-ECONOMIC DEPRIVATION

by

Louise Susan Hunt

A thesis submitted in partial fulfilment for the requirements for the degree of Doctor of Philosophy at the University of Central Lancashire

June 2019

STUDENT DECLARATION FORM

University of Central Lancashire

Type of Award: **Doctor of Philosophy**

School: **School of Community health and Wellbeing**

1. Concurrent registration for two or more academic awards

I declare that while registered as a candidate for the research degree, I have not been a registered candidate or enrolled student for another award of the University or other academic or professional institution

2. Material submitted for another award

I declare that no material contained in the thesis has been used in any other submission for an academic award and is solely my own work

3. Collaboration

Where a candidate's research programme is part of a collaborative project, the thesis must indicate in addition clearly the candidate's individual contribution and the extent of the collaboration. Please state below: NA

4. Use of a Proof-reader

The following third party proof-reading service was used for this thesis: Janey Fisher in accordance with the Policy on Proof-reading for Research Degree Programmes and the Research Element of Professional Doctorate Programmes. A copy of the confirmatory statement of acceptance from that service has been lodged with the Research Student Registry.

Signature of Candidate

Print name: **LOUISE SUSAN HUNT**

ABSTRACT

Inequalities in UK breastfeeding initiation and continuation rates exist whereby socio-economically advantaged mothers are most likely to breastfeed. Breastfeeding peer support (BPS) interventions are recommended as a solution, and consequently third sector breastfeeding organisations are commissioned to deliver UK BPS services in areas of socio-economic deprivation. BPS interventions have a mixed evidence base, and a key evidential gap concerns understanding interaction between context[1] and intervention. This study explored how and why these organisations have developed BPS services within socio-economically deprived contexts.

The study was completed in two phases. During phase one an exercise was undertaken to establish background information about the four main UK breastfeeding organisations. Semi-structured interviews with BPS organisation strategists and representatives (n=7) were undertaken, complemented by a meta-synthesis of published literature. Phase two constituted case studies of two BPS services in different areas of deprivation in England.

Semi-structured interviews were undertaken with: mothers who had (n=10) and had not engaged (n=9) with the BPS services, peer supporters (PSs) (n=9), community health professionals (n=5), infant feeding co-ordinators (n=2), third sector organisation managers (n=3), and public health commissioners (n=2). Inductive grounded theory analytic techniques of open coding and constant comparisons, followed by cross case

---

[1] In this study I use the word context to mean the social and physical environment in which people live. This includes the culture, people and institutions they interact with; ‘the situation within which something exists or happens, and that can help explain it’ (Cambridge Dictionary, 2019a).

comparisons, were used to analyse data. One over-arching theme and four main themes were constructed.

The over-arching theme *‘the transcending influence of society’* explains how the combination of funding availability and data sharing arrangements, determined service operation and PSs access to women. Although commissioners required that more support be given to the target group of women, this was not always achieved. The acceptability of the peer support role, operating at the individual, social group, and community levels was captured by *‘the role’* main theme. The second main theme, *‘access,’* concerns developments to improve the access of target women. The third main theme, *‘embedding’* describes the community-professional connections for supporting access. The final main theme, *‘service management’* captures issues of funding and the relationship with time, communication, and reporting.

Findings suggest that organisational practices do not facilitate the discussion, collection, and use of contextual knowledge to inform ongoing development of BPS services. Recommendations include development of a theoretical tool to facilitate the use of contextual knowledge.

TABLE OF CONTENTS

LIST OF TABLES AND FIGURES

TABLES

FIGURES

LIST OF ABBREVIATIONS

ABM Association of Breastfeeding Mothers

BfN Breastfeeding Network

BFC Breastfeeding Counsellor

BFI Baby Friendly Initiative

BPS Breastfeeding Peer Support

IFC Infant Feeding Co-ordinator

KPI Key Performance Indicator

LLL La Leche League

NCT National Childbirth Trust

PSs Peer Supporters

SEM Social Ecological Model

ACKNOWLEDGEMENTS

Undertaking my PhD has been an exciting and demanding enterprise for me. There are many people who have helped and encouraged me, whom I would like to acknowledge and thank.

Firstly, my supervisory team, Professor Fiona Dykes, Dr Gill Thomson, and Dr Karen Whittaker. Thank you. You have formed a fantastically supportive team throughout. You have always been there for me. Your comments have always been helpful and constructive and your encouragement invaluable. At those moments when I felt as if I could not complete the task, your belief in me helped me keep going. Even through the NHS ethics process which could so easily have claimed me. Thank you for all your time spent reading my work. It has been very much appreciated.

Thank you to the third sector organisations and their representatives that took part in my study. I am so grateful for your involvement and willingness to share. This study would not have been possible without you. Thank you.

Thank you to the mothers, PSs, health professionals, managers, key strategists and commissioners who kindly gave up their precious time to take part in this study. Your openness and honesty in talking to me about both personal experiences and your work has been humbling. I hope I have done justice to your experiences.

To my family and friends for their ongoing support, thank you. To my father John for listening as my ideas developed, to my mother Mary for appearing at my door with lovely dinners ready for the oven, and to my husband Andrew for believing in me throughout. Thank you to my children, Anna for listening to me talk through ideas, and for being the trial audience for several presentations, and Joseph and Elsie for being kind and helpful and bringing me cups of tea and coffee. Thank you too to my friends

Janey Fisher for proof reading my thesis, and Shelly Duncan-Adams for always being so supportive, listening to every twist and turn and believing I could get to the end. Thank you too to my ‘PhD friends’ Steph Heys, Naoimh McMahon and Claire Feeley. You have been supportive throughout every sticky point, and I could not have got through this journey without you all. Thank you.

1.0 CHAPTER 1: INTRODUCTION

1.1 INTRODUCTION

In this thesis, I explore how UK third sector breastfeeding organisations have developed BPS interventions for areas of deprivation. In this chapter, I explain my reasons for wanting to undertake this study, provide a study rationale, summarise the research design including my study's aims and objectives, provide information about the theoretical underpinnings of my study, and provide a summary of the thesis structure.

1.2 MY MOTIVATION TO UNDERTAKE THIS STUDY

In the past I helped to establish a small third sector breastfeeding support organisation in Cornwall, South West England. I have previously served as a director and worked in both paid and voluntary employment both managing projects and as a breastfeeding counsellor and peer supporter for this organisation. This work led me to feel that different people may have different aims and visions for such organisations and that it may be simplistic to see them merely as there to 'do good'.

In 2010, the organisation was commissioned to set up a pro-active telephone BPS service in five trial areas of the county. Several of these areas were areas of deprivation. I set this service up and got it underway. In 2012, a meta-regression analysis of the impact of BPS in the UK and other high-income countries reported no impact on breastfeeding outcomes (Jolly et al., 2012). This publication coincided with a change in commissioning circumstances and priorities in Cornwall, and funding for the BPS service was quickly withdrawn. The Jolly et al., (2012) study was concerned with pre-determined measurable outcomes (i.e. the impact of BPS on breastfeeding duration rates) and could not offer explanations or theoretical insights about its findings. I felt frustrated that just as I was starting to understand the complexities of the operation of the service I was working in, the opportunity to learn more was lost.

Through long-term involvement with BPS services locally I became particularly interested in access to BPS and to question why many women do not access it. This formed the focus of my Research Masters qualification which I completed at UCLan in 2014 (please see Hunt and Thomson, (2016)). During and following this I read about health inequalities theory and research. I also engaged with other UK third sector breastfeeding organisations at conferences when I met some of their members and listened to presentations about their research and work. I started to wonder why, as a general observation, third sector breastfeeding organisations and their members seemed particularly interested in the intricacies of helping individual women, while all I could think about was the relevance of the broad context of women's lives, and the fact that most women stop breastfeeding very early. These experiences form part of my motivation to undertake the current study, and to undertake it using qualitative research methods able to capture service contextual features.

1.3 STUDY RATIONALE

- Breastfeeding is a public health priority, however there are inequalities in UK breastfeeding initiation and continuation rates; mothers living in areas of socio-economic deprivation are the least likely to breastfeed, while older, more highly educated women living in the least deprived areas have the highest incidence of breastfeeding (Mc Andrew et al., 2012). This forms an important part of the larger cycle of nutritional deprivation whereby social, psychosocial, behavioural, physical, and patho-biological factors combine to transmit poor nutritional status through the generations (Dykes & Hall Moran, 2006).

- BPS interventions are nationally and internationally recommended to increase breastfeeding rates (World Health Organisation (WHO) 2003, National Institute for Clinical Excellence (NICE) 2005, 2008 and Department of Health (DoH) 2004), and are also expected to help address inequalities (NICE, 2008).
- The evidence base for BPS interventions is mixed. Qualitative research highlights its value in promoting breastfeeding continuation and maternal well-being (e.g. Thomson, Crossland, & Dykes, 2012a), and Cochrane Reviews found that additional support from both lay supporters and professionals has a positive effect on breastfeeding outcomes (McFadden et al., 2017; Renfrew, McCormick, Wade, Quinn & Dowswell, 2012a). However, as identified earlier, when aggregated together, trials of BPS in high-income countries, and in particular the UK, have been found to be ineffective in increasing breastfeeding rates (Jolly et al., 2012). A key aspect of heterogeneity in the UK trials included in the Jolly et al. (2012) review relates to the context in which they took place. An important gap in the current evidence base is a lack of understanding about how such interventions interact with the context of service provision (i.e. social, cultural, economic, interpersonal issues), and which aspects of the context are important and why.
- The context of socio-economic deprivation is important to investigate because it is both the context within which babies and mothers are most vulnerable, and in which BPS interventions are now most often commissioned.
- Third sector organisations have middle-class roots and membership, yet are being commissioned to provide BPS interventions in areas of deprivation. Little is known about their engagement with the health inequalities agenda, nor how they develop their services to meet the needs of the women they support.

- Current government policy[2] envisages an important role for the third sector within health services generally (NHS, 2019) and as part of efforts to impact health inequalities (Institute of Health Equity (IHE), 2018; Voluntary, Community, and Social Enterprise Review (VCSE), 2016). It is therefore important to explore how interventions run by third sector organisations work in practice.

- We have limited holistic[3] knowledge of BPS interventions that incorporates the views of all key stakeholders. This is because quantitative studies focus on measurable outcomes such as breastfeeding rates (i.e. Jolly et al., 2012), realist approaches may privilege the views of researchers and programme designers (Porter, 2015), and qualitative studies do not often examine whole interventions (Leeming, Marshall & Locke, 2017). Most of the published literature concerns experimental peer support interventions, rather than non-experimental organically developed services (Trickey et al.,2018). A holistic study of non-experimental BPS interventions may enable more natural insights into how services have developed and evolved, and give voice to the experiences of everyone involved.

- BPS interventions have been expected to foster individual, meso, and macro level changes[4] yet we lack overarching theories about how they might be

---

[2] A policy is a plan of what to do in particular situations, or a set of ideas, that has been officially agreed by a group of people, a government, a political party, or a business organisation (Cambridge Dictionary, 2019b).

[3] The word holistic means to deal with the whole of something and not just a part (Cambridge Dictionary, 2019c). For example, a holistic approach to studying an intervention seeks to build a 'big picture' view of the whole intervention from several different perspectives, to consider how different parts of the whole intervention are connected, and to think about how physical, cultural, emotional, and social contexts make up the whole.

[4] Macro level change refers to societal change, meso – to community level change, and individual – to personal level change. Please see McLaren and Hawe (2004) for detailed explanation of the ecological perspective in health.

working at meso and macro levels (Trickey et al.,2018). A context-based holistic study using an approach capable of generating theory may begin to contribute to this knowledge gap.

- It is generally agreed that social inequalities cause health inequalities, but social inequality its-self is often poorly defined (Douglas, 2015). A holistic study of the development of BPS interventions in areas of deprivation may help identify the kinds of social inequalities that are important in this situation.

This rationale highlights the relevance and importance of a study exploring how UK third sector breastfeeding organisations have developed BPS interventions for areas of deprivation. It suggests that a holistic study of non-experimental interventions that focuses on context and is capable of building theory would be of value.

1.4 SUMMARY OF RESEARCH DESIGN INCLUDING STUDY AIMS AND OBJECTIVES

Based on the rationale above, the aim of my study was to understand how third sector breastfeeding support organisations have developed their services for delivery in areas of socio-economic deprivation. The study was undertaken in two phases. In phase one I planned to gain a sense of the history of the key national UK breastfeeding support organisations and their perspectives of providing peer support in these contexts. My objectives were to understand:

- The history, development, values, and ethos of third sector breastfeeding organisations;
- The extent to which the third sector breastfeeding organisations have engaged with the health inequalities agenda, and whether and how each organisation has adapted in order to provide services in areas of socio-economic deprivation.

In order to meet these objectives, I undertook a meta-synthesis and semi-structured interviews with key organisational strategists from the four national UK third sector breastfeeding support organisations. I used the outcomes of this work to inform the design of phase two. Phase two comprised of two case studies of two BPS interventions run by two different third sector organisations in two different parts of England. My choice of site was guided by several factors (see chapter 7, section 7.3.1), but key among them was a site's potential to enable me to learn about service development. This meant that the services delivered at the two study sites differed considerably. The objectives were to understand:

- The context of the lives of women living in areas of socio-economic deprivation;
- The extent to which the support was acceptable to women;
- The interface between the third sector organisations and women's lives, including how context-related issues impact upon the work of the organisations.

1.5 THEORETICAL UNDERPINNING

I adopt social constructionism as the epistemological basis of the study (see chapter 4) which posits that systems of meaning making in society '*precede*' (Crotty, 1998, p.52) each individual. I also take a critical approach in that inherited culture and societal institutions are not accepted as neutral but questioned, and power relations, both in the form of top down bureaucratic power, and bottom up power emanating from individual actions and speech, are accommodated. I use a case study approach useful in addressing 'how' and / or 'why' questions (Yin, 2014), and in facilitating the maintenance of a holistic, 'real world' perspective (Merriam, 1998; Shaw, 1978; Yin, 2014).

1.6 THESIS STRUCTURE

My thesis is structured in the following way.

Chapter 2 Background

In this chapter, I contextualise my study by providing background information about breastfeeding in the UK, health inequalities, UK policy and action related to infant feeding, the history, nature, function and evidence base for BPS, and the place of third sector organisations in UK society.

Chapter 3: Qualitative Meta-synthesis

In this chapter, I present my qualitative meta-synthesis. This provides a synthesis of the published qualitative literature concerning the practices of third sector breastfeeding support organisations in areas of deprivation in the UK. I outline the rationale, aims, objectives and method used to undertake the review. Findings are presented in four themes, and the chapter concludes with a discussion of how these findings inform my study.

Chapter 4 Theoretical Position

In this chapter, I explain and justify the ontological and epistemological underpinnings of my study, my theoretical position, and the case study methodology I have adopted. I explain how these underpinnings relate to study outcomes and the knowledge claims my study is able to make.

Chapter 5 Methods One

In this chapter, I explain why the study was designed in two phases and the aims and objectives of each phase. I detail how ethical issues were addressed. This is followed by a description of the methods used to conduct phase one interviews. Finally, the methods used to demonstrate trustworthiness and reflexivity in my study are detailed.

Chapter 6 Phase One Interview Findings

Here I provide 'pen portraits' of the four UK breastfeeding support organisations that participated in phase one interviews. I then present four themes to explain the strategies, adaptions, and developments the key organisational strategists feel their organisations have used to deliver BPS services in areas of deprivation. Key strategists' insights into the contexts of socio-economic deprivation in which services operate, and the broad societal and political context in which the organisations themselves operate are outlined. I conclude the chapter by presenting two diagrams to illustrate the findings.

Chapter 7 Phase Two Design

In this chapter, I outline how the findings resulting from phase one research activities (the meta-synthesis and phase one semi-structured interviews with key strategists) were brought together and used to underpin, inform, and design phase two.

Chapter 8 Phase Two Methods

In this chapter, I describe the methods used in phase two data collection. The research activities undertaken, and participant groups involved are outlined, inclusion and exclusion criteria, and the study information provided are explained. I justify and explain the research activities of making informal site visits, conducting observations, and undertaking individual semi-structured interviews including how participants were recruited.

Chapter 9 Phase Two Findings

In this chapter, I present the findings of my phase two data collection through one overarching theme of '*the transcending influence of society'*, and four main themes of *'the role', 'access', 'embedding'* and '*service management'*. Together they explain how services have developed for areas of deprivation.

Chapter 10 Discussion and Conclusion

In this chapter, I summarise the findings of the thesis and discuss them in light of other theory, literature and policy. I discuss the strengths and limitations of the study as well as its relevance to research, practice and policy. I then consider my study outcomes and the unique contribution to knowledge my study makes. My thesis concludes with a reflection.

In this introductory chapter, I have explained my own reasons for wanting to undertake this study, provided a study rationale, summarised the research design including my study's aims and objectives, provided information about the theoretical underpinnings of my study, and provided a summary of the thesis structure. In chapter 2, I provide background information concerning the history of UK third sector breastfeeding organisations, and contextualise my study in relation to the concept of health inequalities, the position of the third sector in UK society, and the BPS evidence base.

2.0 CHAPTER 2: BACKGROUND

2.1 INTRODUCTION

In the previous chapter, I introduced my study and explained my own reasons for wanting to undertake it. I provided a study rationale, summarised the research design, and provided a summary of the thesis structure. In this chapter I contextualise my study by providing background information about breastfeeding in the UK, health inequalities, UK policy and action related to infant feeding, the history, nature, function and evidence base for BPS, and the place of third sector organisations in UK society.

2.2 THE IMPORTANCE OF BREASTFEEDING

A recent WHO evidence review of health effects associated with breastfeeding brought together meta-analyses and systematic reviews of the current evidence (Grummer-Strawn & Rollins, 2015). Superseding previous reviews, it indicated breastfeeding's public health relevance for high, middle, and low-income countries worldwide, finding '*substantial*' (p.2) health benefits associated with breastfeeding including protection against a range of short and long-term negative health outcomes for both mothers and babies (Grummer-Strawn & Rollins, 2015). For example, for babies and children breastfeeding was found to be associated with reduced risk of mortality (Sankar et al, 2015), and it has been estimated that increasing breastfeeding across the world could prevent over 800,000 child deaths per year (Victora et al, 2016). Breastfeeding was associated with a reduced risk of obesity (Horta et al, 2015), ear infection (Bowatte, et al, 2015), and with higher IQ scores (Horta, de Mola, & Victora, 2015). Indeed, the worldwide costs of lower cognitive ability associated with not breastfeeding have been estimated to be $300 billion per year (Rollins et al., 2016). For mothers, breastfeeding was found to be associated with reduced risk of breast and ovarian cancer, type two diabetes and post-partum depression (Chowdhury et al, 2015). The WHO authors highlight the '*major contribution'* breastfeeding makes to the health of mothers and babies worldwide (Grummer-Strawn & Rollins, 2015, p.2).

In the UK a cost benefit analysis has found that modest increases in breastfeeding could save over £17 million per year by avoiding the costs of treating four acute diseases in infants (Renfrew, Pokhrel et al., 2012b), and children from low income backgrounds who are breastfed have been found to be likely to have better health outcomes than children from higher income backgrounds who are formula fed (Wilson et al., 1998).

2.3 BREASTFEEDING IN THE UK

Over the first half of the twentieth century breastfeeding rates in industrialised countries declined dramatically (Fildes, 1986) reaching their lowest levels in the UK in the 1960's and 1970's (UNICEF, 2012). The UK government began monitoring breastfeeding patterns in the mid 1970's when the Office for Population Censuses and Surveys (OPCS) undertook the first of a series of national surveys (Carter, 1995). Table 1 below shows UK breastfeeding rates since 1974.

Table 1 UK breastfeeding rates since 1974

Date	Initiation	Six-week rate	Reference
1974-5	51%	24%	(Carter, 1995).
1980	67%	42%	(Carter, 1995).
1995	66%	42%	(Foster, 1997).
2010	81%	55%	(McAndrew et al., 2010).

2016-17[5]	74.5%	44.4% (some breastmilk at six to eight weeks)	(NHS England, 2018).

These national average rates mask significant within population differences in infant feeding practices; in the UK there is a longstanding association between incidence of breastfeeding (the proportion of babies that were breastfed initially) and a mothers age, such that older mothers are most likely to breastfeed (Mc Andrew et al., 2012). The most recent national infant feeding survey found 58% of mothers aged under twenty breastfed, compared to 87% of mothers aged over thirty (McAndrew et al., 2012). Further, compared to white mothers, mothers from all minority ethnic groups have a higher incidence of breastfeeding (McAndrew et al., 2012). For example, 97 % of Chinese mothers and 96% of Black mothers breastfed, compared to 79% of white mothers (McAndrew et al., 2012). Meanwhile, studies exploring mothers' experiences suggest that breastfeeding care can engender feelings of isolation and disempowerment in young mothers (Hunter, Magill-Cuerden & McCourt, 2015), and that there is potential for mothers from disadvantaged groups to disconnect from health service provision (MacGregor & Hughes, 2010). In the 1980s social class was recorded in categories from category 1 (professional and managerial) to category 5 (unskilled) (Carter, 1995). In 1985 a gradient in breastfeeding rates was noted such that 87% of mothers in social class one started breastfeeding as compared to 43% of those in social class five (Carter, 1995 p.6). Similar patterns were noted in 1988 (Martin & White, 1988), 1990 (Carter, 1995), and 2012 (Mac Andrew et al., 2012). This social patterning

---

[5] The UK government cancelled the national infant feeding survey due to take place in 2015. The 2016-17 rates detailed above therefore derive from the public health profiles complied by Public Health England (PHE). The national infant feeding survey and the public health profiles have methodological differences which give differing rates. This means that it is unlikely that rates have dropped since 2010 (personal communication from PHE).

means that '*in general in western countries class and income appear to be the most consistent features* [associated with patterns in breastfeeding rates]*'* (Carter, 1995, p.9). Despite this, Mc Andrew et al. (2012) note the complexity and inter-linking of these patterns and statistics; for example, mothers from minority ethnic backgrounds and young mothers are more likely to live in areas of deprivation and less likely to have managerial and professional jobs (Mc Andrew et al., 2012). Such social patterning forms part of wider social patterns of health described as health inequalities.

2.4 HEALTH INEQUALITIES

The term health inequalities is used to describe differences in health across a population that are '*systematic, socially produced (and therefore modifiable) and unfair'* (Whitehead & Dahlgren, 2006, p.2). Such consistent patterns of health differences are not part of the natural variances in health expected between people, such as elderly people having poorer health than the young, rather, these differences show a consistent pattern across socioeconomic groups (Whitehead & Dahlgren, 2006). Such differences are not confined to a gap between the economically advantaged and disadvantaged, but follow a gradient so that throughout society a higher social position is associated with better health (Marmot, 2017).

In the UK socio-economically patterned differences in health were first reported by Chadwick in 1847 and led to the Public Health Act of 1848 (Oliver, 2008). This act legislated for improvements to living conditions such as provision of sanitation and the establishment and improvement of water supplies (Oliver, 2008). Free access to health care via the establishment of the NHS in 1948 was expected to remove any remaining health inequalities (Oliver, 2008), however the inverse care law demonstrated that rich people accessed free health care (including maternity care) most readily (Tudor Hart, 1971), and socioeconomic inequalities in death rates in the 1970s were the highest since accurate records began (Oliver, 2008). Consequently, an independent commission on health inequalities was established resulting in the publication of the Black report (1980).

The Black report demonstrated that health disparities between socioeconomic groups were present throughout the life-course, and attributed them to differences in incomes, the conditions in which people live and work, as well as standards and levels of education, transport facilities, smoking, diet and alcohol consumption (Black, 1980). It also pointed out that the health service itself contributed only slightly to the observed differences in health (Black, 1980). The Black report recommended a suite of measures designed to improve the material conditions of the worst off in society such as increases in maternity grants and infant care allowances. Black (1980) was followed by further independent inquiries (Acheson (1998) and Marmot (2010)) reaching largely similar conclusions, and giving particular focus to reducing health inequalities among women of childbearing age, babies and young children (Acheson, 1998; Marmot, 2010).

Various theories have located the causes of health inequalities at different points along a spectrum from the level of society (structural theory) to the individual (cultural and behavioural theories) (Smith, Bambra, & Hill, 2015). However, there is general consensus across the health inequalities literature that social inequality causes health inequalities (Douglas, 2015), and that differences in the conditions of daily life, or the social determinants of health, form '*a major part'* (Commission on Social Determinants of Health (CDSH), 2008 p.1) of the health inequalities found both within and between countries (CSDH, 2008). So reliable is the link between living conditions and health that health indicators such as infant mortality rates and life expectancy are used as proxy measures for people’s general living and working conditions (e.g. Esty et al., 1998).

2.5 UK HEALTH INEQUALITIES POLICY

The UK is recognised as a global leader in health inequalities research and policy (Garthwaite, Smith, Bambra, & Pearce, 2015). As described above health inequalities theory and consecutive independent health inequalities reports see health inequalities as a societal level issue and recommend actions to impact upon the social determinants of health, with particular emphasis on intervention early in the life course (Acheson, 1998; Black, 1980; CSDH, 2008; Marmot, 2010). However, throughout the 1980s and 1990s UK health policy was based upon the twin principles of personal responsibility for health and the efficient management of health care services (Popay & Williams, 1994). New Labour policies of the late 1990s and early 2000s recognised the need for state intervention to improve living and working conditions, particularly those of babies and young children (Smith, 2013), and government rhetoric (i.e. persuasive and appealing phrases used in speeches and documents) at the time frequently referred back to the independent health inequalities reports such as Acheson (1998) (Smith, 2013). However, the focus of New Labour policy fell largely upon area-based interventions in communities with significant deprivation (Smith, 2013).

Several authors point out the concept of ‘lifestyle drift’ (Popay, Whitehead, & Hunter, 2010) whereby although living conditions and their material, behavioural, and psychological effects may be recognised as the main determinants of health, the public policies that precede them are not emphasised (Raphael, 2011; Popay et al., 2010). This means that there is a danger that initiatives are put in place that focus on individual behaviours, rather than the underlying factors that affect them (Raphael, 2011; Popay, Whitehead & Hunter, 2010). An analysis of English health inequality policy literature published between 1980 and 2011 demonstrates the presence of this effect as it found that health inequality was problematised as an issue caused by an individual's lack of information, by constraints upon an individual's behaviour, and by an individual's flawed choices (Kriznick, 2015). During lifestyle drift, any health-related intervention targeting disadvantaged groups can be considered to be addressing health inequalities (Douglas, 2016). Individual behaviour change programmes popular during life style drift relate to Popay and William's (1994)'s twin pillars (i.e. personal responsibility for health, and efficient management of health care systems), and breastfeeding interventions have the potential to form an example of such interventions if they focus only on individual behaviour.

Therefore, in the policy literature, health inequalities and actions to impact upon them came to be viewed as discrete individual level issues. There is evidence this perception persists today as a recent report advocates the establishment of 'demonstration projects' whereby third sector organisations work to address a small number of discrete health inequalities (Voluntary, Community, & Social Enterprise (VCSE), 2016). However, despite this tendency towards fragmentation, attempts have also been made to try to address health inequalities by working across the health system. For example, by working on a proportionate universal basis as outlined below.

While recognising that the social determinants of health rather than health care services have the greatest impact on health (Marmot, 2010), a recent review highlights several possible actions health professionals and health services can take in order to have a positive impact upon the social determinants of health (Institute of Health Equity (IHE), 2018). The review explains that health services can focus on preventing ill health and promoting good health in addition to delivering treatment. It recommends focusing on place-based population level health, giving special attention to the most disadvantaged areas, and working collaboratively with other sectors on a proportionate universal basis, in order that social and economic conditions can be improved. Proportionate universal policies are designed to respond to local health needs and risks and direct additional action and resource to communities where deprivation levels are higher (IHE, 2018).

Despite agreement across the health inequalities literature that social inequality causes health inequalities, social inequality itself is often poorly defined (Douglas, 2015). The aspects of social inequality most important to health, and the relative importance of income, power, wealth, and status inequality require definition, theorising and empirical evidence (Douglas, 2015). Just as actions to address health inequalities may take place at structural, community, and/or individual levels, so too determinants of infant feeding behaviours are conceptualised to take effect across similar multiple levels.

2.6 POLICY AND ACTION RELATED TO INFANT FEEDING IN THE UK

The British state has shown concern about whether women breastfeed since the mid nineteenth century when medical officers linked increased infant mortality to a lack of breastfeeding (Carter, 1995). In 1943 the Ministry of Health recommended breastfeeding for three months to provide the *‘flying start’* babies needed (Ministry of Health, 1943, p.7), and in response to research demonstrating the health benefits of breastfeeding undertaken in the 1970’s and 1980’s (for example; DHSS, 1974; DHSS, 1980; DHSS, 1988), the UK government began to strongly encourage breastfeeding (Carter, 1995). Systematic reviews of studies of the determinants of breastfeeding have identified factors operating at the macro (the socio-cultural and market context i.e. the extent to which artificial baby milks can be freely marketed), meso (health services and systems, the family, community and workplace contexts), and individual levels (the mother and infant relationship) (Rollins et al., 2016). Reviews recognise that each of these levels interacts with and influences the next (Rollins et al., 2016). In the UK, there has been a lack of strong political, policy and legislative will to address determinants of breastfeeding operating across the three levels (World Breastfeeding Trends Initiative (WBTI), 2016).

At the structural level, potential interventions involve legislation and policies influencing social trends, media, the products available, and advertising which in turn exert influence across the whole population (Rollins et al., 2016). In the UK women have access to maternity leave (Bragg, 2017), but there is currently no legal right to breastfeeding breaks in the work place (WBTI, 2016). Although the 2010 UK equality act makes it illegal to discriminate against somebody because they are breastfeeding in a public place (Maternity Action, 2018), breastfeeding in public is often perceived to be unacceptable, so that many women feel embarrassed and worried about doing so (Boyer, 2012; Thomson, Esbich-Burton & Flacking, 2015). Formula feeding is most commonly visible within UK media (i.e. O’Brien, Myles & Pritchard, 2016), and within families and social networks there are often low levels of knowledge about breastfeeding (McInnes, Hoddinott, Britten, Darwent & Craig, 2013). To date there has been no multi-media campaign to promote breastfeeding (WBTI, 2016). The international code of marketing of breastmilk substitutes is a voluntary code regulating the marketing of breastmilk substitutes, foods and feeding equipment in order to protect the health of babies and young children worldwide from aggressive marketing practices (UNICEF Baby Friendly Initiative, 2018), yet it is not fully implemented in the UK

(WBTI, 2016)[6]. The Department of Health (DoH) in England currently requires local authorities to report breastfeeding rates and work to increase them as part of the Public Health Outcomes Framework for England (DoH, 2012a), however reporting is incomplete (WBTI, 2016). The UK currently has no national policy or programme co-ordinator for breastfeeding, and no high-level funding or time bound expectations of improvements to infant feeding outcomes (WBTI, 2016).

At the settings level (i.e. this relates to influences that occur at a health services and system level as well as family, community and workplace contexts), a key barrier to breastfeeding is inadequate support from health care services (Aryeetey & Dykes 2018; Rollins et al., 2016). In the UK, cultural norms of routinised care have been reported (Crossland & Dykes, 2011) which can result in health services that do not meet women's needs. Since 1974 (DHSS, 1974) UK breastfeeding policy development has resulted in initiatives such as the UNICEF Baby Friendly Initiative (BFI) (WHO & UNICEF, 2009). The UNICEF BFI was established in 1992, brought to UK in 1995, and reviewed and updated to reflect the current evidence base in 2006, 2009, and 2018 (Aryeetey & Dykes 2018). The current UK requirements for BFI accreditation involve critical management procedures to support breastfeeding including the necessity that the code of marketing of breastmilk substitutes is adhered to, and important clinical practices to support breastfeeding such as skin-to-skin contact, rooming in, and encouraging mothers to recognise and respond to their babies feeding cues (Aryeetey & Dykes, 2018). The importance of BFI accreditation is highlighted by the NHS long term

---

[6] For example, existing regulation is not fully enforced; some professional health worker organisations and government programmes allow inappropriate conflicts of interest; laws preventing the promotion of breastmilk substitutes do not apply to all such products or to baby foods (WBTi, 2016). This means that promotion of follow on milk (for babies aged over six months) has been allowed, and as companies then use the same branding on their first infant formula, their full range of products are promoted (WBTi, 2016).

plan (2019) which requires all maternity services to commence accreditation (NHS, 2019), and is recommended by the National Institute for Health and Clinical Excellence (NICE) guidelines (NICE, 2008, 2011). The aim of NICE guidelines re infant feeding has been to increase breastfeeding rates across the whole population, alongside reducing health inequalities by increasing rates faster in those groups less likely to breastfeed (NICE 2008). The idea has been that by offering multi-faceted interventions, this aim would be better realised. This forms an example of an attempt to reduce the infant feeding health inequalities by means of interventions aiming to change individual behaviour discussed above. However, although the practices included in BFI accreditation have been demonstrated to be effective (WHO, 2017), at present not all UK services are accredited. Currently 64% of Maternity services, 68% of health visiting services, 43% of University midwifery courses, and 17% of University health visiting courses are baby friendly accredited (UNICEF BFI, 2019). Aryeetey and Dykes (2018) highlight the need for government funding and monitoring of the new BFI standards, and Perez-Escamilla, Hromi-Fiedler, Gubert, Doucet, Meyers, and dos Santos Buccini (2018) note that a key barrier to scaling up good practice is a lack of political will. Although BFI does not provide guidance or specific indications for BPS interventions, BPS schemes form part of the multi-faceted interventions mentioned above. They have been recommended by the World Health Organisation (WHO, 2003), the Department of Health (2004) and NICE (NICE, 2005, 2008), as a tool to increase breastfeeding rates and reduce health inequalities.

It is important to consider other ways of increasing breastfeeding rates in UK areas of deprivation that do not concern peer support. However, currently there are no high-quality UK trials examining the efficacy of additional health professional education and support for women living in disadvantaged areas. For example; none of the 28 included studies in a recent review of interventions to increase breastfeeding initiation concerned additional provision by UK health professionals in areas of deprivation (Balogun et al., 2016). Likewise, Lumbiganon et al., (2012) reviewed the evidence for antenatal education to increase breastfeeding rates. Of the 17 trials identified, just one concerned antenatal education delivered by health professionals in the UK, and this trial was not conducted in an area of deprivation (Lavender et al., 2005). A recent review of support for healthy breastfeeding mothers with healthy term infants (McFadden et al., 2017) identified one trial of additional health professional support in an area of deprivation (i.e. Jones & West, 1986). This trial involved women receiving extra support from a lactation nurse both in hospital and at home, and reported extended rates of breastfeeding (Jones & West, 1986). Despite the lack of evidence, it is important to note that health professionals have received additional training aimed to enhance their ability to promote breastfeeding to low income women (Entwistle, Kendall & Mead, 2007), and special intervention programmes such as the Family Nurse Partnership (FNP) have been trialled (Department of Health, 2012b). FNP originated in the USA and was designed to improve outcomes for young first - time mothers many of whom live in areas of deprivation (Department of Health, 2012b). Participating mothers receive intensive, structured visits from a specially trained nurse from early in pregnancy until their child is aged two. Although formative evaluation of the FNP showed that mothers enrolled in the intervention initiated breastfeeding at a significantly higher rate than those of the same age who were not enrolled (Department of Health, 2012b), an evaluation of the short term impacts of the FNP (which did not include breastfeeding rates), recommended the programme was not cost effective (Robling et al., 2016). Educational approaches have sought to improve teenagers’ attitudes towards breastfeeding (Lockley & Hart, 2003), and to increase family support for breastfeeding. For example, in Ingram and Johnson’s (2004) intervention, fathers and grandmothers received an educational visit during the antenatal period. This was associated with increased breastfeeding rates at eight weeks (Ingram & Johnson, 2004). A randomised controlled trial to assess the impact of financial incentives on breastfeeding rates was conducted in areas of deprivation with breastfeeding rates below 40% (Relton et al., 2018). Shopping vouchers with a value of £40 were used at five time points to incentivise breastfeeding. This was associated with a modest but significant increase in breastfeeding rates at 6-8 weeks (Relton et al., 2018). There is some evidence that third sector breastfeeding organisations have been involved in other approaches beyond peer support. For example, interactive educational sessions for use in schools have been developed and delivered (Breastfeeding Network, 2019), and individuals from third sector organisations have led community implementation of the BFI (Thomson, Bilson & Dykes, 2012), and formed part of BFI implementation committees (e.g. Rogers, 2003). In the following section I explain the history and function of BPS, and follow this with consideration of its evidence base.

2.7 THE HISTORY OF BREASTFEEDING PEER SUPPORT

In the 1950's childbirth and infant feeding had become medicalised in the western world, to the extent that in America, formula feeding had become the norm (Palmer, 2009). In response to US health services that did not provide the information, education and support they needed, a group of seven middle-class women who wanted to breastfeed formed a mother-to-mother support organisation called La Leche League (LLL) (Bazelon, 2008; La Leche League, 2018a; Palmer, 2009). Starting within their local community, the women started meeting together in each-others homes. LLL quickly spread across the USA (La Leche League, 2018a). In each new area, women were trained as La Leche League Leaders. A Leader is an experienced breastfeeding mother who has undertaken extensive training enabling her to lead a LLL group and provide one-to-one support to mothers (La Leche League, 2013). In 1987 in areas of deprivation that lacked support for breastfeeding, mothers who did not meet the criteria for training as LLL leaders began to be trained as breastfeeding PSs (Barker, 1999). BPS therefore started as an adaption of a middle-class self-help organisation in order to make it relevant to mothers in more socially deprived areas. Despite the rise in interest in breastfeeding demonstrated by the spread of LLL, it is important to recognise that not all women welcomed its resurgence. Many women valued the benefits associated with artificial feeding, e.g. greater ease in enabling their partners to help with feeding (Binns & Scott, 2002), and the facilitation of greater control of time (Zimmermann & Guttman, 2001).

The third sector refers to '*a space of organisational activity located between the state, market and private familial spheres comprising a diversity of organisational types including charities, social enterprises, faith, community and grassroots groups'* (Rees & Mullins, 2017, p.3).The UK origin of third sector breastfeeding organisations mirrored the USA experience in that the two oldest UK organisations that went on to develop their own BPS training courses, were formed by predominantly middle-class women in response to medicalised childbirth. First the National Childbirth Trust (NCT) originated in 1956, and although it did not start specifically in relation to breastfeeding, it did explicitly seek to challenge medicalisation (NCT, 2018), while La Leche League Great Britain (LLLGB) started in 1971 seeking to challenge practices separating mothers and babies and provide women with information, education and support around breastfeeding (La Leche League, 2018b).

The first UK peer support training was delivered in 1990 in an area of deprivation in Nottingham by a LLL Leader in response to the local health authority call for help to raise city breastfeeding rates (Gill, 2001). Subsequently other UK third sector breastfeeding organisations developed their own peer support training, often delivered by health professionals (Dykes, 2005).

In the late 1990’s and early 2000’s the UK government began requiring Primary Care Trusts (the local NHS bodies of that time responsible for service commissioning) to take steps to increase breastfeeding rates in their areas by 2% per year, with particular emphasis on women from disadvantaged groups (DH, 2002a). At the same time the government sought to stimulate the development of innovative area-based projects that would empower socially disadvantaged women to breastfeed through their Public Health Development Fund (Dykes, 2003). From 1999 – 2002, seventy-nine projects, twenty-six of which were BPS schemes, were supported and evaluated via this fund (Dykes, 2003, 2005). During the ten years from 1990 to 2000 demand for BPS training delivered by LLLGB rose dramatically from one to two training courses per year, to one or two per month (Gill, 2001). BPS was not just being used in areas of deprivation, but much more extensively (Barker, 1999), so that it was described as ‘*currently fashionable’* in 2006 (Hoddinott, Lee & Pill, 2006a, p.28). A recent UK wide survey found that peer support was provided in 56% of areas (Grant et al., 2017).

2.8 THE NATURE OF BREASTFEEDING PEER SUPPORT

Peer support is premised on a belief that learning ‘*occurs more effectively when presented by peers with whom individuals identify, and share common experiences’* (Dennis, 2003, p.326). This combines with evidence that women’s infant feeding behaviour is influenced by social peers (McFadden & Toole, 2006; McInnes et al., 2013). BPS can be delivered one-to-one or in a group (i.e. Hoddinott et al., 2006a), via phone (i.e. Thomson & Crossland, 2013), text (i.e. Martinez-Brockman et al., 2017), in the mother’s home (Scott, Pritchard, & Szatkowski, 2017), or online (i.e. Bridges, Howell & Schmied, 2018), and can be delivered across the ante-natal, intra-partum and post-partum time period (i.e. Thomson, Dykes, Hurley & Hoddinott, 2012b). A concept analysis of peer support within a health care context resulted in the following definition:

> '*The provision of emotional, appraisal, and informational assistance by a created social network member who possesses experiential knowledge of a specific characteristic or stressor and similar characteristics as the target population'* (Dennis, 2003, p.329).

This definition requires PSs share both characteristics and experiences with the people they support. These two components are integral to definitions used in many studies (for example, Dennis, Hodnett, Gallop, & Chalmers, 2002; Dyson et al., 2006; Renfrew et al., 2012a). However, some studies use definitions whereby PSs may share experience OR characteristics with women (for example, Jolly et al., 2012; Mickens, Modeste, Montgomery & Taylor, 2009). Several authors provide evidence of shared experience as an important component of the peer – mother relationship (for example, Thomson et al., 2012a; Rossman et al., 2011). However, the importance of other characteristics (such as having the same race, level of income, and living in the same geographical area as the women who will receive support) that have been used to choose 'peers' in many studies have been assumed by researchers (Hoddinott, Chalmers, & Pill, 2006b). Some studies describe PSs who have received no training (i.e. Hoddinott et al., 2006a), modest training (i.e. Jolly et al., 2011), and others extensive training (i.e., Graffy, Eldridge, Taylor, & Williams, 2004). Related to these differences is the extent to which PSs have been embedded within the health care system and 'professionalised'. Some studies describe PSs working informally within their community with minimal contact with health services (i.e. Curtis, Woodhill, & Stapleton, 2007), and others operating in close integration with health services (i.e. Aiken & Thomson 2013). Heterogeneity within the role of the peer supporter and the way the role has been used within services and interventions makes interpretation of the evidence base problematic and may reflect differing assumptions about how BPS might work (Trickey et al., 2018).

2.9 THE FUNCTION OF BREASTFEEDING PEER SUPPORT

BPS is advocated as a tool to increase breastfeeding rates (WHO 2003, NICE 2005, 2008 and DH 2004). Experimental trials of BPS interventions have sought to test their influence upon individual behaviour change (i.e. women's rates of breastfeeding initiation, exclusive breastfeeding and breastfeeding continuation), and BPS has often been expected to accomplish this through the provision of individual one-to-one support. BPS has also aimed to create a culture of breastfeeding for women (for example, Ingram, Rosser, & Jackson, 2005; Raine, 2003), and to complement health services by extending women's social networks (Dennis, 2003). There is evidence that such cultures do develop, and that women find the increased social support they provide invaluable (Hoddinott et al., 2006b; Ingram et al., 2005; Raine, 2003; Thomson et al., 2012a). BPS is also expected to change communities and society by providing benefits such as the building of community capacity and increased public awareness of the benefits of breastfeeding (NICE, 2008). BPS schemes have been seen as a strategy to break down community barriers to breastfeeding (Ingram et al., 2005), and change social prejudice (Quintero Romero, Bernal, Barbiero, Passamonte, & Cattaneo, 2006). Community action by PSs in the form of their active engagement with local businesses to encourage them to welcome breastfeeding mothers has been described (for example, Raine, 2003), while Thomson et al. (2012b) explain how BPS schemes can work to increase social capital through the generation of bonds at different levels across the wider community and local health services.

BPS is expected to change local care provision by enhancing the experience of care for women on low incomes (NICE, 2008). Some studies have shown that current postnatal care services do not meet the needs of many women (for example, Hoddinott, Craig, Britten & McInnes, 2012), and support from peers can provide the kind of care women want (Schmied, Beake, Sheehan, McCourt, & Dykes, 2011). BPS provision is anticipated to deliver family centred care, improve access to breastfeeding support, and to provide greater choice in service provision (NICE, 2008).

NICE guidelines anticipate BPS interventions will impact upon health inequalities but do not clarify how this might happen (NICE, 2008). The obvious mechanism is that '*Increasing breastfeeding rates is one way of reducing health inequality and breastfeeding peer support is seen an effective method to improve breastfeeding rates in low-income areas'* (Islam, 2015, p.36). A realist review (see section 2.10.4 below for an explanation of realist methods) examined how community-based peer support (not just BPS, although a BPS intervention was included as one of the case studies) increased health literacy and reduced health inequalities (Harris et al., 2015). It found that the creation of supportive social environments provided a better base from which people could grow in confidence and feel able to undertake healthy behaviours in future (Harris et al., 2015). Despite the extensive and varied expectations of BPS projects, theories underpinning how such changes might take place (especially at the meso and macro levels) have not been well developed within the literature (Thomson & Trickey, 2013; Trickey et al., 2018).

2.10 THE EVIDENCE FOR BREASTFEEDING PEER SUPPORT

In this section I summarise the BPS evidence base, starting with consideration of the qualitative evidence, followed by quantitative evidence, and realist studies.

2.10.1 Qualitative evidence

Qualitative evidence for BPS reveals that women who engage with it value it and find it helpful. For example, it can provide the time women want and need for support with breastfeeding (Battersby & Sabin, 2002; Thomson et al., 2012a), and it can provide a sense of belonging that women value (for example, Hoddinott et al., 2006b; Ingram et al., 2005; Thomson et al., 2012a). A sense of belonging is a feeling of being part of a community, of connectedness and belonging gained through attendance at a breastfeeding group (Ingram et al., 2005). BPS can help women to continue breastfeeding when they would otherwise have stopped, although these increases may not coincide with routinely collected data on breastfeeding continuation gathered as part of trials (e.g., Nankunda, Tumwine, Nankabirwa, & Tylleskar, 2010; Rossman et al., 2011; Scott & Mostyn, 2003; Thomson et al., 2012a; Thomson et al., 2012b).

Qualitative evidence also suggests that BPS can provide the kind of support women want. Women want practical support for breastfeeding (Graffy & Taylor, 2005; Meier, Olson, Benton, Eghtedary, & Song, 2007) which BPS can provide (i.e. Thomson et al., 2012a). Women value empathy, approval, and appraisal support including ‘belonging’ (as mentioned above), which can also be provided by BPS (for example, Meir et al., 2007; Rossman et al., 2011; Thomson et al., 2012a).

A meta-synthesis of qualitative evidence of women’s experiences of peer and professional support for breastfeeding undertaken by Schmied et al. (2011) described support occurring along a continuum. Support found to be helpful was characterised by a facilitative style and experienced as '*authentic presence'* (p.51) while unhelpful support was associated with a reductionist style, and experienced as '*disconnected encounters'* (p.56). Authentic presence was founded on trust, based in relationships, and fostered by continuity of supporter (Schmied et al., 2011). PSs were more likely to be reported as being there for women, as having a relationship with them, and to share the experience with them than professionals (Schmied et al., 2011). It is important to note that qualitative studies do not often examine BPS interventions holistically (Leeming et al., 2017), and that there may be times when BPS has not met women's needs, but these may have been less likely to be reported (Thomson et al., 2012a).

2.10.2 Quantitative evidence

Cochrane reviews of interventions to increase breastfeeding duration and exclusivity report that additional breastfeeding support from professionals, lay people (i.e. PSs), or both, significantly improve duration of breastfeeding (Britton, McCormick, Renfrew, Wade, & King, 2007; Chung, Raman, Trikalinos, Lau, & Ip, 2008; McFadden et al., 2017; Renfrew et al., 2012a). However, a meta-regression analysis that just focused on BPS interventions in low, middle and high-income countries including the UK found that UK trials were ineffective (Jolly et al., 2012). The trials included in the analysis differed from each-other in several important ways; a key area of heterogeneity was their context; some trials in high income countries took place in areas with low levels of socio-economic deprivation and high background breastfeeding rates (i.e., Dennis, Hodnett, Gallop, & Chalmers, 2002), while others took place in areas with low background breastfeeding rates where levels of socio-economic deprivation were not reported (i.e., Muirhead, Butcher, Rankin, & Munley, 2006). The trials differed in design so that intervention components in terms of timing, type and intensity of contacts across the perinatal period varied greatly.

In addition to heterogeneity, UK trials also demonstrate significant problems with implementation and uptake. For example, 38 % of women randomised to the peer support arm of the Graffy et al. (2004) trial received no support from a peer, and although the Jolly et al. (2011) trial intended to deliver five or more contacts, many women randomised to receive peer support did not receive that many (Jolly et al., 2011). In a trial by Muirhead et al. (2006), PSs were not informed of delivery in a timely manner, so that many women had stopped breastfeeding before support could be given. Indeed, one of the conclusions of the meta-regression was that it was impossible to know whether the interventions lack of efficacy was due to their being ineffectual, or because uptake was poor (Jolly et al, 2012). These implementation difficulties point to the relevance of access to BPS interventions.

2.10.3 Access to peer support

The importance of context, and problems with uptake and implementation are reflected across the literature base; McFadden et al. (2017) recommend support for breastfeeding be tailored to the needs of local populations, and Dykes (2005) highlights that adequate investigation of local context can facilitate successful intervention design. However, across the evidence base the views of mothers and their families about support interventions are not well reported (Renfrew et al., 2012a). A UK national survey has shown that although at discharge from maternity hospital 69% of breastfeeding women were given contact details of voluntary organisations or community groups offering breastfeeding support (e.g. peer support provision), only approximately a quarter sought support from these sources (McAndrew et al., 2012). Likewise, several studies report that women often do not ask for help with breastfeeding (Dennis, 2002; Graffy & Taylor, 2005; Hoddinott et al., 2006b). Women may experience embarrassment and a sense of failure when struggling with breastfeeding, and in order to avoid further reductions in self-confidence, feel reluctant to seek help (Hegney, Fallon and O’Brien, 2008; Hoddinott & Pill, 1999; Thomson et al., 2015). Several studies mention women wanting to find their own solutions to problems suggesting that their sense of agency, confidence and control could be put at risk by asking for help (Hegney et al., 2008; Hoddinott & Pill 1999; Hoddinott et al., 2006b). Studies examining why women who initiate breastfeeding do not access peer support concur with these sentiments, suggesting that women may anticipate continuation of a rules-based approach to support experienced from health professionals, that they may expect to encounter pressure and judgement from PSs (Hunt &Thomson, 2016), and that they may feel reluctant to take up support from somebody they have not already met (Islam, 2015).

Health professionals may be important facilitators of women’s access to BPS (Anderson & Grant, 2001; Hoddinott et al., 2006b; Hunt &Thomson, 2016; Raine, 2003; Shaffer, Vogel, Viegas and Hausafus, 1998), and positive relationships between PSs and health professionals may require ongoing work and investment (Ahmed, Macfarlane, Naylor, & Hastings, 2006; Aiken & Thomson, 2013; Battersby and Sabin, 2002; Kaunonen, Hannula, & Tarkka, 2010; Meier et al., 2007). Health professionals may demonstrate differing attitudes towards peer support (Raine, 2003), with some displaying reluctance to allow lay people involvement in the care of women (i.e. Muirhead et al., 2006), particularly in the presence of concerns about women feeling pressurised to breastfeed (Thomson, Ballam, & Hymers, 2015). Health professionals working in areas of social deprivation may not see leading groups that enable mothers to meet each-other as good use of their time (Hoddinott, Britton, & Pill, 2009a), while their commitment to such work may also be affected by simultaneous service re-organisation and change (Hoddinott, Britten, Prescott, Tappin, Ludbrook, & Godden, 2009b).

Jolly et al., (2012) propose that BPS may not be effective in the UK because there is already postnatal care provision. Evidence for this conclusion is not clearly explained. In their serial qualitative study looking at low income women's infant feeding experiences, Hoddinott, Craig, Britten and McInnes (2012) found timely support was lacking, while other qualitative literature examining the experiences of women who did engage with BPS in the UK shows no evidence that they felt overwhelmed by too much care. Additionally, a national survey found that 85% of women who stopped breastfeeding in the first two weeks would have liked to have breastfed for longer (McAndrew et al., 2012).

2.10.4 Realist evidence

The mixed evidence base coupled with the under-development of theories underpinning how BPS might be working has prompted the use of a realist approach to explore the evidence base (Thomson & Trickey, 2013; Trickey et al., 2018). A realist approach to research aims to explain rather than judge, is based on a realist ontology of science (i.e., the idea that at least part of reality is independent of the human mind), looks for mechanisms and middle range theories to explain 'why' or 'how' questions, and can be helpful for making sense of complex interventions which have outcomes that depend on the context (Wong, 2018). A realist approach seeks to identify an intervention's underlying theory by asking '*what works, for whom, in what circumstances and in what respects, and how?"* (Pawson & Tilley, 1997 p.1). An in-depth realist exploration of experimental UK one-to-one BPS interventions investigated how these complex interventions interacted with their contexts to generate context – mechanism – outcome configurations[7]. Through these configurations a series of propositional statements were developed explaining how one-to-one BPS might work (Trickey et al., 2018). Propositional statements suggested schemes may be more effective if they are congruent with local infant feeding norms and are integrated within existing healthcare systems (Trickey et al., 2018); PSs should be practically and emotionally accessible to mothers to help overcome barriers to help seeking behaviour; that in order to avoid only the most motivated, confident women getting support, proactive support should happen within a framework of minimum contacts mapping onto local pivotal points at which breastfeeding stops; and that in order to enable mothers to overcome challenges and continue breastfeeding, warm and affirming relationships with PSs should be engendered (Trickey et al., 2018). A key finding from this study was that community and societal factors influence individual behaviours. This means that the context in which an intervention takes place is highly relevant and leads to the conclusion that enabling environments for breastfeeding need to operate at multiple levels. The authors conclude that if our overall aim is to create communities and a society supportive of breastfeeding, interventions operating at the individual level alone are unlikely to produce sustained change (Trickey et al., 2018). However, authors also note that background contexts were not well described in many studies, that experiments differ in important ways from non-experimental, organically developed interventions, and that we know more about experiments (Trickey et al., 2018). It is also important to note that one of the problems with a realist approach is that it inevitably privileges the views of researchers and policy makers regarding how interventions might be working, rather than the key stakeholders concerned (Porter, 2015).

---

[7] In a context – mechanism – outcome configuration the context consists of all the resources in the existing setting plus the new resources the intervention brings; the mechanism is the response or reasoning of the participants; and the outcomes are the intended and/or unintended consequences of the intervention (Trickey, et al. 2018).

2.10.5 Summary

In summary, breastfeeding has a powerful impact on the health of mothers and babies (Grummer-Strawn & Rollins, 2015), and the socio-economic patterning of breastfeeding rates is longstanding (Carter, 1995). BPS is an intervention recommended to impact upon breastfeeding rates and its mixed evidence base points to the importance and relevance of the wider social context of support in its efficacy. Renfrew et al. (2012a) explain that infant feeding is closely related to health inequality, and that it is the social determinants of health rather than individual decisions that form the strongest influence upon feeding behaviour; socio-economic differences in breastfeeding rates thereby form both a cause and symptom of social inequality.

2.11 THE THIRD SECTOR

In this section I give a brief history of UK volunteerism and the third sector, and explain its relationship to the state. This allows contextualisation of the work of the organisations that form the focus of my study. The third sector has been defined as '*a space of organisational activity located between the state, market and private familial spheres comprising a diversity of organisational types including charities, social enterprises, faith, community and grassroots groups'* (Rees & Mullins, 2017, p.3). This group of organisations is diverse and has only been conceived of as a 'sector' since the late 1990's (Alcock, 2017).

The several-hundred-year history of charity and volunteerism in the UK can be divided into four distinct phases (Alcock, 2017); in the first phase charities and voluntary organisations provided direct help in the form of essential services many people needed but could not afford. However, charities and their functions were extremely varied

(Daunton, 1996; Davis Smith et al., 1996). Their work formed a mix of help provided alongside moral education, mutual aid (whereby people joined together in friendly societies to provide contingency should they become ill or die), provision of services where fees were charged, and to members who paid subscriptions, and the acceptance of donations (Daunton, 1996). Political protest and campaigning were also important. For example, in the nineteenth century charities campaigned for factory legislation, sanitary improvements, and prison reform (Daunton, 1996). Indeed, de Tocqueville, writing in the 1840s about American society, saw this kind of activity as essential to protect democracy from state omnipotence (de Tocqueville, 2003), although Kramnick (2003) explains that some scholars feel de Tocqueville mistook the state (i.e. the civil government) for the market (i.e. the commercial arena) on this point. Hence voluntary organisations have been theorised to exist because markets are inappropriate providers of some services (Hansmann, 1980), and historically philanthropy, mutuality and campaigning have been central to UK volunteerism (Davis Smith, 1995).

By the end of the nineteenth century the work of UK charities and voluntary organisations was co-ordinated by the Charity Organisation Society (COS) who wanted future welfare provision to be led by voluntary organisations. However, the Fabian society and others campaigned for the idea that the government should intervene to provide welfare services to the public because '*of the failure of the market and voluntary action to ensure that comprehensive protection was available to all'* (Alcock, 2017, p.22). Although the Fabian society's view was initially in the minority, eventually this state interventionist position won out and ushered in the second phase of UK volunteerism; that of the voluntary sector acting in a complementary role to state provision (Alcock, 2017). In the early 20th century local government lead growing state public service provision through initiatives such as public housing and state education.

In 1942 the Beveridge Report argued for social security protection for all and the post 2nd world war establishment of National Insurance and the NHS resulted in the creation of the welfare state (Alcock, 2017).

Although in this period state provision increased, voluntary and private provision of some services continued, indeed Beveridge himself argued for the voluntary sector to provide additional and specialist support as an extension of the welfare state (Alcock, 2017).

In the 1960's a new wave of volunteerism began which was often led by young women (Davis Smith et al., 1995). Rather than adopting the deferential attitude of more established voluntary organisations, some new wave organisations challenged government authority (Crowson, 2011) and questioned and challenged state provision (for example, Shelter and the Child Poverty Action Group (CPAG)) (Davis Smith et al., 1995). Such organisations embodied what has generally been seen as a secondary role for voluntary organisations separate from direct service provision; their role to advocate for and give voice to the concerns of the people and communities with whom they work (Cairns, Hutchison, & Aiken, 2010). As discussed above, the two UK third sector breastfeeding organisations that originated at around this time (the NCT and LLL Great Britain) followed this pattern as they challenged the medically dominated state services of the time.

During the later part of the twentieth and early twenty-first century, services were increasingly provided to the public by non-state organisations using state money (Alcock, 2017). By the 1970s welfare pluralism in the form of provision by the voluntary sector, the family and the market as well as the state was in place (Beresford & Croft, 1983). This type of service provision fitted well with the neoliberal policies of the 1980s (King & Wood, 1999). Decentralisation is the policy of delegating central government powers to local or regional authorities (Merriam-Webster, 2019). It theorises that local actors are closer to communities, more sensitive to local conditions, and better able to respond to local needs (World Bank, 1997). However, the dismantling of state institutions is desired by neoliberal politicians (Bourdieu, 1998), therefore, the idea that communities will reap benefits from service decentralisation suits their purposes. By the 1990s relationships between voluntary organisations involved in providing services funded by the state were characterised by contracts and targets (Alcock, 2017; Davis Smith et al., 1995). This constituted the third phase of the history of the voluntary sector in the UK.

The New Labour government of 1997 put forward a ‘third way’ distinct from Keynsian economics on the one hand (i.e. a big state where the state plans and controls the economy and public services are provided by the state) and neo-liberalism (i.e. a small state which does not try to plan and control the economy, the market is fundamental and the state does not provide a lot of public services, rather the market provides what is needed) on the other (Clifford, Gaine-Raheme, & Mohan, 2012). They adopted Etzioni’s (1999) communitarian idea that the state should not try to replace local communities but may need to support and empower them to bring about their own solutions to social problems. Thus, an expanded role for the third sector in UK society whereby it worked in ‘partnership’ with the government was central to the third way project (Fyfes, 2005). This formed the fourth phase of the history of the UK voluntary sector (Alcock, 2017).

New Labour recognised divisions within society and the existence of communities experiencing significant deprivation as the negative side of neo-liberalism (because, as part of the neoliberal ideal of a small state described above, a non-redistributive economic policy of low taxation is favoured which leads to increasing income and wealth inequality (Collins, McCartney & Garnham, 2016)) and sought to address them (Fyfes, 2005). Neo-liberal economic policies were maintained (i.e. by continuing to not redistribute income through taxation) and combined with social programmes in areas of deprivation (Giddens, 1998). The causes of social problems were thereby located within the communities affected which were termed ‘socially excluded’ rather than at a societal level within the unequalising forces of neo-liberalism itself (Fyfes, 2005; Powell, 2012). As I explained above (section 2.5), there was something of a gap between the recommendations of independent health inequalities reports and the policy outcomes that were enacted. However, area-based interventions such as ‘Sure Start’ did aim to impact upon living conditions in the early years of life (Smith, 2013). Further, the Public Health Development Fund (Dykes, 2003) outlined above was an opportunity for third sector breastfeeding organisations to lead and innovate projects designed to increase breastfeeding rates in areas of deprivation, fitting well with the government’s overall policy agenda. Indeed, three of the four third sector organisations I have studied in this thesis were involved with projects evaluated by Dykes (2003) on behalf of the DH.

New labour rhetoric and policy supported the significant involvement of third sector organisations in service provision and focused on the value of their knowledge of and closeness to communities, their flexibility and ability to innovate, their values and sense of mission (Buckingham, 2009), their value for money (Billis & Glennerster, 1998), and their expertise in solving intractable social problems (Milbourne, 2013). Even today making best use of the special knowledge third sector organisations have of communities is a key government recommendation in health and social care (VCSE, 2018). However, Dickinson, Allen, Alcock, Macmillan, and Glasby (2012) point out that there is little evidence to support the claim of special knowledge and call for research into *how* improvements in service delivery take place. It must be recognised that the third sector provided an ideological alternative to both state and market provision of public services (Milbourne, 2013), and became strategically important in order to foster desired social cohesion and economic vitality the New Labour government wanted (Fyffes, 2005).

The main outcome of this fourth phase of UK voluntary sector history was the increase in public income flowing into the third sector (Alcock, 2017); from 2000 to 2010 third sector public income in England and Wales rose from £8.6 billion to £13.9 billion (Clark, Kane, Wilding, & Bass, 2012). Numerous funds were provided to enable third sector organisations to build capacity (Alcock, 2017) and in exchange for accepting such funding organisations were expected to adopt corporate management styles and competitive practices (Harris, 2010). Such restructuring has been seen to result in the creation of mere public service delivery agencies (Macmillan, 2010). Indeed, government partnership with the third sector has been considered a way of making this sector (and therefore a larger proportion of society as a whole) '*governable terrain'* (Carmel & Harlock, 2008 p.157).

As third sector organisations became drawn into instrumental service delivery roles, and it became accepted that the causes of social problems fell within affected communities, the attention of third sector organisations was deflected away from advocacy and campaigning (Rochester, 2013). They could now be seen to have stopped speaking truth to power, and rather to be aiming to try to '*speak to power and get a bit of the cake'* (Rochester, 2013, p.86). However, other writers have alternative ideas about the potential role of the third sector within contemporary neo-liberal societies. For example, Bellah, Madsen, Sullivan, Swindler, and Tipton (1985) propose that people's involvement with civil society organisations could form a mechanism to generate solidarity within society so that the system itself might be challenged. They view the third sector as a potential building ground for societal change (Bellah et al., 1985).

Under the Charity Commission legislation of 2008 charities had been permitted to engage in political activity as long as it furthered their charitable objectives, campaigning did not become their sole interest, and they maintained their independence (Charity Commission, 2008). However, in 2014 the Lobbying Act came into law. Part two of the act regulates and restricts campaigning by non-political party bodies such as charities, trade unions and pressure groups during a regulated period in the run up to parliamentary elections (Abbott & Williams, 2014). This provoked widespread controversy among civil society organisations (House of Commons Library, 2014) and has the potential to result in organisations becoming increasingly cautious about speaking out (Abbott & Williams, 2014).

In the early stages of the Coalition government of 2010 ‘Big Society’ rhetoric envisaged that local voluntary action would step in to meet need as government expenditure reduced (Clifford, Gaine-Raheme, & Mohan, 2012). However, research has shown that disadvantaged areas are more likely to be served by publicly funded voluntary organisations than more affluent areas, and that economic stability is a prerequisite for voluntary participation (Clifford et al., 2012). Health has been conceptualised as a process responsive to, and generated by, the resources available to people living in any given community (Cowley & Billings, 1999). Such resources have been theorised to be both personal and situational; personal resources are individualised and internal (e.g. emotional resources such as a sense of trust in self and others and self-esteem), while situational resources arise from the situation in which people live (e.g. employment that provides economic stability, support from wider family, and programmes and formal services) (Cowley & Billings, 1999). Personal and situational resources are connected, and personal resources can enable people to make use of and strengthen situational resources (Cowley & Billings, 1999). Census data is used to bring together information about the availability of different types of resources such as housing, employment, and car ownership in an area, generating a measure of the area's deprivation (UK Data Services, 2019), meaning that, by their very nature and definition, areas of deprivation have fewer resources. When public funding is reduced, people living in disadvantaged areas may be less likely to volunteer within their own communities due to their own complex combination of situational and personal resources. This suggests that the 'Big Society' idea, as a remedy to counteract the impact of reduced government expenditure, will have a disproportionately negative impact upon the services available in disadvantaged areas compared to affluent areas. Although the 'Big society' idea had withered by 2012 (Rees & Mullins, 2017), reductions to government expenditure have continued giving rise to questions about the relative impact of such policies on areas of deprivation (Clifford et al., 2012). Since 2012 policy relating to the third sector has been minimal to non-existent (Macmillan, 2013), however the Open Public Services government white paper (HM Government, 2011) sets out a competitive environment of market competition where corporate contractors are favoured and private businesses are positioned as essential to provide public services (Rees & Mullins, 2015). This suggests that voluntary organisations may be increasingly restricted to undertaking unpaid community work (Milbourne & Cushman, 2015).

In order to contextualise my study, in this chapter I have provided background information about breastfeeding in the UK, health inequalities, UK policy and action related to infant feeding, the history, nature, function and evidence base for BPS, and the place of third sector organisations in UK society. The next step in my exploration of how third sector organisations have developed their services for areas of deprivation is to establish what is already known about the practices of these organisations in these contexts. I now address this in chapter three.

3.0 CHAPTER 3: QUALITATIVE META-SYNTHESIS

3.1 INTRODUCTION

In chapter 2, I provided background information about the key issues of concern in this study: the context of breastfeeding in the UK, the concept of health inequalities, the place of the third sector in UK society, and the evidence base for BPS. Here I present a meta-synthesis designed to systematically evaluate the published literature concerning the practices of third sector breastfeeding organisations in areas of deprivation. A meta-synthesis is an in-depth exploration of a narrow section of qualitative-based literature. However, I acknowledge that peer support delivered by third sector organisations is but one way of increasing breastfeeding rates in areas of deprivation, and that there are other ways of providing such care (please see chapter 2, p39-41).

In this chapter I outline the rationale, aims, and objectives for this qualitative review. I detail the inclusion criteria, search strategy, method for assessing quality, and the method of synthesis itself. I then present the findings in four themes; *'forming a trusting mother-peer supporter relationship'*, *'being on the journey together'*, *'weaving a strengthened, supportive community where breastfeeding is normal and visible'*, and *'embedding peer support in local health care provision'.* Findings are followed by a discussion.

3.2 RATIONALE

3.2.1 The review approach

A number of methods are available when combining and or comparing research evidence (Dixon-Woods et al., 2005), hence before meta-synthesis was adopted for the current study, several different possible methods were contemplated. Appendix one contains a table outlining the methods that were considered. The utility of each approach in relation to the aims and purposes of the review were evaluated. For example, because the research question focusses on organisational practices rather than outcomes, a meta-synthesis was considered more useful than an integrative review that would have also combined quantitative data. Although some contextual and practice related information would have been available as part of quantitative studies, such studies were not anticipated to contribute greatly to the understanding of practice in context. Meta-narrative and integrative reviews were particularly considered as possible alternatives to meta-synthesis. Meta-narrative was disregarded because it seems most appropriate when there is considerable conflict within a research area (Greenhalgh et al., 2005), and this did not seem to be the case in this instance. Both meta-narrative and integrative review might also have resulted in emphasis falling more greatly on the organisations themselves rather than on the contexts; an integrative review aims to 'present the state of the science' (Whittlemore & Knafl, 2005), and may include a very broad spectrum of evidence. Similarly, a meta-narrative review takes as its unit of analysis the 'storyline' (Greenhalgh et al., 2005). Focus on the 'storyline' of each organisation had the potential to direct attention towards the organisation rather than the context.

3.2.2 Meta-synthesis as evidence

Methods used to aggregate primary quantitative research findings, i.e. a meta-analysis aim to increase certainty in causes and effects, and to better inform policy and practice (Walsh & Downe, 2005a). However, there is controversy concerning combining qualitative research findings; '*qualitative research appears endangered both by efforts to synthesize studies and by the failure to do so'* (Sandelowski et al., 1997, p.365). It is argued that policy makers and practitioners need to be able to make use of evidence generated from a full range of research methodologies (Dixon-Woods et al., 2005).

They must base their work on evidence; however, time constraints can prevent practitioners from accessing multiple qualitative accounts (Dixon-Woods, Fitzpatrick, & Roberts, 2001). Indeed, as the volume of qualitative accounts increases, the importance of comparing such accounts becomes more pressing (Noblit & Hare, 1988). A meta-synthesis is a rigorous analysis of existing qualitative studies through which new knowledge of a subject area might be developed (Thorne, Jensen, Kearney, Noblit, & Sandelowski, 2004). By providing an interpretation of available qualitative accounts as a whole, a meta-synthesis may better enable real world impact (Dixon-Woods et al., 2001). This is important because there are many uncertainties in health care which can only be addressed via qualitative endeavours (Dixon-Woods et al., 2001).

3.2.3 Meta-synthesis and the nature of knowledge

Some researchers see dangers in undertaking synthesis that relate to the nature of knowledge. They recognise their qualitative research findings as constructions embedded in one particular time and place and suggest that synthesis dilutes the very thing that gives their work value (Sandelowski et al., 1997). Others suggest that undertaking a meta-synthesis can enable comparisons of different accounts in a manner that retains the importance of their context and respects the nature of the knowledge itself (Walsh & Downe, 2005a). Furthermore, meta-synthesis can enable examination of the perspectives of different authors, of how different accounts relate to one another, of where there might be gaps in the evidence, and of any areas where differences in interpretation are evident (Noblit & Hare, 1988).

3.2.4 Meta-synthesis and context

Meta-synthesis is an approach that brings together qualitative studies with the aim of increasing understanding and explanation of a particular phenomenon (Walsh &

Downe, 2005a). It differs from methods that simply aggregate findings together because it promises the possibility that through interpretive synthesis, something bigger than the sum of the parts may be formed (Noblit & Hare, 1988). Although some suggest the method is reductionist, aiming for one explanation of phenomena, and therefore refuting the existence of many different explanations, others consider that the interpretations of a meta-synthesis can acknowledge multiple layers of context, and reveal underlying processes (Sandelowski et al., 1997). Indeed, examination of multiple studies through this method can enable '*nuances, taken-for-granted assumptions, and the textured milieu of varying accounts to be exposed, described and explained in ways that bring fresh insights'* (Walsh & Downe, 2005a, p.205). Hence, as a technique capable of deepening understanding of '*the contextual dimensions of healthcare'* (Walsh & Downe, 2005a, p.204), qualitative meta-synthesis is an appropriate approach to the current research problem, namely that for BPS programmes, there is lack of understanding of the interaction between context and intervention.

3.2.5 Choosing the meta-synthesis method

The meta-synthesis, namely a meta-ethnography developed by Noblit and Hare (1988) was chosen over other approaches because, in addition to its logical approach with few steps, it fits well with the overall interpretive theoretical position adopted for the study; that inquiry should be inductive. The employment of an external theoretical framework to complete the analysis required by Thomas and Harden's (2008) method, and the complexity of the Joanna Briggs method (Pearson, 2010) meant these approaches were rejected.

3.3 AIMS AND OBJECTIVES

Noblit and Hare (1988) identify a seven-phase approach to undertaking a meta-synthesis. Phases one and two concern developing a clear idea of the area of interest of the synthesis, its scope and purpose. Phase three requires repeated reading of the studies and the noting down of the main interpretations within them. Undertaking phase four involves '*determining how the studies are related'* (Noblit & Hare, 1988 p.28). This is achieved by listing interpretations found within the studies and considering whether the studies are '*roughly about similar things'* (i.e. reciprocal translation) (Noblit & Hare, 1988 p.38), or whether the interpretations within them '*refute*' one another (i.e. refutational translation) (Noblit & Hare, 1988 p.48). Phases five and six require that the studies are translated into each other and made into a whole which is '*something more than the parts alone imply'* (Noblit & Hare, 1988 p.28). If appropriate, a '*line of argument'*, statement of inference is constructed about the whole, based on the interpretive work of the synthesis (Noblit & Hare, 1988, p.62). Finally, phase seven concerns communicating the synthesis. Table 2 below shows how each phase relates to research activities.

Table 2 Phases of the meta-synthesis and their corresponding research activities.

Phase number	Aim	Research Activity
1 and 2	To develop a clear idea of the synthesis' scope and purpose	Identifying the review problem, deciding inclusion and exclusion criteria, undertaking the searches and assessing for quality. By the end of these phases having a list of included studies.
3	To become familiar with the included studies	Reading and re-reading included texts. Creating first level codes. Noting the main interpretations present.

4	To work out how the studies relate to each other	Making lists of all the ideas present in each study. Considering how the ideas relate across studies. Juxtaposing the studies. Constructing tentative second and third level codes.
5	To work out the extent to which accounts are similar	Translating studies into one another by drawing comparisons. Assessing the differences and similarities between studies. Using these comparisons to find best way of fitting concepts together.
6	To make a whole	Bringing all concepts together.
7	To express the synthesis	Writing up.

During the first two phases of Noblit and Hare's (1988) plan I clarified the aims and objectives of the synthesis, made decisions about its scope and purpose, and undertook searches for the studies to be included. The overall aim of the current meta-synthesis was to understand how United Kingdom national third sector breastfeeding organisations have implemented BPS interventions in areas of socio-economic deprivation.

3.4 SEARCH STRATEGY

When '*deciding what is relevant to the initial interest'* (Noblit & Hare, 1988, p.27) for a meta-synthesis, Noblit and Hare (1988) explain the importance of justifying decisions around the inclusion and exclusion of studies and consideration of the utility of the resulting synthesis (Noblit & Hare, 1988). In the present review, my search strategy aimed to identify (as far as practicably possible) all published and grey accounts of BPS projects taking place in areas of socio-economic deprivation by UK national third sector breastfeeding organisations. Once these were identified and assessed, final decisions about inclusion in the synthesis were made (see section 5 below). This completes phase two of Noblit and Hare's (1988) approach to synthesis.

3.4.1 Inclusion criteria

The PEO framework for building inclusion criteria (Bettany-Saltikov, 2012) was used in the following way:

P	Population and their problems	Women living in areas of socio-economic deprivation
E	Exposure	BPS interventions provided by UK national third sector breastfeeding organisations
O	Outcomes or themes	Breastfeeding

The exposure to be included in the review concerned interventions provided by United Kingdom national third sector breastfeeding organisations. These were defined for the purposes of this study as; a United Kingdom national organisation, whose sole or major purpose concerns the delivery of non-professional breastfeeding support services, is independent of government, 'value-driven' with social goals, and which re-invests any surplus back into those social goals (derived from National Audit office definition, 2016). Although it is recognised that there are many smaller, locally arising organisations which deliver non-professional BPS services, for the purposes of this study, interest lies in large national organisations. This is because these organisations are commissioned most often to run such services, and comprehensive consideration of all smaller organisations lies outside the scope of this study.

In this review peer support was defined in the following way; '*the provision of emotional, appraisal, and informational assistance by a created social network member* *who possesses experiential knowledge of a specific behaviour or stressor and similar characteristics as the target population, to address a health related issue of a potentially or actually stressed focal person'* (Dennis, 2003, p.329). This does not refer to support derived from persons within a community '*to whom others naturally turn for advice, emotional support and tangible aid'* (Eng & Smith, 1995, p.24).

Areas of socio-economic deprivation form the second aspect of the included population. Galobardes, Lynch and Davey-Smith (2007) outline multiple ways by which socio-economic conditions have been described and measured in health research, explaining how different measures reflect differing philosophical assumptions about the patterning of socio-economic resources. Although significant controversy surrounds the use of many measures (Braveman, Cubbin, & Egerter, 2005; Galbardes et al., 2007), it is recognised that the search for 'one best' indicator may not be useful because differing measures highlight different aspects of socio-economic patterning which in turn relate in different ways to different areas of health interest (Galobardes et al., 2007). Hence, for the purposes of this review, any studies in which the authors had deliberately sought to work in an area of deprivation – defined as such by any measure, was included in the review.

Table 3 Meta-synthesis inclusion criteria

	Include studies that	Exclude studies that
Population	Concern women living in areas of socio-economic deprivation.	Do not concern women living in areas of socio-economic deprivation
Exposure	Concern BPS practices and interventions provided by	Do not concern BPS practices and interventions

	UK national third sector breastfeeding organisations	provided by UK national third sector breastfeeding organisations
Outcome	Concern breastfeeding	Do not concern breastfeeding
Language	Are published in English and other key languages	Are published in uncommon languages

3.4.2 Searching the literature

The search strategy aimed to identify both published and unpublished studies and formed three parts; the search of published literature, the search of grey literature, and the employment of Bates's (1989) berry picking procedures to identify further literature. Bates's procedures resemble more closely the way people seeking information really search (Bates, 1989), and are useful in negotiating the complex ways in which information is now stored and archived (Bates, 1989).

3.4.3 Searching the published literature

The following search terms were used in order to search the published literature.

Table 4 Meta-synthesis search terms

P	Population and their problems	Wom?n, maternal, mother*, patient, consumer, service user, service-user
P	Population and their problems	Socio*, socioeconomic*, deprive*, marginali?*, disadvantage*, low income, poverty, inequalit*, poorest, underprivileged, vulnerable.

E	Exposure	Peer support, lay support, volunteer support, mother to mother, mother-to-mother, counsel*, non-professional, volunteer*, peer group, lay*, peer*, peer-counsel?*, voluntary worker*
O	Outcomes	Breastfeeding, breast-feeding, breast feeding, breastfed, infant feeding, lactat*, milk human, nursing mother*, breastfe*, breast-fe*, breast fe*.

The following databases were searched; Embase, Psyc INFO, CINAHL complete, MEDLINE, MEDLINE with full text, Cochrane, and Dissertation abstracts. When searching the Cochrane database, the search terms were adapted and the following terms were used: Woman*, women*, maternal, mother*, breast feed, breast feeding, peer*, peer counselling, lay support*, voluntary workers, and peer group.

Appendix 2 shows the meta-synthesis search strategy, and appendix 3 the resulting flow diagrams explaining the results of these searches including the number of articles found, the numbers screened at different levels, and the reasons for exclusion. Of the 6188 records identified through the published literature search, seven met the inclusion criteria and were put forward for quality appraisal.

3.4.4 Searching the grey literature

Several systems for searching grey literature have been described, but no gold standard for a ‘systematic’ grey literature search strategy currently exists (Godin, Stapleton, Kirkpatrick, Hanning, & Leatherdale, 2015). The ‘systematic’ grey literature search strategies employed by Godin et al., (2015) and McGrath, Sumnall, Edmonds, McVeigh, & Bellis (2006) whereby experts are consulted, and web-based searches undertaken, were used to guide the grey literature search strategy. Each third sector organisation was contacted. The aims and purpose of the study and their possible involvement was explained, and a key informant was shown a list of target websites (see appendix 4) and asked to suggest further websites and sources. Provision of additional relevant grey literature was requested. All suggestions and sources were followed up. Following the suggestions from the key informants, a list of targeted websites (see appendix 4) was constructed and searched using the following method: If a website had a ‘search’ function the following terms were used to search the website: “Breastfeeding peer support”, “Peer support in areas of deprivation”, “Socio-economic deprivation and peer support”. The first 50 hits resulting from these searches were reviewed by title and first lines of the article/page. If a website did not have a ‘search’ function, it was hand searched. Following these searches, a table of 12 studies where it was unclear whether the inclusion criteria were met was drawn up. The supervisory team were consulted and suggested all but one of these studies be included. The Prisma diagram for grey literature in appendix 3 shows a flow diagram explaining the results of these steps, the number of articles identified and excluded at different stages, along with the reasons for exclusions. Of the 718 articles identified via this search, 21 went forward for quality analysis.

3.4.5 Applying Bates’s (1989) berry picking procedures

All studies forming part of the list of studies meeting the inclusion criteria were subjected to Bates’s (1989) berry picking procedures in the following manner; footnote chasing was undertaken whereby the references of each study were checked for eligibility in relation to the inclusion criteria. Citation searching was performed which necessitated all citations of each study be checked for eligibility in relation to the inclusion criteria. A journal run proceeded which involved hand searching all issues of the Journal of Maternal and Child Nutrition. This was the journal in which several studies meeting the inclusion criteria were published. Finally, a key author search was undertaken whereby all publications by all authors contributing two or more studies meeting the inclusion criteria were checked in relation to the inclusion criteria. All studies found via these methods were subject to the inclusion criteria as above, and then subjected to the same berry picking procedures until no further studies could be identified.

After completing the berry picking searches, there were 12 studies for which it was unclear whether the inclusion criteria had been reached. A table outlining these studies was drawn up. The supervisory team was consulted and suggested the inclusion of all twelve studies. A total of 1348 records were found via berry picking procedures, of these 22 met the inclusion criteria (see appendix 3 for flow chart depicting berry picking search). Fifty studies in total met inclusion criteria (see appendix 5). Despite exhaustive attempts, 12 records could not be obtained (see appendix 6). Practicality and time constraints necessitated that the synthesis continued.

3.5 QUALITY ASSESSMENT

Sandelowski et al. (1997) explain how differing qualitative research traditions embrace different ideas about what constitutes ‘good’ research, and that the issue of whether to include all, or only high-quality qualitative research is contentious. I considered the use of different quality assessment tools including the Critical Appraisal Skills Programme (CASP) qualitative checklist (CASP, 2018), and the quality framework designed by Spencer, Ritchie, Lewis and Dillon (2003). The Downe, Walsh, Simpson and Steen (2009) tool was chosen because it is grounded in the assumption that knowledge is constructed (Walsh & Downe, 2005b) which is consistent with the theoretical underpinnings of my study (see chapter 4), draws on all elements of rigour, has a section considering researcher reflexivity, and is not too complex making it practical to use (Downe et al., 2009). All 50 studies that met the inclusion criteria were assessed using the Downe, Walsh, Simpson, & Steen (2009) appraisal tool which employs a clear format. Each study was given a score from A-D reflective of quality in relation the checklist (see appendix 5). When I examined the list of fifty studies, I noted that the quality of the grey literature studies was low, and that there were more published studies of high quality than I had initially expected to find. After further reflection including re-examination of the nature and purpose of this review (as explained in section 3.0 above), and discussion with the supervisory team, the following inclusion criteria was agreed upon for the synthesis: All studies included in the synthesis (in addition to meeting the initial inclusion criteria), must be empirical qualitative research studies that had been published in peer reviewed journals. By applying these criteria, the list of 50 studies was reduced to twenty. There were four studies where I was unsure whether the inclusion criteria were fully met. Following consultation with the team, two were included (Dykes, 2003 and South, Kinsella, & Meah, 2012), and two excluded (Dykes, 2005 and South et al., 2010). This meant that in total sixteen studies were included in the final synthesis.

Table 5 Sixteen studies included in final synthesis.

Study number	Author name and date	Study title
3	Thomson et al. (2012b)	Incentives as connectors: insights into a breastfeeding incentive intervention in a disadvantaged area of North-West England.
4	Ingram (2013)	A mixed methods evaluation of peer support in Bristol, UK: mothers', midwives' and peer

		supporters' views and the effects on breastfeeding.
11	Fox, McMullen, & Newburn (2015)	UK women's experiences of breastfeeding and additional breastfeeding support: a qualitative study of Baby Café services.
24	Thomson et al. (2015)	Building social capital through breastfeeding peer support: insights from an evaluation of a voluntary breastfeeding peer support service in North-West England.
25	Curtis et al. (2007)	The peer-professional interface in a community-based, breast feeding peer-support project.
26	Thomson et al. (2012a)	Giving me hope: women's reflections on a breastfeeding peer support service.
32	Aiken and Thomson (2013)	Professionalisation of a breast-feeding peer support service: Issues and experiences of peer supporters.
33	Crossland and Thomson (2013)	Issues of expertise: health professionals' views of a breastfeeding peer support service. Chapter within Hall Moran eds (2013) Maternal and Infant Nutrition and Nurture: controversies and challenges.
41	Graffy and Taylor (2005)	What Information, Advice, and Support Do Women Want with Breastfeeding?
43	Ingram et al. (2005)	Breastfeeding peer supporters and a community support group: evaluating their effectiveness.

31	Battersby (2001)	The Worldly Wise project: a different approach to breastfeeding support.
27	Dykes (2003)	Infant feeding initiative report evaluating the breastfeeding practice projects 1999-2002
28	Kirkham et al. (2006)	Doncaster Breastfriends chapter in Maternal and Infant Nutrition and Nurture. Eds Hall Moran & Dykes
1	Raine (2003)	Promoting breast-feeding in a deprived area: the influence of a peer support initiative
2	Raine and Woodward (2003)	Promoting breastfeeding: a peer support initiative
36	South et al. (2012)	Lay perspectives on lay health worker roles, boundaries and participation within three UK community-based health promotion projects.

3.6 DATA EXTRACTION AND SYNTHESIS

The transparent articulation of how comparisons and synthesis are undertaken forms the biggest challenge of the meta-synthesis endeavour (Sandelowski et al., 1997). Phases three to seven of Noblit and Hare's (1988) process concern this issue (see table 2 above).

3.6.1 Gaining familiarity with the studies

During the third phase of the synthesis included texts are read and re-read several times to engender familiarity and enable identification of the interpretations made within each study. Fourteen of the sixteen included studies were available in digital format and were uploaded onto MAXQDA software. Each study was read and re-read several times. Codes to describe ideas and actions within the findings sections of each text were made, and as each paper was worked through, additional codes were formed. The study by Dykes (2003) included 26 case studies of peer support interventions. Eighteen of these fitted the inclusion criteria. In addition to coding the appropriate findings section in Dykes (2003), I also coded the project summaries of the eighteen relevant projects. Each of which was given a number. When Dykes (2003) is referenced, I provide a number in brackets so that the exact project can be identified. Appendix 7 provides a table linking each project to its number. The study by Graffy and Taylor (2005) yielded very few coded sections because it utilised a questionnaire which, although allowing women to write freely in some sections, did not facilitate large quantities of material about peer support practices. My codes aimed to name and describe what was happening in the text rather than encompass abstracted ideas. Sometimes theme titles utilised by the authors were adopted, at other times new codes were created. This formed an iterative process whereby each paper was returned to time and time again, and the names of codes adapted as necessary until the ‘bank’ of descriptive codes was felt to encompass all the ideas expressed within the texts. The two studies that were in paper format were treated similarly, with pencil used to mark the codes. Although having two paper articles at first seemed a disadvantage, as the analysis continued this proved to be a bonus; as being forced to return to the physical paper article made it easier to consider the meaning of the text as a whole and to keep in mind the relation of different coded themes with each-other. The value of this during the later stages of analysis is explained in section 6.3 below.

My first attempts at coding proved difficult. I found it hard to concentrate only on what was happening in the text. I kept thinking about explanations for what I was reading about and had to revisit codes to make sure they stayed close to the data. Table 6 below shows an example of a section of initial coding which includes codes that could actually encompass several ideas within them. After discussion with supervisors and reflecting on this coding the codes were simplified and adapted.

Table 6 Example of initial coding

Code name	Coded section of text
Complimenting Health Professional services	‘joined up support’ ‘we feel that peer supporters have a clear and complimentary role to play alongside the midwifery team’ ‘I think with the peer supporter, breastfeeding counsellor and health visitor, yes, they all worked well,… it was the peer supporter and the breastfeeding counsellor, they kept me going really’ ‘setting up and running the service took a while as relationships, communication and trust were established, but we would be very disappointed if the service was not continued as this is a valued role within the midwifery team in our area’

After several false starts, collapsing codes into one another on occasion, and adaptions of the names of several codes, a first version of the first level codes seemed complete.

3.6.2 Determining how the studies relate to one another

This fourth phase of the analysis method of Noblit and Hare (1989) involves determining how the studies might relate to one another. During this phase, lists are made of the ideas present in each study, and how these relate to each other. The studies are then juxtaposed in order to gain an initial tentative idea about their relationships. Noblit and Hare (1988) identify that an important part of this process is to identify findings that refute (where opposing or conflicting insights are reported), or reciprocate (where similar insights are reported) each other. The first level codes were roughly grouped together into four areas of interest. These were initially called; ‘forming the mother – peer supporter relationship’, ‘being on the journey together’, ‘forming a social network’ and ‘embedding the project within health services’. The first action was to examine all the coded sections in each of these areas and determine whether the ideas contained within them seemed to relate or contrast to each-other. In some areas there were obvious and close relationships, for example in the theme concerning the forming of the bond between a mother and peer supporter, the coded segments concerning the use of shared language showed similarities across several texts.

Table 7 Code ‘Sharing language’

Study	Coded segment
Thomson et al. (2015)	‘good at talking to people’
Ingram (2013)	‘she was just really easy to talk to’

Thomson et al. (2012a)	‘You could ask her questions and she’d explain them in a fashion that you could understand without being too medical...and you ‘could talk to her. (Kayla) ‘the terminology they (peer supporters) used was identified to enhance women’s knowledge and understanding’.
Raine and Woodward (2003)	‘It’s the way she talks, I think. You feel more comfortable with her’
Dykes (2003) (3) As explained above, this number in brackets refers to the exact project summary within Dykes. Please see appendix 6.	Five mothers were interviewed. They appreciated the support and generally found the peer supporters easier to communicate with than health professionals,
Battersby (2001)	‘the support workers were easier to talk to’

	‘the peer supporters spoke the same language’

In other areas there were differences between studies in relation to the ideas encapsulated within the codes. For example, in relation to the code named ‘attending a group’ the coded sections seemed to reflect a wide range of situations, ranging from women feeling *‘nervous’* (Fox et al., 2015, p8) and *‘reluctant’* (Ingram, 2013, p7), to descriptions of groups being *‘homely’* (Dykes, 2003, p83). Furthermore, groups were reported to be *‘too busy’* (Ingram et al., 2005, p115), attendance being ‘*generally high’* (Thomson et al., 2015, p7), and in contrast on occasion described as *‘poorly’* (Dykes, 2003, p109) attended, or, *‘not too busy’* (Ingram, 2013, p7) so that new mums from the intervention were needed in order to help *‘keep the support groups going’* (Ingram, 2013, p7). Overall however, the first initial impression of how the group of studies related to one another was that they were broadly reciprocal, but that there were some areas where some conflict was evident, for example concerning the extent to which PSs were woman centred and the extent to which they were directive in their interactions with women. Once broad groupings had been made, each grouping was systematically checked through. Every section of codes was read and re-read to ensure the groupings fitted together well. As this proceeded, second level codes positioned between the first level initial codes and the third level theme codes were created. Adaptions were made as necessary. This meant that the relationship between the third level themes and the first level codes could be easily understood. For example, table 8 shows one section of the three levels of coding.

Table 8 Example of three levels of coding

First order interpretations	Second order interpretations	Third order interpretations
'Sharing language', 'sharing a role', 'Sharing age, class or culture'.	'Identifying with the peer supporter'	'Forming a trusting mother – peer supporter bond'
'Being non-judgemental', 'listening', 'being interested', 'valuing any breastfeeding'.	'Being woman centred'	
'Spending time', 'enabling asking of questions', 'being there', 'using different forms of communication'.	'Developing a sense of presence'	

As this analysis was taking place, I took time to reflect on the group of studies as a whole and the third level themes identified. I used free writing to regularly express and record my ideas. At any point I would stop analysing and do some free writing. Sometimes I wrote down ideas in the middle of the night. These writings enabled reflection on thought progression and embryonic formation of ideas about bringing the synthesis together as a whole.

3.6.3 Translating the studies into one another

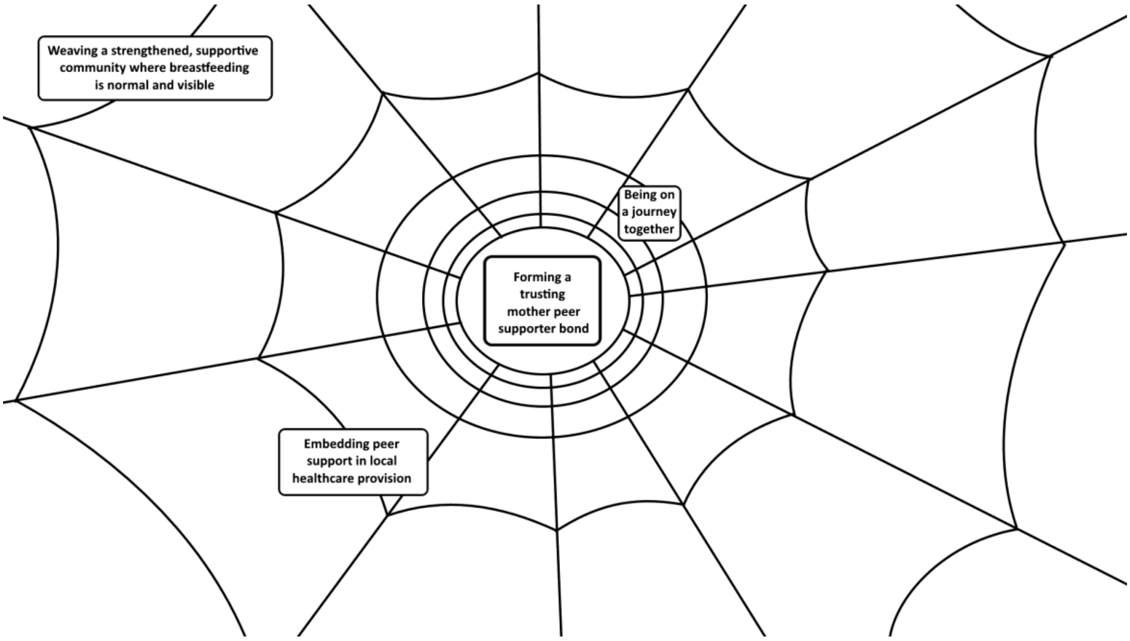
During this step comparisons are drawn whereby the differences and similarities between the studies are systematically assessed. Comparisons of the way each key theme is accounted for in each study are made both within and between studies, but as this happens it is important not to lose sight of each study as whole, or of the way the main themes relate to each-other within each study. It was during this stage of the synthesis that the benefit of having two studies available only in paper form was felt. It was essential to return to these paper copies regularly and this forced consideration of holism and of the relation of themes one to the other within the studies. In turn these 'paper' studies prompted re-consideration of these issues within the 'digital' studies. An example of a section of translations can be seen in consideration of the theme of 'being on a journey'. Each study in turn was examined to see whether and to what extent this theme was represented within it. In addition, how this idea related to others was also considered. For example, Ingram (2013) contained a theme called 'encouragement and enhanced self-confidence', and throughout the findings section of Thomson et al. (2012), PSs were seen to be 'alongside' women as they engendered hope. Although named differently, these themes related directly with the idea of 'being on a journey' which were expressed in those very terms in Fox et al. (2015) and Thomson et al. (2012b). In addition to these comparisons the manner by which 'the journey' related to other ideas within each study was also considered. For example, in Ingram (2013) and Thomson et al. (2012a), this theme was closely related to the sense women expressed that their peer supporter was *'there'* for them. This relationship was repeated in Thomson et al. (2012b) as the bonds between the mother and peer supporter were explained first, and the journey flowed on based on this. All studies were similarly compared. In this brief example, this translation was therefore deemed reciprocal.

As well as using this translation analysis to assess whether study concepts fit together in the most obvious ways, other alternative arrangements were also considered and ‘tested’ for cogency via this method of translations. For example, the idea of fitting study concepts together around the following three important and shared aspects of the context was considered; lack of knowledge about breastfeeding, social isolation, and imbalances in power relations. This work ‘testing’ alternative approaches served to deepen understanding of concept relations and ensure conclusions were not arrived at too swiftly. Following this translational work however, the ‘best fit’ arrangement for the relations between the concepts was found to be the original plan.

3.6.4 Forming a whole

The final phase of Noblit and Hare’s synthesis involves *‘making a whole’* which forms more than the sum of the parts (Noblit & Hare,1988 p.28). In this synthesis, the global analogy of a spider’s web has been used as an overarching image to incorporate all the ideas suggested within the studies (see figure 1 below). Taken as a whole, the studies revealed commitment to the belief that changes would be wrought by way of changing the culture so that it is supportive of breastfeeding. The spider’s web analogy can illustrate the interventions attempts to affect this cultural change.

Figure 1 The analogy of a spider's web



3.7 FINDINGS

The findings are presented by way of four themes; theme one, 'forming a trusting mother-peer supporter relationship' reveals the strong bonds that can be generated between mothers and PSs, while the manner by which this bond can become an ongoing relationship of companionship in the form of 'being on the journey together' is outlined in theme two. Theme three, 'weaving a strengthened, supportive community where breastfeeding is normal and visible' illustrates how, by way of multiple links, bonds and relationships, a wider web of support can be built, and theme four, 'embedding peer support in local health care provision' reveals the importance of relationships with health professionals in peer support projects, and how these can greatly strengthen the overall web of support. Table 9 shows the three levels of code names and illustrates how the four themes fit together.

Table 9 Coding tree for meta-synthesis themes

Theme 1

First order interpretations	Second order interpretations	Third order interpretations
'Sharing language'(31,27,2,26,4,24) , 'sharing a role'(27,2,33,26,41), 'Sharing age, class or culture' (36,27,2,11).	'Identifying with the peer supporter'	'Forming a trusting mother – peer supporter bond'
'Being non-judgemental' (27,3,26,41,25,24), 'listening' (36,27,3,26,41,32,25,11,28), 'being interested'(36,27,2,3,26,11,4,24), 'valuing any breastfeeding' (28,1,26,4).	'Being woman centred'	
'Spending time' (36,27,2,33,3,26,31,28), 'enabling asking of questions'(33,3,26,11,4), 'being there'(36,27,2,3,26,11,4,43,24,31), 'using different forms of	'Developing a sense of presence'	

communication' (36,27,1,3,26,11,4,24,31,28).		

Theme 2

First order interpretations	Second order interpretations	Third order interpretations
'being pro-active' (27,33,3,26,4,24), 'valuing early support' (26,4,24,27), 'being a life line'(2,4,26,24).	'being companions for the journey'	'Being on the journey together'
'using formal knowledge' (2,33,26,4,27,32,26,41,11,4,24,36,28), 'using embodied knowledge' (36,27,1,33,26,11,24,28), 'learning the practicalities'(27,2,26,4,43,11,31,28),	'being a knowledgeable companion'	
'reassuring' (27,2,3,26,41,11,4,24,31), 'affirming' (27,3,26,31), 'highlighting evidence of success'(26), 're-iterating benefits'(26), 'increased confidence and self- belief' (27,1,33,26,4,43,24,31), 'helping me keep on' (27,3,26,4,43,24,31), 'adapting feeding goals'(31,27,1,26,11,24).	'normalising breastfeeding experience'	

‘being honest’ (27,33,26,4,24,31), ‘suggesting’ (27,26,11,4), ‘advising’(36,27,2,3,41,11,4), ‘connecting to self’(3), ‘identifying actions that threaten goals’(26,33), ‘helping at pivotal points’(3,26,11,24).	‘being an honest companion’	

Theme 3

First order interpretations	Second order interpretations	Third order interpretations
‘Attending a group’ (1,3,2,4,11,24,26,27,36,43), ‘public feeding problematic’ (1,2,11,43,24,3), ‘community lacking knowledge of breastfeeding’ (31,27,1,2,26,11,43,28,24), ‘aims of peer support’ (27,1,2,25,28,31).	‘Enabling access to the breastfeeding group’	‘Weaving a strengthened, supportive community where breastfeeding is normal and visible’
‘Involving partner and family members’ (1,3,26,11,4,43,24), ‘struggling to engage fathers’(4).	‘weaving in family and friends’	

‘forming friendships / social contacts’ (1,2,3,36,27,26,11,43,24), ‘social isolation’ (1,2,3,25,36,43,11,24), ‘being the only one breastfeeding’ (1,2,26,28,43,11), ‘normalising being a breast feeder’ (27,43,24,11,26), ‘making breastfeeding visible for mothers’ (27,43,24), ‘belonging’ (2,3,11,43,24,26,27,36), ‘not all about breastfeeding’ (2,3,11,43,26,24), ‘forming their own subgroups’ (24,43), ‘accessing vicarious knowledge’ (36,27,26,11,43,24), ‘the functioning of the group’ (27,11,43,28).	‘Creating a social network in a context of social isolation’	
‘giving something back’ (24,43,32,36,31), ‘PS gaining confidence and knowledge through training’ (27,1,25,43),’imbalance of	‘Growing the peer supporters’	

power and status' (11,1,27,2,33,32,25,28,4,24,26), 'PS empowerment' (27,25,1,28), 'matching role to person' (2,32,36,27,24,28), 'enjoying being a peer supporter' (1,3,25,43,24), 'supporting the supporters' (1,2,27,24,25,28,31), 'feeling isolated' (32,2,27).		
'Wanting to tell others' (2,43,25,31), 'making breastfeeding visible in community' (1,2,27,25,24,28), 'normalising breastfeeding as part of community' (2,27,43,24), 'seeking to reach more mums' (27,24,11,2,28), 'linking with women not necessarily planning to breastfeed'(31,4,24), 'adapting to local need' (24,27)	'Reaching beyond the breastfeeding group'	

Theme 4

First order interpretations	Second order interpretations	Third order interpretations

‘needing clear boundaries’(27,33,32,25,4,24,28,31), ‘being a supplementary support’ (36,27,1,2,33,32,25,4,28). ‘needing a joined-up approach’(1,2,3,31,27,33,26,25,11,4,43,24,28,31), ‘making the PS role visible in hospital’ (33,32). ‘tensions between HP and PS’ (1,2,27,32,25,28,33,244), ‘being accountable’ (27,32,31,26,3,24,4,36,33), ‘box ticking’(27, 32).	‘Defining a clear PS role’	‘Embedding peer support in local health care provision’
‘needing good communication’ (1,2,3,27,26,24), ‘referring back’ (2,3,4,27,26,24,25,36,31), ‘gatekeeping’ (27,1,2,25,32,33,28), ‘HP learning from PS’(27,33,32,25,28).	‘Building a trusting PS-HP relationship’	
‘differing agendas’ (33,24,28). ‘HP role within service’(31,28,1,25,2,27,28) .	‘Negotiating power relations’	

3.7.1 Theme One: ‘Forming a trusting mother-peer supporter relationship’

In this theme, the way that a trusting bond can be formed between the mother and the peer supporter is revealed. This is explained through the second level codes whereby mothers are seen to be 'identifying with the peer-supporter', the manner by which the peer supporter is 'being woman centred', and in how the peer supporter is 'developing a sense of presence' with the mother. Social capital theory[8] has been used to explain the bonds in this theme (South et al., 2012; Thomson et al., 2015), bonds that relate to links between similar people of parity in power and status (Crossland & Thomson, 2013). These bonds can be seen to correspond to strong bonds close to the centre of a spider's web where intensive activity takes place to maintain and strengthen them (see Figure 1, section 3.6.4).

'Identifying with the peer-supporter'

As the peers were mothers who had had their own experience of breastfeeding, this was felt to create a shared common language that encouraged easy and understandable peer-mother dialogue (Battersby, 2001; Dykes, 2003 (3); Ingram, 2013; Raine & Woodward, 2003; Thomson et al., 2012a; Thomson et al., 2015) where communication was in *'a fashion you could understand*' (Thomson et al., 2012a, p7). PSs were felt to be, e.g. *'on their (the mothers) level'* (Raine & Woodward, 2003, p212) which enabled trust to be built (Battersby, 2001; Crossland & Thomson, 2013; Dykes, 2003 (3); Ingram, 2013; Raine & Woodward, 2003; Thomson et al., 2012a; Thomson et al., 2015):

> *'I don't know that I would trust a breastfeeding buddy that had never breastfed before. It definitely made a difference'*. (Sally, mother. Thomson et al., (2012a) p.6).

---

[8] Bourdieu conceptualised four main types of capital; economic, cultural, symbolic and social (Bourdieu, 1986). Social capital concerns the properties of exchanges between people such as trust, co-operation, shared identity, norms, and values, and is the property of individuals (Williams, 1995). Bourdieu emphasised structural constraints upon people and their unequal access to resources and power (Williams, 1995).

Some studies suggested similarity in age, cultural background and class between PSs and women was important (Fox et al., 2015; Dykes, 2003 (8, 12); Raine & Woodward, 2003; South et al., 2012):

> *'I just look around and there was old mothers at mature age'* (Fox et al., 2015 p.9).

However, the study by Graffy and Taylor (2005) was the only study which did not specifically aim to recruit women who were already part of the study community, and therefore similar in these respects.

'Being woman centred'

Women expressed the sense that their PSs had a genuine interest in them and their situations (Dykes, 2003 (2, 18); Fox et al., 2015; Ingram, 2013; Raine & Woodward, 2003; South et al., 2012; Thomson et al., 2012b; Thomson et al., 2012a; Thomson et al., 2015). PSs were described, for example, to *'very much listen'* (Curtis et al, 2007, p152) to mothers (Aiken & Thomson, 2013; Curtis et al., 2007; Dykes, 2003 (7, 12, 16); Fox et al., 2015; Graffy & Taylor, 2005; Kirkham, Sherridan, Thornton, & Smale, 2006; South et al., 2012; Thomson et al., 2012b; Thomson et al., 2012a), and to be non-judgmental in their approach so that irrespective whether they continued to breastfeed, women were positive about the support they received (Curtis et al., 2007; Dykes, 2003 (7, 12); Graffy & Taylor, 2005; Raine & Woodward, 2003; Thomson et al., 2015; Thomson et al., 2012a):

> *'She [Star Buddy] never made me feel once like I was letting him down or anything'* (Mother who had stopped breastfeeding. Thomson et al., (2012a) p.11).

PSs were seen to value all and any breastfeeding mothers engaged in feeling that through their support somebody might continue to breastfeed for a little longer, or for the *'first few feeds in hospital'* (Ingram, 2013, p5) (Ingram, 2013; Kirkham et al., 2006; Raine,2003; Thomson et al., 2012a). When studies were compared, this aspect, the notion that PSs were woman centred, did not come across in all studies. While there was no evidence for judgemental attitudes or of PSs ignoring women in any of the studies, some studies did not explore in depth and detail the nature of the peer supporter – mother relationship. This could be seen to reflect data collection methods, for example open questions in a questionnaire e.g. Ingram (2013) and Graffy and Taylor (2005).

'Developing a sense of presence'

Across the studies the importance of PSs having time to give to mothers was emphasised (Aiken & Thomson, 2013; Battersby, 2001; Crossland & Thomson, 2013; Dykes, 2003 (2, 8); Ingram, 2013; Kirkham et al., 2006; Raine & Woodward, 2003; South et al., 2012; Thomson et al., 2012b ; Thomson et al., 2012a), and that through giving time, PSs were able to understand women's anxieties about breastfeeding, and to answer their questions (Crossland &Thomson, 2013; Ingram, 2013; Thomson et al., 2012b; Thomson et al., 2012a):

> *'I was very anxious about it and (peer supporter) came to see me and she was here about an hour and she answered all my questions and after that visit I felt so much better and more confident"* (Ingram, 2013, p5).

In this way, the PSs were seen to develop a strong sense of their presence and of being there for women (Battersby, 2001; Dykes, 2003 (3, 11); Fox et al., 2015; Ingram, 2013; Ingram et al., 2005; Raine & Woodward, 2003; South et al., 2012; Thomson et al., 2012b; Thomson et al., 2012a; Thomson et al., 2015):

> *'When I see the peer supporters working they are not rushed at all. The women are made to feel – I am here for as long as you need me. That is how it should be'.* (Rachel, Midwifery) (Crossland & Thomson, 2013 p.190).

The availability of PSs provided a sense of reassurance for women (Ingram, 2013; Thomson et al., 2012a). Indeed, in one study the PSs, acting as the *'calm in the storm'* formed '*an embodied basis of space and time'* for the women (Thomson et al., 2012a, p12). While time being available was important across the studies, this aspect had the potential to be threatened when services became formalised as PSs felt they no longer, e.g. *'spend as much time with the mums as I used to'* (Aiken & Thomson, 2013 p.148).

Central to the development of a sense of presence was the way by which PSs used many different forms of communication in order to tailor their flexible support to each woman using her preferred channel, thus forming, e.g. a *'personalized service'* (South et al., 2012, p664) via the use of leaflets, books, contact via the phone, email, the internet, texts, posters, and home visits (Battersby, 2001; Dykes,2003 (1, 3, 9); Fox et al., 2015; Ingram, 2013; Kirkham et al.,2006; Raine, 2003; South et al., 2012; Thomson et al., 2012b; Thomson et al., 2012a; Thomson et al., 2015). In projects involving one to one peer support, it was noted that initial contact was often by telephone or text, and that face to face visits tended to be used when women were 'struggling' or experiencing specific difficulties (Ingram, 2013; Thomson et al., 2012b). It was recognised that for some issues *'you need that one to one; you need to see somebody face to face'* (Fox et al., 2015 p.8). However, the breastfeeding incentive scheme facilitated regular face to face contact, which formed a *'foot in the door',* when there was no specific issue at hand (Thomson et al., 2012b, p6). This was felt to have important consequences to the quality and depth of the relationship:

> *'I don't think she would have trusted me if I hadn't been seeing her so regular'* (Thomson et al., 2012b, p.9).

Increased face to face contact enabled access to vulnerable women and enabled PSs to better identify women's worries and concerns which in turn led to closer contact with health professionals and referrals to other agencies (Thomson et al., 2012b). The importance and impact of increased face to face contact was revealed in the incentives study because it formed an extension to an existing project. In other studies, for example Ingram (2013), no such comparison was available.

3.7.2 Theme 2: 'Being on the journey together'

This theme explains the way that the initial mother – peer supporter relationship becomes that of 'being companions for the journey', how having a 'knowledgeable companion' on the journey can be important, and how PSs are seen to use their knowledge in 'normalising breastfeeding experiences' as the journey progresses. The importance of PSs 'being honest companions' is also explained. Several studies used the analogy of a journey, and this resonated across the body of work as a whole. Thomson et al. (2012a) use hope theory to explain how the work of PSs can be seen as behavioural manifestations of hope. Ongoing peer support could be seen to be analogous to a web supporting women while PSs can be seen to be tailoring the structure of the web to individual women's needs and accompanying the women on their journey across the web (see figure 1, section 3.6.4).

'Being companions for the journey'

Whilst health professionals in one study felt that women did not like proactive peer support (i.e. PSs contacting the women irrespective of need) (Crossland & Thomson, 2013), and in another, that they might feel under pressure to accept it (Dykes, 2003 (3)), peer support was proactively provided in a number of studies (Aiken & Thomson, 2013; Crossland & Thomson, 2013; Ingram, 2013; Thomson et al., 2012b; Thomson et al., 2012a; Thomson et al., 2015). Early opportunities for breastfeeding support which this proactivity enabled were identified as important (Dykes, 2003 (11, 16); Ingram, 2013; Thomson et al., 2012a; Thomson et al., 2015). When PSs maintained proactive contact with women throughout the perinatal period they were able to extend their initial sense of presence (as explained in theme one), into something ongoing, described in a number of studies as *'a life line'*(Thomson et al, 2012a, p9) or *'a safety net'*(Raine & Woodward, 2003, p212; Thomson et al, 2012b, p8), (Raine & Woodward, 2003; Thomson et al., 2012b ; Thomson et al., 2012a; Thomson et al., 2015), meaning that women gained support they might not have sought out (Thomson et al., 2012a; Thomson et al., 2012b). This proactive contact could enable PSs to help at critical points such as when women were at risk of breastfeeding discontinuation (Ingram, 2013; Thomson et al., 2012b; Thomson et al., 2012a):

> '*She phoned me in the morning and that fell really well, because ...I had ended up in tears the previous night. It was because I was thinking, I'm not producing milk, nothing would seem to satisfy him, winding him, changing him. I'm*

> *thinking, it must be me. So it was really lucky when she phoned the next morning and just put my mind at ease'* (Thomson et al 2012a, p.9).

Where peer support was not proactive and mothers had to seek out help, mothers described times of crisis resulting from issues that had not been addressed earlier in their breastfeeding journey (Fox et al., 2015):

> '*I was struggling for him to latch on. Couldn't get any help from anywhere, I was absolutely end of my tether, beside myself, and on the verge of giving up, so I got a friend to bring me up here and [facilitator] took one look at him and diagnosed a tongue tie, arranged for me to have it snipped and gave me some tips on positioning. Within minutes, I thought 'You know, actually, I think I can do this'* (Mother, age 36, first baby (Fox et al., 2015 p.9).

'Being a knowledgeable companion'

PSs were recognised as being knowledgeable in a number of the included studies (Battersby 2001; Crossland & Thomson, 2013; Dykes, 2003 (3, 8); Graffy & Taylor, 2005; Kirkham et al., 2006; Raine, 2003; Thomson et al., 2015; Thomson et al., 2012a). However, the type of knowledge used was not always clearly explained (Dykes, 2003 (3, 15); Graffy & Taylor, 2005):

> '*They* [the mothers] *liked the fact that they* [the PSs] *... were knowledgeable*' (Graffy & Taylor, 2005 p.183).

The importance of health professionals and PSs having i.e. *'shared, explicit factual knowledge'* (Crossland & Thomson, 2013, p196) that was consistently applied was recognised (Crossland & Thomson, 2013; Raine & Woodward, 2003), and one way this was reported to be achieved was via shared training (Raine & Woodward, 2003). Sometimes PSs were reported to use knowledge emanating from their personal experiences (Crossland & Thomson, 2013; Dykes, 2003 (8, 12); Fox et al., 2015; Kirkham et al., 2006; Raine, 2003; South et al., 2012; Thomson et al., 2012a; Thomson et al., 2015), for example:

> *'The Bengali supporter utilised personal experience to enable women to consider an alternative to their cultural norm. Recognising that Bengali women commonly combine breast with bottle feeding and feel embarrassed about breastfeeding in front of others, the supporter explained that she expresses her breast milk so that she can give it from a bottle if visitors arrive. This enabled her to exclusively breastfeed'* (Dykes, 2003 p.138 (12)).

However, PSs were also considered to use their formal knowledge of breastfeeding to aid parent's understandings (Crossland & Thomson, 2013; Ingram, 2013; Kirkham et al., 2006; Raine & Woodward, 2003; Thomson et al., 2012a). For example, during an antenatal visit one father recalled:

> *'Then she [the peer supporter] told us about the size of the baby's stomach over a period of time, that was interesting'* (Ingram, 2013 p.5).

Furthermore, Thomson et al. (2012a) provides an example revealing the two types of knowledge (formal and experiential) intertwined:

> *'I was planning on 6 months [breastfeeding] and then going back to work...[But] the [Star Buddies] have given me the confidence to know that I can feed her in the morning and at night that my body will regulate and I can then still feed as normal at the weekends'*. (Mary) (Thomson et al., 2012a, p.8).

These different types of knowledge (formal and experiential) were clearly distinguished between and acknowledged in some studies (Crossland & Thomson, 2013; Dykes, 2003 (8); Kirkham et al., 2006; Raine, 2003; Thomson et al., 2012a), however, some health professionals did not appear to acknowledge women's embodied knowledge as being a *'valid'* (Dykes, 2003, p107) and useful source of information for other mothers (Crossland & Thomson, 2013; Dykes, 2003 (8); Kirkham et al., 2006).

There were differences across the studies in the levels of instrumental support PSs felt equipped to provide to women, whereby some felt they could not provide the same level of practical help as a midwife (Dykes, 2003 (7)), and others were keen to learn how to help with practicalities (Ingram et al., 2005). Across many studies practical support in the form of checking the *'breastfeeding latch'* (Thomson et al., 2012a, p11), helping mums to get *'the technique right'* (Ingram, 2013, p6), fit breastfeeding into normal life, and adapting the physical environment in order to facilitate breastfeeding, were key to peer support activities meaning knowledge of how to practically help a woman to breastfeed was an important knowledge area (Battersby, 2001; Dykes, 2003 (8, 18); Fox et al., 2015; Ingram, 2013; Ingram et al., 2005; Kirkham et al., 2006; Raine & Woodward, 2003; Thomson et al., 2012a):

> '*She [Star Buddy] just saw what he was doing and she said he is a large baby, get rid of his nursing pillow, get rid of this and she sorted it out in a way that*

> *no-one else had thought of, it was a different hold than anyone else had tried on me before and she had him latched on in ten minutes...and I burst into tears'*. (Sally) (Thomson et al., 2012a, p.7).

Although as explained above PSs were seen to use their embodied, experiential knowledge of breastfeeding, while health professionals may favour formal knowledge, this relationship was not always clear cut. For example, in the Crossland and Thomson (2013) study the issue of whether a breastfeeding helper ought to use her hands to practically help a mother attach a baby to her breast was explored. While it was unclear whether the peer supporter's '*hands off'* (Crossland & Thomson, 2013, p192) approach was borne from adhering to their formal training, stemmed from their own personal experience, or emerged from a combination of both, some health professionals felt the '*hands on'*(Crossland & Thomson, 2013, p202) approach they, as health professionals, sometimes adopted, emanated from their own experiential knowledge:

> '*I'll probably get shot for saying it, but sometimes they* [mothers] *want you to be a little bit hands on, they want you to guide their hands, they want you to show them, rather than just say, keep on with the skin to skin and see what happens'* (midwifery focus group)(Crossland & Thomson 2013 p.193).

In Thomson et al.'s (2012b) study of an incentive scheme, regular contact between PSs and women facilitated by the incentive gift giving meant that rather than feeling *'pressured'* to give women information, or impart to their knowledge, PSs could *'choose when it was most appropriate'* to bring up a particular subject (Thomson et al., 2012b, p9). PSs were also seen to utilise other forms of knowledge, such as how they might enable women to gain access to other services (South et al., 2012; Thomson et al., 2012b; Thomson et al., 2015):

> *'I instantly got on to the sign language and they got lessons for her and its things like that. Fire, safety in the home, we do that, get the fire brigade round, link that in'*. (PS_2) (Thomson et al., 2015 p.10).

'Normalising breastfeeding experiences'

Through an approach of *'mutual exchange and validation of experience'* (Dykes, 2003 (7) p101), mothers were reported to find their PSs reassuring (Dykes, 2003 (7); Fox et al., 2015; Graffy & Taylor, 2005; Ingram, 2013; Raine & Woodward, 2003; Thomson et al., 2012b; Thomson et al., 2012a; Thomson et al., 2015). This was often expressed in generalised terms, for example, post-natal phone calls were described as *'helpful, supportive and reassuring'* (Ingram, 2013, p4). However, in other studies reassurance concerned the PSs use of their knowledge of the normal course of breastfeeding (Battersby, 2001; Thomson et al., 2012a). When a mother with *'so many doubts'* expressed concern that her baby was *'like nodding off…and on again'*, after asking questions and answering the mother's questions, her peer supporter was able to say *'yes, it's normal'* (Thomson et al., 2012a, p.12). Such reassurance stopped mothers from panicking:

> '*So I'd feel reassured rather than panicking and thinking, oh I don't know what's what'* (Nicky). (Thomson et al., 2012b, p.7).

Discussion of expected *'output'* (wet and dirty nappies), babies' skin tone and sleeping patterns were utilised as *'positive indicators'* of progress (Thomson et al., 2012a, p11).

By pointing out normality in this way PSs could be seen to provide the clear criteria women needed in order for them to compare their own experiences with breastfeeding normality and avoid erroneously finding *'themselves to be wanting'* through lack of knowledge of breastfeeding normality (Kirkham et al., 2006, p257). In the Thomson et al. (2012a) paper such reassurance and normalising was found to enable women to re-focus their energy and increase their motivation to continue. Alongside this use of their knowledge, PSs were also found to provide affirmation and praise for women's infant feeding efforts (Battersby, 2001; Dykes, 2003 (1, 7, 11, 18); Thomson et al., 2012b; Thomson et al., 2012a). This could be verbally; '*you're doing a great job'* (Thomson et al., 2012a p.11), through the giving of gifts perceived as *'instant encouragement'* (Thomson et al., 2012b, p.9), or through expressing belief in women's abilities; *'you can do it'* (Battersby, 2001 p.31). Reiteration of health benefits along the journey reaffirmed women's commitment to breastfeeding:

> [Star Buddies] *'made me see more benefits…some of health benefits to mum and baby that I didn't realise… the muscles we use in the face for feeding can actually protect ear infections…never gave that a second thought before'* (Thomson et al., 2012a, p.11).

Through combining reassurance based on explicit criteria, reiterating benefits, and affirmation, PSs were able to increase self-confidence and belief (Battersby, 2001; Crossland & Thomson, 2013; Dykes, 2003 (3); Ingram, 2013; Ingram et al., 2005; Raine & Woodward, 2003; Thomson et al., 2012a; Thomson et al., 2015), and sense of their experience being 'normal' (Thomson et al., 2012a) which enabled women to continue breastfeeding (Battersby, 2001; Dykes, 2003 (2, 3); Ingram, 2013; Ingram et al., 2005; Thomson et al., 2012b; Thomson et al., 2012a; Thomson et al., 2015). In a number of studies women’s feeding goals were adapted (Battersby, 2001; Dykes, 2003 (3); Fox et al., 2015; Raine, 2003; Thomson et al., 2012a; Thomson et al., 2015) due to their increased confidence as a result of peer support (Dykes, 2003 (3); Thomson et al., 2012a), or via vicarious accounts:

> *‘So I spoke to those other mums that had done twelve months and you just thought, yes there is other mums out there that breastfeed for a long time’* (Thomson et al., 2015 p.7).

‘Being honest companions’

Honesty was a recurring characteristic used to define the peer-mother relationship (Battersby, 2001; Crossland & Thomson, 2013; Dykes, 2003(12); Ingram, 2013; Thomson et al.,2012a; Thomson et al., 2015). Because of their repeated contacts along the journey, this honesty could be expressed at numerous opportunities (Battersby, 2001; Ingram, 2013; Thomson et al., 2012a). In the antenatal period women appreciated honesty about what breastfeeding might be like (Battersby, 2001; Dykes, 2003 (12); Ingram, 2013; Thomson et al., 2012a):

> *‘One woman having her 4th baby said that I had really opened her eyes and that she was going to ‘give it a go’ with this baby as she has a more realistic picture of what breastfeeding is about”.* (PS #2) Ingram, 2013 p.5).

Meanwhile, while PSs were seen to support women’s choices (Raine, 2003; Thomson et al., 2012a), they did not shy away from explaining the possible risks to breastfeeding from various post-natal practices (Crossland & Thomson, 2013; Thomson et al., 2012a):

> '*Photographs that they showed with dummies and how it can stop you seeing signs [feeding cues], this actually made me decide not to give a dummy as I was in two minds about it...it made me want to know him [son] better than that'*. (Charlotte) (Thomson et al., 2012a, p.8).

Mothers expressed relief at being able to be open with their peer supporter about their feelings (Crossland & Thomson, 2013; Ingram, 2013; Thomson et al., 2012a; Thomson et al., 2015):

> *'I felt I could ring her and say I was struggling'* (Ingram, 2013 p.6).

This openness could be recognised by health professionals too:

> '*Maybe they are a bit more open and honest with them about 'oh I'm really struggling', or 'I'm not sure if I want to do this'* (Health professional) (Crossland & Thomson, 2013 p.191).

In one study PSs were seen to provide *'realistic assessments'* about women's situations and progress (Thomson et al., 2012a, p7). The major area of conflict within the texts surrounds the way PSs approach conversations with women when they needed help with a breastfeeding predicament (Ingram, 2013; Thomson et al., 2012a). Such issues could include:

> *'mastitis, thrush, engorgement, readmissions to hospital (for mother or baby) and difficulties in achieving a successful latch at the breast'* (Thomson et al., 2012a, p.7).

In several studies the word advice was used either by the women quoted in the study or by the authors themselves (Dykes, 2003 (16); Fox et al., 2015; Graffy & Taylor, 2005; Ingram, 2013; Raine & Woodward, 2003; South et al., 2012; Thomson et al., 2012b), they explain how *'helpful advice'*(Graffy & Taylor, 2005, p182) was provided and how mothers contacted PSs *'for advice'*(Ingram, 2013, p4). On the other hand, in other studies, neither participants nor authors used the word advice, rather PSs were said to provide alternative strategies or to give women ideas (Curtis et al., 2007; Thomson et al., 2012a; Thomson et al., 2015). In some studies, there were examples of both the word advice, and less directive terms such as tips being used within the same study (Fox et al., 2015; Ingram, 2013; Thomson et al., 2012b). Kirkham et al. (2006) explain how non-directive information giving was central to the communication skills of PSs in their project.

3.7.3 Theme 3: 'Weaving a strengthened, supportive community where breastfeeding is normal and visible'

During this theme the manner by which breastfeeding groups form an integral role in weaving a strengthened, supportive community is explained. Returning to the web analogy, when moving further out from the centre of the web, out from the close strong bonds of partner, close family and one to one peer support, the breastfeeding group can be found. 'Enabling access' to the group and 'including the support system' can be seen to be steps towards 'creating a social network in a context of social isolation', acting as somewhere for 'growing peer supporters', and forming a hub from where links 'reaching beyond the group' and impacting further into the community can stem. These links can be seen to be analogous with lines of the spider's web attaching to structures in the environment all around it (see figure 1, section 3.6.4).

‘Enabling access to the breastfeeding group’

Common across the studies were communities where breastfeeding was not spoken about or seen, where there was no knowledge of breastfeeding, and where breastfeeding skills and traditions had been lost (Battersby, 2001; Fox et al., 2015; Ingram et al., 2005; Kirkham et al., 2006; Raine, 2003; Raine & Woodward, 2003; Thomson et al., 2012a; Thomson et al., 2015). For example:

> *‘The community has no knowledge generally of breast-feeding, and although it might seem that it should just be something that mothers would know, it isn’t at all’* (project co-ordinator) (Raine, 2003, p646).

Related to this lack of knowledge and the invisibility of breastfeeding was women’s anxiety about breastfeeding in public (Fox et al., 2015; Ingram et al., 2005; Raine, 2003; Raine & Woodward, 2003; Thomson et al., 2012b; Thomson et al., 2015). For example, *‘when you first come out of hospital, you’re frightened to go somewhere and breast-feed in public’* (Raine, 2003, p467). On occasion this discomfort was described to extend to feeding in front of other people within women’s own homes (Raine, 2003). Breastfeeding groups were utilised by many of the projects (Dykes, 2003(1, 2, 3, 5, 7, 9, 12, 14, 16); Fox et al., 2015; Ingram et al., 2005; Ingram, 2013; Raine, 2003; Raine & Woodward, 2003; South et al., 2012; Thomson et al., 2012b; Thomson et al., 2015; Thomson et al., 2012a). They aimed to provide spaces where women could share their embodied experiences of breastfeeding, making them available as a community resource which might help change social attitudes (Curtis et al., 2007; Dykes, 2003 (in main text and also in 7, 1, 14); Kirkham et al., 2006; Raine, 2003; Raine & Woodward, 2003). Groups might also aim to de-professionalise breastfeeding (Kirkham et al.,2006).

Group attendance across the studies was variable. Some studies reported that groups were poorly attended (Dykes, 2003 (9); Ingram, 2013), while other studies reported high attendance (Ingram et al., 2005; Thomson et al., 2015), indeed on occasion groups were found to be '*too busy'*(Ingram et al., 2005, p114). Practical issues such as timings, the need for welcoming, culturally acceptable and convenient venues that are familiar to local women, and the provision of crèche facilities and food were discussed as important issues to encourage access (Dykes, 2003 (2, 5, 14, 16); Fox et al., 2015; Thomson et al., 2015). However, it was personal relationships and bonds that were central to understanding the varying group attendance patterns described above:

> '*Some mothers prefer to see their own peer supporter when they go to a group and are a bit reluctant to go if we are not going to be there'*. (PS #4) (Ingram,2013, p7).

Indeed, in the incentive intervention when the personal bonds between PSs and women were strengthened due to increased face to face contact, group attendance increased (Thomson et al., 2012b). In Dykes (2003) access was enhanced when women knew a peer supporter from their own ethnic community would be attending. The extent to which health professionals promoted breastfeeding groups through their personal interactions with women was also seen to relate to group attendance levels (Dykes, 2003 (9); Fox et al., 2015). And, as explained in theme two, when services were organised so that women were required to initiate group attendance independently, some women described feeling apprehensive about the prospect of attending a group (Fox et al., 2015; Ingram, 2013). The potential for breastfeeding groups to be attended more readily by more socially advantaged mothers was recognised with those who were younger, less confident, or less affluent having the potential to miss out (Dykes, 2003 (14); Fox et al., 2015).

'Including the support system'

Harnessing the encouragement of women's own systems of support in their bonding work by *'getting as many of the family'* involved as possible, was felt to *'make a huge difference'* (Thomson et al 2015, p8), and was recognised as important in enabling women to reach their breastfeeding goals (Fox et al., 2015; Ingram, 2013; Ingram et al., 2005; Raine, 2003; Thomson et al., 2012b; Thomson et al., 2012a; Thomson et al., 2015). This could take the form of involving partners and family at every contact and communication opportunity (Ingram, 2013; Thomson et al., 2015; Thomson et al., 2012a; Thomson et al., 2012b), opportunistically enabling family members to access support via being known and visible in the community (Thomson et al., 2015), via a grandmother peer support training course (Thomson et al., 2015), or by making partners and family members welcome at breastfeeding groups (Fox et al., 2015):

> *'We thought fathers were not allowed to stay here, but then [facilitator] said 'no, we welcome dads as well' so…he stayed and was chatting to everyone, and I felt really comfortable'* (Mother, age 29, first baby) (Fox et al., 2015, p9).

Family and partners were thereby involved as much as possible, so that their support was woven into the web of support.

‘Creating a social network in the context of social isolation’

Considerable general social isolation was reported whereby study communities contained few informal support networks, so that some women had not had the opportunity to meet other mothers (Curtis et al., 2007; Fox et al., 2015; Ingram et al., 2005; Raine, 2003; Raine & Woodward, 2003; South et al., 2012; Thomson et al., 2012b; Thomson et al., 2015). In addition to this general social isolation women were also isolated from other breastfeeding women (Fox et al., 2015; Ingram et al., 2005; Kirkham et al., 2006; Raine, 2003; Raine & Woodward, 2003; Thomson et al., 2012a):

> *‘At the time I felt like I was the only one breastfeeding. You don’t realise there’s lots of other people around you ‘cause it’s not something you talk about every day’* (breastfeeding mother) (Raine & Woodward, 2003, p212).

There was no mention within the studies of how mothers felt when they were not part of a breastfeeding group. This might be because the studies did not include women who had not engaged with peer support as participants. Of paramount importance across the studies was the function of breastfeeding groups as somewhere for forming new friendships and finding mutual support (Dykes, 2003 (14); Fox et al., 2015; Ingram et al., 2005; Raine, 2003; Raine & Woodward, 2003; South et al., 2012; Thomson et al., 2012a; Thomson et al., 2012b; Thomson et al., 2015). For example:

> *‘I’ve met some really good lifelong friends’* (Thomson et al., 2015, p7).

Furthermore, the friendships forged were not all about breastfeeding (Fox et al., 2015; Ingram et al., 2005; Raine & Woodward, 2003; Thomson et al., 2012a; Thomson et al., 2012b; Thomson et al., 2015):

> ‘*It is great because all the mums are experiencing things and we can all pool together things and ideas and different things, not necessarily breastfeeding, everything and we all support each other with the feeding side and its great, I love it’*. (Angela) (Thomson et al., 2012a, p.10).

Often aided by a brand name (Dykes, 2003 (1, 8, 13); Curtis et al., 2007; Ingram et al., 2005; Ingram, 2013; Thomson et al., 2012a; Thomson et al., 2012b; Thomson et al., 2015), for example ‘Breastfriends’ (Curtis et al. 2007; Kirkham et al., 2006), the social relationships and shared experiences that PSs created for women through groups provided for some, i.e. a sense of *‘a sense of common ground and feeling like you belong’*(Ingram et al., 2005, p114), (Dykes, 2003 (1, 8, 13); Fox et al., 2015; Ingram et al; 2005; Raine & Woodward, 2003; South et al., 2012; Thomson et al., 2015; Thomson et al., 2012b; Thomson et al., 2012a). Relationships were seen to *‘cross previous social boundaries’* (Thomson et al., 2015, p7), and to continue beyond the confines of the breastfeeding group (Ingram et al., 2005; Thomson et al., 2015).

In addition to enabling friendships, a key function of a breastfeeding group was to provide somewhere where feeding experiences could be shared, mothers could meet others in similar situations, and vicarious knowledge of breastfeeding could be accessed (Dykes, 2003 (main text and in 1, 7, 8, 12); Fox et al., 2015; Ingram et al., 2005; Raine, 2003; Raine & Woodward,2003; South et al., 2012; Thomson et al., 2012a; Thomson et al., 2015):

> *‘I think the time when I had got the guts to say...I want to give up ...and then you start realising that everybody else is doing the same thing and it is not just you that is suffering, it is everybody else going through the same thing . . . and*

> *being able to turn round and say I really did want to at some point is just like a relief and everybody could talk about it and laugh about it'.* (Naomi) (Thomson et al., 2012a, p.10).

The sharing of experiences and role modelling was seen to enable women to make decisions about their own feeding journeys (Dykes, 2003, (7); Fox et al., 2015; Thomson et al., 2012a):

> '*I spoke to those other mums that had done twelve months and you just thought, yes there is other mums out there that breastfeed for a long time'*. (M_1) (Thomson et al., 2015 p.7).

Breastfeeding groups both made breastfeeding visible (Dykes, 2003 (16); Ingram et al., 2005; Thomson et al., 2015), and provided an opportunity to talk about breastfeeding, thereby normalising being a breastfeeding mother (Dykes, 2003 (main text and 1, 16); Fox et al., 2015; Ingram et al., 2005; Kirkham et al., 2006; Raine, 2003; Raine & Woodward, 2003; Thomson et al., 2015; Thomson et al., 2012a). This could also relate to specific issues such as the feeding of older babies (Fox et al., 2015), or as mentioned above, involve the opportunity for pregnant women to access groups to make friends and observe breastfeeding first hand (Dykes, 2003 (1, 12); Ingram, 2013; Thomson et al., 2015).

The functions of breastfeeding groups involved two areas, first, as has been explained, their social functions, and secondly their function as a place where women might access a *'skilled breastfeeding professional'* (Fox et al., 2015, p8). Some studies provided groups that sought to address both these functions at the same time (Dykes, 2003(1, 12, 16); Fox et al., 2015; Ingram et al., 2005; Kirkham et al., 2006). Dykes (2003) suggests that ideally groups should be primarily social, but with background support from health professionals. As described in theme two, it was clear that women needed help with practical issues related to positioning and attachment; however, where this help was received differed across the studies. Some studies described practical help being rendered in women's own homes (Battersby, 2001; Ingram, 2013; Thomson et al., 2012a; Thomson et al., 2012b; Thomson et al., 2015), while in others the breastfeeding group was used (Fox et al., 2015).

'Growing the peer supporters'

Across the studies, not all women adopted a passive role as recipients of services. Rather, many wanted to *'give something back'* (Aiken & Thomson, 2013, p147) and become PSs themselves (Aiken & Thomson, 2013; Battersby, 2001; Ingram et al., 2005; South et al., 2012; Thomson et al., 2015). Peer support training was found to increase women's confidence, knowledge and self-esteem, as well as their breastfeeding knowledge (Curtis et al., 2007; Dykes, 2003 (3, 8, 11, 16); Ingram et al., 2005; Kirkham et al., 2006; Raine, 2003).

PSs felt a sense of fulfilment in their role, by virtue of knowing they had helped other mothers and shared their own knowledge and experience (Curtis et al., 2007; Ingram et al., 2005; Raine, 2003; Thomson et al., 2012b; Thomson et al., 2015):

> '*It made me feel right good — special'*. (Fiona) (Curtis et al., 2007 p.151).

Indeed, during the incentives intervention PSs gained a sense of gratification through being more able to fully use their skills; ' *'It's just doing what we're meant to do and* *what we're trained to do in a really valuable, meaningful way'* (Thomson et al., 2012b p.10).

Across the studies there were imbalances in status and power between members of the communities (i.e. mothers and PSs) and health professionals (Aiken & Thomson, 2013; Crossland & Thomson, 2013; Curtis et al., 2007; Dykes, 2003; Fox et al., 2012; Ingram, 2013; Kirkham et al., 2006; Raine, 2003; Raine & Woodward, 2003; Thomson et al., 2015; Thomson et al., 2012b), such that one mother was reticent to attend a breastfeeding group because '*I don't trust Health Visitors'* (Fox et al., 2015, p9), and in one community mothers did not like the peer support brand name because it signified *'becoming one of them'* with health professionals (Kirkham et al., 2006, p254). Moreover, mothers were found to consider themselves as '*just normal mothers'* for whom *'if the doctor said it then it must be right'* (Curtis et al., 2007, p151). Indeed, being considered by a health professional as suitable to train as a peer supporter '*altered their whole being'* (Raine, 2003, p468), and deliberate actions on the part of PSs to gain *'more respect'* from health professionals were also on occasion described (Thomson et al., 2015, p10). Peer support training could counter such imbalances and have a positive effect in communities by acting as a catalyst to mothers accessing other educational opportunities (Curtis et al., 2007; Kirkham et al., 2006; Raine, 2003), thereby increasing community capacity building within the communities themselves (Curtis et al., 2007; Raine, 2003).

PSs roles within the projects were highly varied, from professionalised accountable roles within commissioned services (Aiken & Thomson, 2013; Crossland & Thomson, 2013), to informal roles speaking to other mothers in their own day to day lives (Curtis et al., 2007). The need to make sure the role a peer supporter was undertaking matched with their circumstances was acknowledged so that on-going assessments of this compatibility and adjustments to roles could be undertaken (Aiken & Thomson, 2013; Dykes, 2003 (7, 12); Kirkham et al., 2006; Raine & Woodward, 2003; South et al., 2012; Thomson et al., 2015):

> '*And I could volunteer in the evening to go on the ward but evenings, I was just a bit of a washout really. I thought, I'm not going to be any good talking to a mum who's all emotional because I'm feeling like that myself…so I've kind of been somebody who the Coordinator could [say] can I phone you if I've got too many people to phone and can you do some phone support? And I've been very happy to do that'*. (PS_11) (Thomson et al., 2015 p.7).

It was also recognised that frustrations and setbacks might occur within projects, and that PSs required robust systems of ongoing support (Battersby, 2001; Curtis et al., 2007; Dykes, 2003 (11, 17); Kirkham et al., 2006; Raine, 2003; Raine & Woodward, 2003; Thomson et al., 2015). If this support was unavailable PSs could start to feel isolated (Raine, 2003), a situation which particularly occurred within hospital settings (Aiken & Thomson, 2013; Dykes, 2003 (11)). Ongoing support for PSs functioned to enable them to update their skills (Dykes, 2003 (11, 17); Kirkham et al., 2006; Thomson et al., 2015), and to keep them informed about events and developments within the service (Raine & Woodward, 2003; Thomson et al., 2015). This support was found to be motivating, to help maintain enthusiasm, and to say thank-you (Battersby, 2001; Dykes, 2003 (11, 17); Kirkham et al., 2006; Raine & Woodward, 2003; Thomson et al., 2015):

> *'We do have get togethers, so they can all meet up, just like friends really and let them know as well that they are appreciated'*. (peer supporter 1) (Thomson et al., 2015, p6).

Support could take the form of regular phone calls between PSs and project health professionals (Raine & Woodward, 2003), access to health professionals outside of normal working hours (Raine, 2003), written updates (Raine & Woodward, 2003), and weekly group meetings (Kirkham et al., 2006; Raine & Woodward, 2003), support from other PSs (Aiken & Thomson, 2013), varying forms of regular communication both from the coordinator to the peer supporter and back the other way (Kirkham et al., 2006; Raine & Woodward, 2003; Thomson et al., 2015), shadowing opportunities, informal supervision and mentoring (Thomson et al., 2015), and social occasions which included other family members (Thomson et al., 2015). These connections were appreciated by PSs (Curtis et al., 2007; Thomson et al., 2015).

'Reaching beyond the breastfeeding group'

On a personal level, some PSs were motivated to promote breastfeeding *'at every opportunity'* (Curtis et al., 2007, p151), wanting to tell others about breastfeeding being *'so good for their babies'* (Ingram et al., 2005, p114) (Battersby, 2001; Curtis et al., 2007; Ingram et al., 2005; Raine & Woodward, 2003). However, this could be a *'fine line'* to tread in order to insure they understand the situations of individual women who might not have continued to breastfeed (Raine & Woodward, 2003, p213).

Another way by which PSs reached beyond breastfeeding groups was through the formation of strong partnerships with health professionals which could enable them to gain access to more mums via statutory services (Battersby, 2001; Dykes, 2003 (12, 14); Fox et al., 2015; Ingram et al., 2005; Kirkham et al.,2006; Thomson et al., 2015), for example:

> *'Volunteers also worked alongside a range of statutory and informal professional run activities and groups, i.e. baby clinics, antenatal clinics, baby groups, lactation consultant-led breastfeeding group, young mother's groups, toddler groups, baby massage groups and weaning talks'* (Thomson et al., 2015 p.9).

By engaging with outreach workers PSs were able to reach women from different ethnic backgrounds (Thomson et al., 2015). These links were also found to enable PSs to make contact with women not necessarily planning to breastfeed (Battersby, 2001; Ingram, 2013; Thomson et al., 2015). The necessity for peer support projects to respond to local women and thereby ensure the services were appropriate was also recognised (Dykes, 2003 (1); Thomson et al., 2015):

> *'You have to find what works with the people you're working with and everybody's different, every area is different. [...]. Because as the years go by people change and how they want it changes, so it's keeping on top of that'*. (peer supporter_2) (Thomson et al., 2015, p8).

In addition to wanting to be better known as a source of support for women, PSs also wanted to make breastfeeding visible in their communities and to get information *'out there'*(Thomson et al., 2015, p9) (Curtis et al., 2007; Dykes, 2003 (8); Ingram et al., 2005; Kirkham et al., 2006; Raine, 2003; Raine & Woodward, 2003; Thomson et al., 2015). This could take the form of using local media (Dykes, 2003 (8); Thomson et al., 2015), working to introduce local breastfeeding friendly café and town schemes (Raine, 2003; Raine & Woodward, 2003; Thomson et al., 2015), engaging in educational work in schools (Kirkham et al., 2006; Thomson et al., 2015), or organising and taking part in local community events (Raine & Woodward 2003; Thomson et al 2015). 'Being known' and 'visible' in the community was also achieved through PSs taking steps to identify themselves and their roles while on and off duty (Curtis et al., 2007; Thomson et al., 2015):

> '*The taxi driver asked me once where I was going and I said 'I'm one of the Breastfriends' volunteers'* (Ann, volunteers' focus group) (Curtis et al., 2007 p.151).

This could involve wearing their distinctive T-shirts to their own personal healthcare appointments:

> *'I saw my doctor as a personal thing for me and she said, "Oh you do something around breastfeeding don't you?" So I don't know whether, again, that makes any difference in her other role, but maybe a mum goes to her and says, oh I'm finding it hard and she might go, oh well I know that there's a group'. (PS_6*) (Thomson et al., 2015 p.9).

All these activities, in addition to the presence of a breastfeeding group were felt to form '*ripple*s' (Thomson et al., 2015, p9) of influence, designed to act to normalise breastfeeding within the community (Dykes, 2003 (3); Ingram et al., 2005; Raine & Woodward, 2003; Thomson et al., 2015). These activities may be seen as analogous with threads being thrown out widely away from a spider's web, seeking to link up to a broad range of structures in the greater environment, advertise the presence of the web to a greater number of people, and strengthen the anchoring of it within the environment (see figure 1, section 3.6.4).

3.7.4 Theme 4: ‘Embedding peer support in local health care provision’

This theme explains how peer support schemes can become embedded within local health services. The manner by which embedding requires the ‘definition of a clear peer support role’ is explained, the necessity of ‘building a trusting relationship with health professionals’ is outlined, and the presence of ‘power’ within these relationships is described. The embedding of peer support within local health services can be seen to be analogous with strands of a spider’s web that are attached to important structures in the environment (health services). Maintenance and development of these strands is essential to the overall stability and sustainability of the web and to enabling women to access it (see figure 1, section 3.6.4).

‘Defining a clear peer support role’

Several studies highlighted the importance of a peer support role that was clear and well defined (Aiken & Thomson, 2013; Battersby, 2001; Crossland & Thomson, 2013; Curtis et al., 2007; Dykes, 2003 (7, 10, 18); Ingram, 2013; Kirkham et al., 2006; Thomson et al., 2015), and it was acknowledged that this could not be taken for granted:

> ‘*Midwives did not know about peer supporters and I think to an extent peer supporters don’t know about midwives’* (Amanda-V) (Aiken & Thomson, 2013 p.147).

The peer support role was widely regarded to be complimentary and additional to that of health professionals, providing *'another layer'*(Crossland & Thomson, 2013, p196) of informal support (Aiken & Thomson, 2013; Crossland & Thomson; Curtis et al., 2007; Dykes, 2003; Ingram, 2013; Kirkham et al., 2006; Raine, 2003; Raine & Woodward, 2003; South et al., 2012):

> *'Peer supporters complement statutory services, supplying an additional, informal level of support to breast-feeding mothers'* (Raine, 2003, p467).

This was especially welcomed as health professionals recognised that in their own roles they often lacked time to devote to supporting women with breastfeeding (Crossland & Thomson, 2013; Curtis et al., 2007; Dykes, 2003 (18); Ingram, 2013; Kirkham et al., 2006).

There were many examples of partnership working involving co-operation between professionals and PSs where information was exchanged, and in which the feeling of being a team was expressed (Battersby, 2001; Crossland & Thomson, 2013; Curtis et al., 2007; Dykes, 2003 (1, 2, 3, 8,12); Fox et al., 2015; Ingram, 2013; Ingram et al., 2005; Kirkham et al., 2006; Raine, 2003; Raine & Woodward, 2003; Thomson et al., 2012b; Thomson et al., 2012a; Thomson et al., 2015). For example:

> '*And, of course, if I was to look at people like X [volunteer peer supporter], I just absolutely know that she's going to be there. I can ring her, she's always supportive of me, she'll ring back, she'll feedback and I know that my client's going to get a really good service. So I can't wish for more really'*. (HP_5) (Thomson et al., 2015 p.10).

However, there were tensions underlying this seemingly straightforward complementary role. For example, the extent to which health professionals had time to engage with PSs was important, so that on occasion projects were left without adequate health professional staffing, and lack of designated time (Dykes, 2003 (5, 6, 7, 8, 11, 17); Raine & Woodward, 2003). Moreover, the need for PSs to be accepted by health professionals was acknowledged (Aiken & Thomson, 2013; Curtis et al., 2007; Dykes, 2003 (2); Kirkham et al., 2006), and the extent to which health professionals were seen to accept or resist PSs varied greatly across studies ranging from the relationship being *'generally positive'* (Dykes, 2003 (8), p107) to situations where lack of acceptance and acknowledgement was reported (Aiken & Thomson, 2013; Curtis et al., 2007; Kirkham et al., 2006):

> *'Examples were provided of staff striking up conversations with women when a peer supporter was in the midst of providing support; peer supporters being 'shouted at' for disrupting clinical duties, and occasionally being made to feel like 'an interference'*(Aiken & Thomson, 2013, p147).

On occasion this led to PSs finding health professionals '*intimidating*' (Aiken & Thomson, 2013, p147), and Aiken and Thomson (2013) provide examples of times when health professionals lack of acceptance led to undermining the work of PSs. For example, after a peer supporter had spent considerable time helping a mother with breastfeeding, a midwife would suggest topping up when they were absent. Several studies reported variability in the extent to which individual health professionals accepted peer support (Aiken & Thomson, 2013; Curtis et al., 2007; Kirkham et al., 2006; Raine, 2003; Raine & Woodward, 2003):

> ‘*You get your lovely midwives who are really up for helping and what you’re doing but you get some that just see you as a bit of an interference‘* (Chloe-V) (Aiken & Thomson, 2013 p.148).

This could lead to tensions between PSs and health professionals at times (Kirkham et al., 2006). Particularly in the hospital environment, tension also centred around whether health professionals considered PSs had appropriate, sufficient skills to support mothers (Crossland & Thomson, 2013), and to concerns about their practices (Aiken & Thomson, 2013; Crossland & Thomson, 2013; Thomson et al., 2015), for example as explained in theme two, there were concerns around hands on or hands off approaches to helping mothers position their babies for feeding.

Perhaps part of the difficulty in defining clear peer support roles emanates from the differing extents to which peer support is professionalised. While varied levels of professionalisation and burdens of administration were described among the projects, for example some PSs were paid (Aiken & Thomson, 2013; Battersby, 2001; Crossland & Thomson, 2013; Dykes, 2003 (2, 3); Ingram, 2013; South et al., 2012; Thomson et al., 2012a; Thomson et al., 2012b; Thomson et al., 2015), professionalisation was found to impact upon the role itself (Aiken & Thomson, 2013; Dykes, 2003 (2)). For example, a positive result of professionalisation was recognised as enabling more women to have access to the service (Aiken & Thomson, 2013), however, as mentioned in theme one, additional official paperwork associated with more formalised working could take PSs time away from direct support (Aiken & Thomson, 2013; Dykes, 2003 (2, 3)), and even feel ‘*antithetical’* to a project’s values when it becomes ‘*all about data collection’* (Aiken & Thomson, 2013, p148). PSs being paid had the potential to lead to tension when hours of work exceeded those paid (Dykes, 2003 (2)), and between paid and voluntary PSs (Dykes, 2003 (2)). Furthermore, administration within some projects could be *'cumbersome'* for example adhering to necessary police checks (Dykes, 2003 (2), p25).

'Building a trusting relationship with health professionals'

This section outlines how communication can be used to build trusting relationships between PSs and health professionals which in turn facilitate greater access to women.

In addition to the importance of a preparatory phase of liaison and planning before a project commenced (Dykes, 2003 (1)), at the level of the project itself, good communication between PSs and health professionals could consist of updating professionals about project progress which could act to reinforce their enthusiasm (Dykes, 2003 (12); Raine, 2003; Raine & Woodward, 2003). As discussed in theme three, positive links with health professionals could lead to increased access to women via peer support attendance at a greater range of statutory services.

At the level of the individual peer supporter, good communication could take the form of face to face contact with health professionals dropping into breastfeeding groups (Dykes, 2003 (12)), and telephone communication (Thomson et al., 2012b; Thomson et al., 2012a):

> *''I've had a lot more contact phoning midwives and health visitors to say mum's worried about this and she's asked me to speak to you and.....* '(Thomson et al., 2012b p.8).

Such communication facilitated *'collaborative relationships'* (Thomson et al., 2012b, p8) whilst simultaneously bolstering awareness of the programme (Thomson et al., 2012b; Thomson et al., 2012a; Thomson et al., 2015). In this way PSs were seen to use communication with health professionals on two levels, firstly to communicate women's needs, and secondly in a more strategic way to further the embedding of their project:

> *'I think at first the health visitors were the hardest but now they're great. Because it's showing them how you can help them as well, that you're there to support them, that's what it's about'.* (PS_2) (Thomson et al., 2015 p.10).

A key aspect of effective peer – professional communication relates to pathological issues being recognised by PSs and at such times PSs recognising their boundaries and referring back to health professionals (Battersby, 2001; Curtis et al., 2007; Dykes, 2003; Ingram, 2013; Kirkham et al., 2006; Raine & Woodward, 2003; South et al., 2012; Thomson et al., 2015; Thomson et al., 2012a; Thomson et al., 2012b):

> '*And the Breastfriend said (to the mother) 'Well it's up to you, how do you feel? Ideally it would be better to carry on (breastfeeding)'. And she very much listened to the mother. Also she referred on, and I thought that was a classic example she knew her boundary. They know their boundaries; they know where they're at.'* (Annette, health professionals' focus group) (Curtis et al., 2007 p.152).

However, this kind of communication was also reported to be lacking at times (Ingram, 2013; Thomson et al., 2015), with *'no liaison going on'* (Thomson et al., 2015 p.10):

> '*But when there are difficulties with feeding, that's when it would be really helpful to have the good communication and information sharing'*. (HP_11) (Thomson et al., 2015 p.10).

Related to this referring back, was the provision of feedback to health professionals about their work (Thomson et al., 2015), and, as explained in theme three, referring onwards to other services (South et al., 2012; Thomson et al., 2015; Thomson et al., 2012a; Thomson et al., 2012b):

> '*I had one on Friday that came through, went out on Friday night to see the mum, baby with tongue-tie, referred her to tongue-tie clinic, phoned the health visitor back which is a health visitor I had never dealt with before and told her what had happened, what I'd seen and that I had referred the lady through already and she was like "oh my gosh that's great have you done that, do I not have to do anything". Sometimes, the health visitors and midwives don't know we can do stuff like that'*. (PS Group Interview) (Thomson et al., 2015 p.10).

Communication therefore could be seen to foster trust by way of PSs revealing their work to health professionals. In some studies professionals watched or expressed their desire to watch, listen or debrief PSs (Crossland & Thomson, 2013; Curtis et al.,2007; Ingram, 2013):

> '*it would be nice to know what they are saying'* (Crossland & Thomson, 2013 p.200).

However, there was conflict in relation to how these desires were reported; on the one hand this was viewed negatively as a desire for surveillance in order to monitor and gain greater control over PSs (Crossland & Thomson, 2013; Curtis et al.,2007), whereas on the other hand it was viewed positively and undertaking joint visits was seen as an opportunity to increase mutual understanding (Ingram, 2013). Following a joint visit where a maternity support assistant had observed a peer supporter at work she commented:

> *"I was very impressed with how the discussion was conducted, it was absolutely brilliant!"* (MSW #1) (Ingram, 2013 p.5).

Building trusting relationships might be expected to result in mutual learning, and there was some evidence of this amongst the studies (Aiken & Thomson, 2013; Crossland & Thomson, 2013; Curtis et al., 2007; Dykes, 2003 (12); Kirkham et al., 2006). Professionals were found to learn informally from their interactions with PSs via adoption of some of their support practices (Crossland & Thomson, 2013), or on occasion to directly seek the opinion or support of a peer supporter (Aiken & Thomson, 2013). Furthermore, professionals in Curtis et al.'s (2007) study reported learning a *'big lesson'* about not making *'assumptions'* about women based on their socio-economic circumstances such that some professionals felt PSs had helped them to *'redefine'* their *'practice'* (Curtis et al., 2007, p152). However, this was the only example of health professionals taking advantage of the community insights lay interventions may provide (South et al., 2012), and in some projects little learning by professionals through engaging with peer support was found to have taken place (Dykes, 2003 (8); Kirkham et al., 2006). Apart from the formal learning of their official peer support training as described in theme three, there was no mention across the studies of PSs learning informally from health professionals.

‘Negotiating power relations’

Across the studies there were examples of times when professionals and PSs seemed to have differing aims or agendas (Crossland & Thomson, 2013; Kirkham et al., 2006). For example; midwives can be seen to be assuming PSs share their functional aims related to *‘getting baby breastfeeding’* when they do not refer women to peer support because they feel *‘if we (midwives) can’t get them breastfeeding, there’s a real problem’* and therefore *‘peer supporters are unlikely to be successful’* (Crossland & Thomson, 2013 p.199). This aim was also reflected when health professionals favoured a hands on approach to positioning and attachment in their desire to *‘get the job done’* (Crossland & Thomson, 2013, p194). These miss-matches in aims and agendas seem to reflect the uncertainties explained in earlier themes concerning the extent to which PSs are woman centred and non-directive in their approach.

The studies reveal the varied roles health professionals play in organising and maintaining projects from initiating the project (Battersby, 2001; Kirkham et al., 2006); recruiting PSs (Battersby, 2001; Curtis et al., 2007; Dykes, 2003 (8); Kirkham et al., 2006; Raine, 2003) and training them (Dykes, 2003 (3, 11, 17); Raine, 2003; Raine & Woodward, 2003), to providing out of hours health visitor support (Raine & Woodward, 2003), being present in the background during groups (Dykes 2003, (1, 16)), and as explained in theme three, supporting PSs in an ongoing manner. These differing roles may also reflect differing power relations, for example in one study, health professionals felt comfortable with PSs working *‘for them’* (Curtis et al., 2007 p.154), very much viewing them as a resource to be directed by them:

> *'I would imagine we'll (health professionals) pull them (volunteers) in at various things'* (Curtis et al., 2007 p.153).

Kirkham et al., (2006) suggest that some health professionals see power '*as a finite commodity'* (p.268), and this could explain resistance to peer support. In theme three the imbalance in status and power between community women and health professionals was explained. While theme four has outlined the importance of embedding peer support within local health services, it has also revealed tension inherent in doing this. The importance of peer – professional communication has been outlined and aspects of these communications or lack there-of can also be seen to reflect power relations, and as explained above, the extent of health professional engagement in peer support projects was variable. Reflecting on the areas of conflict and uncertainty identified across the themes, perhaps issues of power can be seen to be common across them.

3.8 DISCUSSION

I now discuss the findings of the synthesis focussing firstly on the application of the 'web' analogy, and secondly on questions arising within four areas of practice that were identified as areas of potential conflict between the studies. I then consider how the different organisations contributed material for the synthesis.

Overall the studies were found to be reciprocal, in that they were 'roughly about similar things' (Noblit & Hare, 1988 p.38), and the analogy of a spider's web was used to illustrate how peer support projects can work on many levels to form a web of supportive bonds to effect cultural change. A conceptual framework describing the behavioural manifestations of hope, as expounded by Morse and Doberneck (1995), was used by Thomson et al. (2012a). The work of PSs both in the formation of the initial bond with the mother and also in the provision of ongoing support throughout the journey were found to correspond to these theories of hope. Thomson et al. (2015) and South et al. (2012) draw on concepts of social capital to reveal the work PSs undertook building different forms of links and bonds between women, peers, health professionals, and services. These theories offer a kind of scaffold for the weaving of the web and therefore cultural change in these contexts. Underlying these theories, issues concerning power relations may be seen to be important when the key values, concepts and theories that underpin the practices of the organisations within this context are considered.

Recognition of the importance of PSs having time available, thus enabling women to ask questions relevant to them was recognised across the studies. The importance of this aspect is highlighted when the lack of knowledge about breastfeeding in this context is considered. However, as explained in themes one and two, there was variability in the emphasis placed upon the importance of PSs being woman centred and non-directive in their approach. This issue reflects where agency and decision making, and therefore power, lies within the mother–peer supporter relationship. Differences in the extent to which this underlying value was given prominence, and the presence of directive and non-directive terms within some studies, and across the body of studies, suggests there is conflict in the extent to which this issue is viewed as important by authors and perhaps by PSs on the ground. Perhaps it is important to consider the assumptions which might be being made about the information being relayed during supportive exchanges and how support is enacted. For example, in the study by Graffy and Taylor (2005), the data collection method comprised of asking women about the most and least helpful advice they had received with breastfeeding. The whole premise of the study was built upon the breastfeeding support encounter centring around advice, women's need for advice and their passive subordinate role as receivers of it. This is a significant problem, because if a woman centred, non-directive approach is important to how peer support ‘works’, lack of recognition of this could be crucial both in designing interventions and generating research evidence. Therefore, a question emerging from this synthesis might be, in this context, how important is women centred, non-directive support and why?

As explained in themes one and two, there was variability in the extent to which face-to-face and proactive support were considered important in how peer support might ‘work’, whereby face-to-face contact may better enable access, better build trust within the peer supporter-mother relationship and may better enable the meeting of needs. Given the aspects of the context identified as important across the studies (a lack of knowledge about, and invisibility of breastfeeding within the community, considerable social isolation, and imbalances of status and power between women and health professionals), these areas of divergence in the importance of how services are delivered might be seen to relate to concerns of power. For example, if services are arranged so women must reach out and seek support, this might be difficult when status and power imbalances are present, and when lack of knowledge about breastfeeding within the community may make recognising the need for support more difficult. Therefore, better understanding of the role of proactive contact and face-to-face communication is of particular importance in this context.

A key theory emerging from the synthesis is that cultural change involves making breastfeeding visible and building a supportive community for it. A breastfeeding group can be part of this via building supportive networks, enabling access to vicarious knowledge, and normalising breastfeeding. Differences between the studies concerning whether the function of a breastfeeding group centres around these social functions or centres around problem solving may be seen in terms of the balance of power relations. A woman owned space where embodied knowledge is shared, and breastfeeding is made visible places the women of the community in a more powerful position when compared to their position as recipients of expert support, or as PSs attending a group where expert help is dominant, where peer support might be viewed as an additional side-line. Therefore, it may be pertinent to ask within this context, to what extent are breastfeeding groups important for cultural change and why?

None of the potential mechanisms of action so far discussed can function if PSs are not in contact with women. In this regard the variable response of health professionals to peer support and its relationship to access forms another area of uncertainty amongst the studies. Furthermore, as suggested by Curtis et al. (2007), it is also possible that health professionals holding more positive views might have been more likely to take part in research, hence more negative views may be under-represented. The miss-matches in aims between PSs and health professionals explained in theme four may be seen to reflect the areas of conflict arising in earlier themes of the synthesis discussed above. Once again, power relations seem important.

There were differences in the extent to which the practices of the four different third sector breastfeeding organisations contributed to the synthesis. The NCT contributed one recent in-depth study (Fox et al., 2015), one study where limited data was gathered via open ended questions on a questionnaire (Graffy & Taylor, 2005), two in-depth studies concerning one project where peer support training was designed by an NCT tutor (Curtis et al., 2007 and Kirkham et al., 2006), and several case studies contributing to the large study by Dykes (2003). La Leche League contributed five studies concerning four projects where La Leche League provided the peer support training (Battersby, 2001; Ingram, 2013; Raine, 2003; Raine & Woodward 2003 and South et al., 2012). Of these, the studies by Raine (2003), Raine and Woodward (2003), and Battersby (2001) scored a grade C on the quality assessment tool. Their research methods involving small numbers of participants did not result in great conceptual richness and depth. The main focus of the study by South et al. (2012), concerned how lay public health interventions are viewed by community members and featured several different case studies, the BPS project being just one of them. Hence, while scoring A for the quality analysis, this study did not contribute extensive data to the current synthesis. The study by Ingram (2013) employed mixed methods; hence the qualitative component was limited to some degree in its contribution. Projects using La Leche League training also contributed to some case studies in the Dykes (2003) study, and in the mixed methods study by Ingram et al. (2005) the peer support training was designed jointly by a La Leche League Leader, an ABM trainee counsellor and a health professional. This was the only contribution of the ABM within the synthesis. The design of these studies utilising La Leche League training, or La Leche League and ABM inspired training means that their organisational practices are not explored in-depth in a manner to provide conceptual richness. It is possible that the model La Leche League have developed whereby local health professionals are trained to deliver LLL peer support training may also limit the organisations involvement in the projects and consequent research studies. In contrast, the Breastfeeding Network (BfN) contributed five high quality, in-depth studies concerning two projects over which they had full control (Aiken & Thomson, 2013; Crossland & Thomson, 2013; Thomson et al., 2012a; Thomson et al., 2012b; Thomson et al., 2015). Consequently, they tended to contribute strongly to the synthesis due to their great conceptual richness. Because these studies were undertaken by one research group, this resulted in a relatively small number of researchers contributing significantly to the synthesis. Research design differences between the organisations are important to recognise in relation to the outcomes of the synthesis. It is also important to reflect upon what research designs might suggest about the attitude of each organisation towards differing types of knowledge, and the kinds of evidence they might be interested in gaining about their practices. An important aspect of the group of studies as a whole concern the lack of representation of the views of women living in the study communities who did not engage with the projects. It is unknown to what extent the practices of these organisations may meet or may not meet their needs or why they do not engage. This observation might be of particular significance when considering the importance of issues relating to access across the synthesis.

In this chapter, I have outlined the rationale, aims, and objectives of my meta-synthesis, and detailed the inclusion criteria, search strategy, method for assessing quality, and the method of synthesis itself. I then presented the findings by way of four themes; ‘forming a trusting mother-peer supporter relationship’, ‘being on the journey together’, ‘weaving a strengthened, supportive community where breastfeeding is normal and visible’, and ‘embedding peer support in local health care provision’. I followed these with a discussion that highlights key questions such as the extent to which PSs are woman centred and non-directional in their practices, the extent to which face to face and proactive contacting are important in this context, the function of breastfeeding groups, and the relevance of health professional – peer supporter relationships in enabling women’s access to peer support. In chapter 4, I explain and rationalise the methodology and methods I have used in this study, and consider my ontological and epistemological position.

4.0 CHAPTER 4: THEORETICAL POSITION

4.1 INTRODUCTION

In the previous chapter (Chapter 3, Qualitative Meta-synthesis) I provided a systematic evaluation of the published literature concerning the practices of third sector breastfeeding organisations in areas of deprivation. In this chapter I refer to my ontological and epistemological positions. I then explain the way I view the world and make sense of it; my theoretical stance and consider its impact on my study. Finally, I discuss the methodology used in this study and my rationale for its utilisation.

4.2 THE CHARACTER OF THE STUDY

My study aims to explore how third sector breastfeeding support organisations have developed their services for delivery in areas of socio-economic deprivation. To meet my study objectives, I need to understand this from the view-points of several different participant groups. In phase one from the view point of key organisational strategists, in phase two from the view-points of everybody involved in a service, for example, women, PSs, managers, health professionals and commissioners. The study investigates the construction of meanings in the complex open system of a community-based BPS service. It focuses on human experiences and meanings in the context of providing or receiving support. BPS interventions are recommended to impact upon health inequalities (NICE, 2008). By exploring the development of these services in areas of deprivation, my study is also concerned with fairness and equity in society and requires theoretical underpinnings capable of supporting a critical stance.

4.3 ONTOLOGY AND EPISTEMOLOGY

Ontology relates to the '*study of being'* - the nature and basis of existence and reality (Crotty, 1998, p.10), it concerns ideas about '*how things really are, and how things really work'* (Scotland, 2012, p.9). Epistemology deals with what it is possible to know about reality (Crotty, 1998), and the relationship between this, and the person knowing it (Lincoln & Guba, 1985). These, impact upon, and form the underpinning basis of, the knowledge claims made by research (Marsh & Furlong, 2002; McNeil & Chapman, 2005).

In an objectivist view of reality, meaning and reality exist whether or not anybody is consciously aware of them, and one true reality, already full of meaning, is considered to be out there just waiting to be discovered and described (Crotty, 1998). In a subjectivist view of reality, meanings are considered to be created wholly within peoples' minds without reference to things in the world, and then applied ready formed to objects in the world (Crotty, 1998). In social constructionism, the meanings assigned to objects, events and 'things' encountered in the world are generated from our conscious awareness (Humphrey, 1993). This perspective argues that before humans were in the world, 'things' (objects, events, etc) existed, but held no meaning until they were represented by a mind (Humphrey, 1993). It is not that the 'things' in the world do not matter, but that their meaning is not inherent (Humphrey, 1993). Simultaneously, meanings are not solely created within the mind and applied onto the things in the world (Burr, 1995). Rather, social constructionism infers that meanings are constructed from the interaction between our minds (our conscious awareness) and the things in the world (Burr, 1995). In this way *'Constructionism brings objectivity and subjectivity together, and holds them there'* (Crotty, 1998, p.44).

We construct meaning onto the 'things' (objects, events, experiences) we encounter, and these interpretive strategies are already embedded in us (or we in them) (Fish, 1990). The systems of intelligibility into which all knowers are born, are quite stable and '*crystallised'* (Guba & Lincoln, 1994, p.110). For example, a women's assumptions about how a baby might be fed. This means that culture (situated in its own historical, economic, social, political and geographic place) can be seen as *'an inherited 'lens' through which an individual perceives and understands the world'* (Helman, 2001, p.2). Social constructionism takes the position that we are all completely absorbed, or encultured into social institutions and conventions, and it is only through these conventions that we can access *'a publicly available system of intelligibility'* (Fish, 1990, p.332). This conception of reality coincides with my own and others' experiences of infant feeding. It was only when I started breastfeeding my first baby and found it difficult, yet also felt adamant I would not stop, that I realised breastfeeding was important to me, and that I had grown up expecting to breastfeed. Through my role as a peer supporter I have come to understand that breastfeeding is much less important for some mothers. Hence, breastfeeding seems to mean different things to different women, and infant feeding practices seem to have different meanings in different contexts (e.g. Burns, Schmied, Sheehan & Fenwick, 2010).

Being born into a particular culture, does not mean people are bound to only ever be able to act in one particular way, but rather there is a balance between the influence of culture, or structure, and the influence of individual agency and experience (Spradley, 1980). This also concurs with my experience, that my own cultural background affects how I view the world, yet my inherent systems of intelligibility also allow me to reflect on my views and to think and act outside of the cultural constraints into which I have been socialised.

These assumptions about reality have implications for me as a researcher. Because my view point can constrain what I am able to see, if I want to see outside of this view point, I need to make a conscious effort to do so. Hastrup (1995) uses the analogy of a horizon to illustrate how although I accept my own socio-cultural standpoint is not fixed, there can be *'no way of seeing from 'nowhere in particular'* (Hastrup, 1995, p.4), hence, my own standpoint inevitably affects my horizon of understanding (Hastrup, 1995). For example, as a mother who has breastfed, I have a particular standpoint, and that might make it difficult for me to understand the horizon of a formula feeding mother. My own standpoint might allow me to 'see' some things but not others. Recognising, exploring and reflecting upon the subjectivity of the researcher however, can be a strength of the research process (Oakley, 1992). In my own study, I recognise that my background and experiences inevitably impact upon the study, and that I may bring assumptions and 'givens' that are so engrained that I am not consciously aware of them. Reflexivity has been an integral part of this study. It has helped me to try to identify my own positions and try to understand how they impact upon how I comprehend and interpret the perspectives of others. The manner by which I attended to reflexivity is explained in Chapter 5 (Methods One, section 5.5.4).

4.3.1 Some challenges with social constructionism

Most interpretivists who align with social constructionism consider culture and recognise its influence. However, they often have an uncritical attitude towards it and are less concerned with the larger social context in which individuals or groups exist (Stahl, 2011). Furthermore, although within social constructionism people are positioned as social actors, the extent to which an individual can change themselves and the relationship between the individual and society, is not theorised (Burr, 2003). Researchers adopting a more critical stance recognise that our inherited past (that we are socialised into, and which impacts on how we interpret the world) is founded on exploitation and domination (Crotty, 1998). This renders reality itself problematic and obliges a critical researcher to seek to identify where inherited culture impacts upon, and influences experiences and meaning making (Crotty, 1998). In my experience, society does not seem to be a fair, just and equal place, and inherent systems of intelligibility are not benign. For example, particular groups of people in society seem to consistently have access to more resources than other groups.

In my study it is important for me to be able to make sense of both an individual and societal view of my research question, and to adopt a theory of the world able to accommodate these different levels of human society. I need to be able to understand service development from the individual perspectives of women and PSs, but I also need to zoom out to consider service development from the perspective of whole populations and of government policy. For me, power structures and societal discourses must be taken seriously, because, like Cohen, Manion, and Morrison (2007), I accept the idea that knowledge is both socially constructed and influenced by power relations within society.

4.4 THEORETICAL PERSPECTIVE

I have adopted a critical theoretical perspective for my study. A broad conception of critical theory enfolds philosophical ideas stemming from Kant, Marx, and the social philosophy of Foucault (Czerniak & Michalski, 2015), and attempts to move ideas about power, oppression and domination beyond the concepts of economic and class struggles (Kim & Holter, 1995; Stirk, 2000). Czerniak and Michalski (2015) trace the concept of power through the history and broad spectrum of ideas of critical theory, identifying two conceptions of power. The first idea of power originates from Aristotle, Hobbes and Weber, it concerns how bureaucratic processes such as laws, policies, and the work of societal institutions exert power as dominion (top down power). The second conception of power originates initially from Nietzche, and was then further developed by Foucault (Czerniak & Michalski, 2015). This type of power is dynamic and viewed as a network of small powers operating at different levels such as individual speech and action (Foucault, 1978). It is the basis through which activity and interaction can enable social activities and discourses, in other words, how individuals can enact change at a societal level (bottom up power). In the context of my study, these two levels of power might equate to the influence of government policy (top down) or individual peer-mother communication (bottom-up) on service development. I feel that adopting a critical theoretical perspective to my study is appropriate because it means I can theorise the influence of power relations on two levels.

4.4.1 The power of the researcher

When considering my position as a researcher, I find myself '*within fields of discourse that articulate the world and organize social institutions and practices'* (Ceci, Limacher, & McLeod, 2002, p.714). I am already engaged in a power system of language and knowledge which does not afford equal legitimacy and power to all the different ways of making sense of the world (Weedon, 1997). Since all knowledge claims enact relations of power (Ceci et al., 2002), mainstream research practices often unwittingly maintain systems of class, race and gender oppression (Kitchenloe & McLaren, 1994). As it is impossible to step outside of these discourses, the status of researchers making knowledge claims is particularly important to consider (Foucault, 1980). My critical approach therefore necessitates not only reflexivity in how my background and biases affect the study, but also examination of the power relations associated with my position as a researcher. Chapter 5 (Methods One), section 5.3.4 explains the steps I took to address this.

4.5 METHODOLOGY

Methodology is the '*plan of action'* that underpins a study's use of research methods, linking them to its outcomes (Crotty, 1998, p.3).

4.5.1 Case Study

This study has utilised a case study methodology. A case study has been defined in various different ways; Yin (2014, p.16) emphasises study process when he defines a case study as '*an empirical enquiry that investigates a contemporary phenomenon (the 'case') in its real-world context, especially when the boundaries between the phenomenon and its context may not be clearly evident'*. Stake (1995) meanwhile, highlights the unit of enquiry, defining a case study as *'a specific, complex, functioning thing'* (Stake, 1995, p.2). Furthermore, for Merriam (1988) a case study is the holistic end product of the research. While Merriam (1998) suggests that confusion may have arisen due to these varying definitions, she highlights that together they provide insight into what undertaking a case study might entail; the study of the 'real-life' context of a defined system that is closely entwined with its setting, and the production of a holistic end report.

4.5.2 The value of the case study approach

The gaps in the current BPS literature whereby UK trials have been found to be ineffective, yet understanding about interactions with their contexts is limited, mirror the issues outlined by Simons (2009). She explains how in the 1960s and 70's evaluations of educational programmes tended to be experimental or quasi-experimental and used quantitative outcome measures of programme effectiveness that could not capture programme complexity (House, 1993; Norris, 1993; Simons, 1987). By measuring only pre-post testing of learning, evaluations failed to capture the programmes in action or their broader gains (Simons, 2009). Developers, stakeholders and others wanted to know how the results were achieved, why some projects succeeded while others did not, and what were the key factors in a particular setting that led to certain outcomes (Simons, 2009). It was argued that without such explanation, outcome measures were inadequate to inform development, policy, or practice, and were potentially unfair (Simons, 2009). Case study research in education developed in response to this situation.

Because case studies focus on the particular (the particular case), they are beneficial for the study of how/why questions arising from practice (Merriam, 1998; Yin, 2014). They enable the study of how certain groups of people deal with specific problems through the generation of in-depth holistic understanding of the situation and meaning for those involved (Merriam, 1998; Shaw, 1978; Yin, 2014). This can result in the exposure of previously unknown relationships that may lead to a re-thinking of the phenomenon under study (Stake, 1995). Case studies are helpful for investigating process rather than outcomes (Merriam, 1998), thus enabling understanding of how things come to be the way they are (Stake, 1995). Furthermore, in educational research, case study methods have been found to be emancipatory as they can foreground and give voice to the perspectives of different actors, changing the balance of power away from the researcher as the evaluator (Simons, 2009). This means that case study seems a particularly apt methodology for my own study as I am concerned with the process of service development grounded in context, and my theoretical perspective means that I am keen to use a methodology with potential for some level of emancipation.

A case study can be quantitative or qualitative in nature and can accommodate a range of different theoretical underpinnings and disciplinary perspectives (Merriam, 1998; Simons, 2009; Stake, 1995; Yin, 2014). Correspondingly, case study researchers bring a range of ontological and epistemological assumptions to their work. For example, Yin's (2014) work is underpinned by a realist philosophy and is concerned with the explanation of causal links in 'real life' interventions, while Stake (1995) approaches case study research with interpretivist assumptions. Furthermore, case studies have been categorised in many different ways. For example, Stake (1995) describes three types of case study; intrinsic (the case is studied for its own intrinsic value), instrumental (the case is studied because it provides insight into something else), and collective (when several cases are studied to form a collective understanding of a phenomenon). A case study may be theory-led in that a particular theoretical perspective is used to explore a case, the theory of a programme is the focus of the case and guides data collection, or theory is generated as it arises from the case data its self (Simons, 2009).

The development of BPS interventions central to my study meet Stake's criteria of a case, as they are a '*specific, complex, functioning thing'* (Stake, 1995, p.2). I decided to adopt Stake's (1995) inductive approach that develops ideas into patterns to create theories (Cresswell, 2009). This was because this approach was consistent with the theoretical underpinnings of my study outlined above, I wanted to remain open to ideas arising from participants, and I wanted to build theory about service development. My own study then can be categorised as an interpretive, intrinsic case study which is theory led (in that it aims to generate theory).

4.5.3 Limitations of case study methodology

Case study research has the potential to impact excessively upon the lives of participants (Simons, 2009). There is also a risk that this type of research, which can aim to give voice to people who are part of disadvantaged groups, can be experienced as stigmatising (Garthwaite, et al., 2015). Another often cited drawback of case study methods is that they do not allow for study outcomes to be generalised (Merriam, 1998; Simons, 2009). However, there has been considerable confusion around the term generalisation which emanate from ontological and epistemological differences in its meaning (Stake, 1999). Generalisability, the ability to assert that the study findings can be generalised to similar sample populations, is not necessarily a desired outcome (Ritchie & Lewis, 2003).Trustworthiness (Lincoln & Guba, 1985) within qualitative research concerns the extent to which ideas about why things happen (at the level of ideas, explanations and theories) might be generalisable (Ritchie & Lewis, 2003). In this way, relationships based upon statistical generalisation are ontologically distinct from explanations based upon theory (Sharp,1998). Ritchie and Lewis (2003) describe three ways in which the outcomes of qualitative research may be generalised; first, representative generalisation - the extent to which outcomes can be expected to be found within the wider population from which the sample was drawn. Second, inferational generalisation - the extent to which outcomes may be applied to settings outside those sampled. Stake (1995) suggests that by providing plenty of information about the case and its context, readers can make their own decisions as to whether and to what extent case outcomes might be transferred to other contexts. Third, theoretical generalisation, whereby theoretical statements, ideas or explanations arising from the research might be applied more generally. Despite Stake’s (1995) assertions, because case studies do not claim to be typical of some parent population, they usually only claim to enable theoretical generalisation which is valuable and worth pursuing (Sharp, 1998).

The inductive case study methodology outlined above is designed to enable construction of theories emanating from the perspectives of women that are the intended recipients of

BPS interventions, PSs who deliver the interventions, and health professionals who work in partnership with these interventions in addition to more powerful commissioners and managers. Taking a critical perspective means that the perspectives of all participants are valued, and fore-grounding the view-points of less powerful actors is considered important. This kind of inductive, interpretive study design and the knowledge it constructs is important because it has the potential to be used to improve future service design.

In this chapter, I have explained the methodology used in this study and its rationale. I have considered the nature of my study and my ontological and epistemological position. I then explained the way I look at the world and make sense of it (my theoretical position). In chapter 5, I describe the methods used in phase one. The chapter also describes how I achieved trustworthiness in my study (including reflexive practices), the data analysis methods employed, and how I addressed key ethical issues for both phases of my study.

5.0 CHAPTER 5: METHODS ONE

5.1 INTRODUCTION

In chapter 4, I explained the assumptions I have made about the nature of being and knowledge and outlined the methodological approach adopted for my study. In this chapter I explain how and why the study has been designed in two phases and the aims and objectives of each phase. I then give an account of ethical issues I have considered for both phases, provide details of the methods used to conduct my phase one interviews, and outline how I have ensured trustworthiness (including methods of reflexive practice) in my study.

5.2 STUDY DESIGN, AIMS AND OBJECTIVES

I decided to break the study into two phases. Gaining a '*sense of history'* of a case (Stake, 2006 p.3) can be an important first step when undertaking a case study, and while staying open to new issues and ideas, early identification of the main issues and questions pertinent to a case can help guide future data collection (Stake, 2006). I wanted to use the first phase of research activities to gain a sense of the history and perspectives of the organisations and their practices in this context, and I wanted to use the outcomes of this work to inform the design of the second phase. The objectives of phase one were to understand:

- The history, development, values, and ethos of third sector breastfeeding organisations.
- The extent to which the third sector breastfeeding organisations have engaged with the health inequalities agenda, and whether and how each organisation has adapted in order to provide services in areas of socio-economic deprivation.

The objectives of phase two were to understand:

- The context of the lives of women living in areas of socio-economic deprivation.
- The extent to which the support was acceptable to women.
- The interface between the third sector organisations and women's lives, including how context-related issues impact upon the work of the organisations.

To meet phase one objectives, I undertook a qualitative meta-synthesis, described in chapter 3, and interviews with key organisational strategists (described below). To meet phase two objectives, I explored two cases of BPS interventions run by two different third sector organisations in two different parts of England. Chapter 7 (Phase Two Design), explains how theoretical insights resulting from phase one were used to inform the design of phase two. Chapter 8 (Phase Two Methods), describes the methods used to undertake the second phase of research. Please see table 10 below.

Table 10: Research activities by phase and associated thesis chapters describing methods.

Research Phase	**Research activities**	**Chapters describing methods**
Both phases	Methods demonstrating trustworthiness including reflexive practices Methods in relation to ethical considerations	Chapter 5 Methods One (this chapter, section 5.5 below). Chapter 5 Methods One (this chapter, section 5.3 below).

	Data analysis techniques	Chapter 5 Methods One (this chapter, section 5.4.6 below)
Phase one	Qualitative Meta-synthesis	Chapter 3 Qualitative Meta-synthesis
	Phase 1 interviews with organisational key strategists	Chapter 5 Methods One (this chapter, section 5.4 below)
	Bringing together theoretical insights from meta-synthesis and interviews with key strategists to design phase two.	Chapter 7 Phase Two Design Chapter.
Phase two	Two case studies of BPS interventions run by two different third sector organisations in two different parts of England.	Chapter 8 Phase Two Methods.

5.3 ETHICAL CONSIDERATIONS FOR BOTH PHASES

In this section, I explain four theoretical principles of ethical research and relate them to the conduct of both phases of my study. I then detail the ethical approvals which I gained. For clarity, the data collection activities undertaken during each phase of the study to which these ethical principles apply are detailed in table 11 below.

Table 11 Data collection activities.

Research Phase	Data collection activity
One	Individual semi-structured telephone interviews, field notes.
Two	Informal visits to study sites, field notes, individual semi-structured interviews conducted both face-to-face and via telephone, collection of demographic data from mother and peer supporter participants taking part in individual semi-structured interviews, an observation of a peer support supervision session.

Four theoretical ethical principles of autonomy, non-maleficence, beneficence, and justice underpin the conduct of ethical research (Murphy & Dingwall, 2001). Each principle will be explained in turn and related to the conduct of my study.

5.3.1 Autonomy

Autonomy is the principle that the decisions and values of research participants should be respected (Murphy & Dingwall, 2001). The declaration of Helsinki outlines ethical principles of research on human subjects (WHO, 2001), and free and informed consent is a fundamental component of these principles which is required by the declaration (WHO, 2001). Informed consent requires participants have a full understanding of exactly what their participation will involve, and that they freely agree to take part. In order to ensure my participants were fully informed, I created study information sheets and covering letters (see appendix 8 and 10 respectively). Covering letters explained who I was, the nature of the study, and the ethical approvals obtained. Each information sheet employed simple language to explain the study, including the purpose of the proposed research activity, and the broad subject areas that would to be covered should participation be desired. In the case of an observation, the sorts of interaction I would be noting were outlined. Information sheets provided details about how confidentiality would be maintained, and how data would be used and stored. Research team contact details were provided, and potential participants were encouraged to make contact should any questions arise.

Potential mother participants who were recruited at health visitor drop in clinics or at breastfeeding/baby feeding groups were given written study information at least twenty-four hours before any interviews took place. All other participants were given their written study information at least a week before participation. These practices allowed time for all potential participants to read the information and discuss potential participation with family and friends.

The capacity to understand and make decisions is vital to the process of informed consent, and the researcher must be sure of this capacity (Royal College of Nursing [RCN], 2011). In order to assess capacity for women, I made time and space to have a meaningful conversation with potential participants both at the time when study information was given, and before interviews. This allowed me to listen to them, respond to their body language and verbal responses, and to make a decision about their capacity to consent.

At the time of each interview and observation I asked all potential participant (s) whether they had read the relevant information sheet and if they had any questions. I kept several spare copies available if needed. I verbally re-iterated the main features of the information sheet, checked participant’s understanding, and made time available to address any questions before giving the appropriate consent form (see appendix 9). I left adequate time for potential participants to read/take in each section of the consent form before signing/verbally agreeing to it. Before the observation and phase two face to face interviews, participants completed the consent form themselves. Before telephone interviews (phases one and two), I read each section of the consent form to potential participants aloud and they gave their verbal consent on all occasions. As part of the interview consent form process, participants were asked whether they would like to have the main themes sent to them, and whether they would like to be contacted for a second time for a member check interview. The vast majority of participants indicated they would like to be contacted again.

5.3.2 Non-maleficence

Non-maleficence is the principle of avoiding causing any form of harm to participants (Murphy & Dingwall, 2001). During both phases of the study, for each group of research participants I considered the potential harm that might arise from participation. I identified that there was a possibility that participants may become upset during or following interviews if discussions touched upon difficult personal experiences. For professional participants this might also include how their work was managed. I made sure the broad topic areas that would be discussed in an interview were made clear in the information sheets so that potential participants knew what to expect should they decide to participate. I prepared supportive information and prepared to act in a manner suitable for each participant group. For professional participants such as key strategists taking part in phase one telephone interviews and health professionals, managers, and PSs taking part in phase two interviews, I was ready to encourage them to contact their line manager, GP, or another person within their organisation able to support them, and prepared information about counselling services. If a professional participant wanted to make a complaint about an organisation, the complaints policy / procedure for the relevant organisation would have been provided, along with contact details of union representatives. If a woman participating in phase two interviews had become upset or required additional support, the information sheets made it clear that I would take positive action myself; I would have offered to call the woman’s health visitor, midwife or Children’s Centre worker to make sure she had additional support in place. I would also have provided signposting information to other relevant and appropriate services available for help. If a mother had wanted to make a complaint about her care, information about the relevant organisation’s complaints policy / procedure would have been provided. In the event, no participants became upset. However, on two occasions women participants required additional BPS. After discussion and agreement at the end of the interview, on both occasions I contacted the women’s local peer supporter and asked her to contact the woman. I then contacted the woman myself again to make sure that had happened. Case study research seeking to give voice to disadvantaged participants has the potential to be experienced as stigmatising. I took care that the demands asked of participants were not excessive and tried to be aware of the potential for participants to feel stigmatised. I took care with the language I used throughout. For example, when recruiting mothers for phase two I produced a contact sheet (see appendix 11) that was given to potential participants. This requested their age and postcode and explained that because the study was small, I was unable to interview everyone. This sheet was worded carefully to avoid stigmatisation, yet it enabled me to make sure I interviewed only mothers living in target areas.

Health professional and peer supporter information sheets stated that any issues of professional conduct arising during interviews would be referred to management. These participants were also asked not to use the names of colleagues or discuss professional concerns during interviews and or observations. Mother participants sheets advised that if any concerns emerged regarding their safety, or the safety of any children in their care, I would take appropriate steps, such as informing relevant authorities in line with safeguarding adults/children training I had undertaken (for all information sheets please see appendix 8).

Information sheets made clear that when interviews were transcribed any information that could identify participants, their organisations or their areas would be removed so that anyone reading the transcript could not identify them, and that all personal data would be kept only until they had finished participating in the study (after the first or second interview and after main findings had been sent to them) and would then be destroyed. Observation participants were made aware that hand written notes only would be taken which would not include names or identifying places. Participants were advised that while their quotes would be used within reports, publications, and conference presentations generated from the study, no personal details would be included, and they would not be identifiable.

5.3.3 Beneficence

Beneficence is the principle that some sort of positive benefit should result from the research; that it should not be undertaken for its own sake (Murphy & Dingwall, 2001). All study information sheets made it clear that the study aimed to result in knowledge and theoretical ideas that would inform the future design and delivery of BPS services, and that participants may derive satisfaction from reflecting on their experiences of involvement with the services under study. For potential women participants in phase two, it was explained that if they chose to participate, I would send them a £10 thank you gift card following both the initial and member check interview in recognition of their time.

5.3.4 Justice

Justice is the principle that everyone should be treated equally and with fairness (Murphy & Dingwall, 2001). In order to adhere to this principle information sheets for potential women participants made it clear that nobody from within the third sector organisation providing the service would be aware of whether they had decided to participate in the study or not, and that participation/non- participation would not impact upon the support or care they would receive.

Information sheets made clear that data storage conformed to data protection law (European Commission (EC), 2018) and the requirements of my ethical permissions. All paper consent forms, and paper demographic forms (filled in by mother and peer supporter participants in phase two) were assigned a participant code, scanned onto a password protected encrypted file, and stored on the University of Central Lancashire secure server as per University regulations seperately from any data collected. Once uploaded the paper forms were destroyed. Audio recorded consent (from phase two telephone interviews) was seperated from the rest of the interview, assigned a participant code, and stored on password protected encrypted files as above. The original recordings were then deleted from the machine. All interviews were audio recorded with participants consent. Audio-recordings were assigned a participant code, downloaded onto the University computer system (as above), and deleted from the machine.

Transcription was undertaken as soon as possible after the event. I transcribed all phase one data and some phase two data, although authorised University research assistants who adhered to the data storage procedures outlined above transcribed most of it. As transcription took place, all information that might enable anybody to identify either the participant or their organisation was removed, and pseudonyms applied. Once verification of the anonymised transcript had taken place, the downloaded un-anonymised recordings were deleted. Anonymised transcripts were stored on password protected encrypted files on the University secure server.

My interpretive approach meant I chose research methods capable of foregrounding participant’s voices and endeavoured to listen to participants and take their experiences and meanings seriously. In light of the powerful position of the researcher (Raheim et al., 2016), I carefully considered my behaviour when I was gathering data; I knew it was possible a participant who viewed me as powerful may feel compelled to participate, or to answer questions they would rather not. I tried to counter this possibility by attempting to reduce the sense of my power. For example, I wore casual clothes, used friendly, warm tones of voice, sought to break the ice early in the conversation, kept an open body posture, and used active listening skills to demonstrate my genuine interest. I made sure that when informed consent was gained, I clearly reiterated the participant’s right to stop the interview at any time without giving a reason, and freedom to refuse to answer any question without giving a reason. It was difficult for me to anticipate what potential participants might expect I might ‘want to hear’ from them, and hence any possible impact of the Hawthorne effect (James & Vo, 2010). In order to try to counter any impact of this effect, the study information sheet gave all participants the same information about my background; explaining that I had worked for a small third sector breastfeeding organisation in the past (2006-2011). It was important that I represented participant’s views fairly. In order to make sure of this I used the reflective practices described in section 5 below. My use of member check interviews to seek clarification as to whether my interpretations matched participant’s experiences also demonstrated my desire to respect participant’s perspectives. I considered using methods that involved participants more deeply in the research process such as via data gathering, however, I felt that the constraints and difficulties of ethical processes and requirements would make this approach particularly difficult to execute in practice.

I also attempted to de-emphasise the power of my role as a researcher by meeting potential participants in their own space (i.e. by arranging interviews in places that best suited participants rather than myself, and by attending health visitor drop in clinics and children's centres to approach potential participants, I was an outsider, a guest in their space). I have also attempted to report my research in such a way as participant's voices come across. However, as discussed in chapter 4 (Theoretical Position), I cannot escape the fact that I am a white, middle class, forty-two-year-old woman, and the possible impact of this in terms of status and power upon my participants.

5.3.5 Ethical approvals

Ethical approval to undertake phase one semi-structured telephone interviews with one or two key strategists from four UK National third sector breastfeeding organisations was obtained from the STEMH (Science, Technology, Engineering, Medicine and Health) ethics committee sub-committee at UCLan (project no: STEMH 558) in early November 2016.

Ethical approval to undertake phase two data collection was gained from the Health Research Authority (ref 238698); North West Greater Manchester West Research Ethics Committee (NHS) (ref 18/NW/0089), and the University of Central Lancashire STEMH (Science, Engineering, Medicine and Health) ethics committee (project no: STEMH 558 Phase 2) in spring 2018. In addition, at one of the sites the local authority had its own research governance committee that also required clearance which was gained. I obtained a research passport and clearance from three local NHS Trust research and development departments.

5.4 PHASE ONE INTERVIEW METHODS

In this section I provide a rationale for the use of semi-structured interviews as a method and for interviewing key strategists as participants. I then outline my methods of recruitment, data collection, storage, and analysis, use of member check interviews, and diagrams.

5.4.1 Rationale for using semi-structured interviews

In the field of health care research interviews are considered of particular value in enabling the views of hard to reach groups to be heard, rendering the tacit knowledge of professionals explicit, and within service evaluation, to facilitate the expression of all key stakeholder viewpoints (Flick, 2014). When I considered my study as a whole, I knew I wanted to gain insight into the experiential knowledge of participants, and that I needed several different viewpoints. Hence, interviews seemed a highly appropriate method for both study phases. An interview aims to result in as full a picture as possible of the participant’s view by focusing on their experiences in relation to the study aims (Flick, 2014 p.208). They can enable a researcher to engage with the main issues of a case quickly and in depth (Simons, 2009). A semi-structured interview lies somewhere between the closed nature of verbal questionnaires, and the totally open nature of a narrative interview (Merriam,1998). During a semi-structured interview open questions in the form of an interview guide are used to provide thematic direction, and designed to encourage the participant to answer freely (Flick, 2014). The interview guide however, does not preclude interviewees from bringing their own ideas to the interview (Flick, 2014). This method therefore seemed suitable for my purposes in conducting an inductive case study as I have sought to identify and understand the main issues of the case from participant’s perspectives while remaining open to new ideas. The semi-structured interview guides I used can be found in appendix 12.

5.4.2 Rationale for interviewing key strategists

Interviews with key organisational strategists, or ‘experts’ can enable exploration of and orientation to a field of study and illuminate the positions of potentially powerful actors (Bogner & Menz, 2009). I felt that key strategists would be likely to have experiences that could help me understand the history, values and ethos of the organisations, gain a sense of organisational engagement with the concept of health inequalities, and gain understanding of whether and how the organisations had developed their services for areas of deprivation. This made them suitable to help me reach my phase one objectives. As explained in chapter 3, I decided to study the four large UK national breastfeeding organisations because they are most often commissioned to deliver peer support services, and because inclusion of many varied smaller local organisations would be beyond the scope of my study. I decided to use telephone interviews because they facilitate focus on the issues of interest, are relatively quick to undertake, and are considered appropriate for busy experts (Flick, 2014). They also avoided the need for me to travel long distances to conduct the interviews.

5.4.3 Recruitment

Recruitment packs comprising a participant information sheet and consent form (please see appendices 8, and 9 respectively) were sent to the CEOs, Heads of Research, or Chairpersons of the four breastfeeding organisations in order for them to decide whether their organisation would like to participate or not. When one of these leaders decided their organisation would like to participate, they were asked to pass recruitment packs to one or two key strategists from within their organisation in order that they might consider participation. Potential participants who wished to participate contacted me directly, and an interview was arranged. All four organisations decided to participate. Table 12 in chapter 6 (Phase One Interview Findings) provides participant details.

5.4.4 Data collection

With consent, interviews were digitally audio recorded as described above. I used a semi-structured interview schedule to guide the interviews (see appendix 12). The three broad subject areas covered by the schedule were; organisational history, values and ethos, understandings of peer support and health inequalities, and whether and how peer support services had developed for delivery in areas of socio-economic deprivation. Open questions were used, and participants were encouraged to expand on their answers. In this way, I aimed to address both etic issues (those arising from an outsider perspective) brought to the study by way of the study aims, and stay open to emic issues (those arising from an insider perspective) emerging from the participants themselves (Stake, 1995). Field notes were made immediately after each interview (Stake, 1995). I transcribed the interviews verbatim. As transcription took place, I removed all information that might enable identification of either the participant or their organisation, and applied pseudonyms.

5.4.5 Data storage

Data was stored as described above (section 5.3.4).

5.4.6 Data analysis

During both phases data collection and analysis was undertaken concurrently (Eisenhardt, 1989, 2002; Stake, 1995). Stake (1995, p.71) explains that there is no precise moment when data analysis begins, rather that analysis and interpretation are the ‘making sense of’ what we find in the field. Eisenhardt (2002) suggests using inductive analytic techniques developed via grounded theory methods when a case study aims to build theory. The principals of grounded theory analysis techniques outlined by Charmaz (2006) were therefore used. Part of Eisenhardt's (2002) analysis technique includes cross case analysis, which Yin (2014) suggests can help break simplistic thinking about cases. Although I have explained each analytical step in turn below, these did not proceed in a linear fashion, rather, the process was highly iterative, and I returned to earlier steps frequently.

Open coding

Kathy Charmaz (2006, p.47) explains that open coding should 'stick closely' to the data, with codes created that name and categorise the text and reflect action. After repeated reading of a transcript and its associated field notes, I created codes for each section of text. I found it helpful to proceed fairly quickly through the transcript creating codes freely. I then returned and thought more carefully about the adequacy and level of abstraction of my coding. I was trying to move away from descriptive codes, towards codes which gave a sense of what was happening. This process was iterative and required codes to be grouped and re-named several times. I needed to re-read my data multiple times to make sure I had adequately represented it.

During initial coding, sometimes I found I had several codes concerning very similar issues, which were subsequently grouped together. At other times the codes were not wholly reflective of the meaning conveyed, and a new code was created. This process was highly iterative. Sometimes I would create a new code and realise that I must return to a transcript I had coded previously to re-code a section with the newly created code. For example, my initial code of the following extract was descriptive; 'becoming a breastfeeding counsellor (BFC)'. I returned to this code, tried to capture a sense of what was happening within the organisation during this section of text, and re-named the code ‘growing peer supporters’;

Code	Extract
Growing peer supporters	‘*What used to happen was with the peer support programme is that um the trainers would actually visit the areas and do enrichment days and that’s where one of them went to me ‘why don’t you become an organisation ‘B’ BFC?’, and I went ‘ok, what do I do?’, ha, um, and it sort of snowballed from there’* (Jessie, Org B, [147]).

This iterative process continued until I felt confident codes adequately encompassed the data. The flexibility of MAXQDA software, which allows easy re-naming of codes, helped me to feel relaxed about coding and interpreting the texts.

Memos

Memos record questions about codes and instances within the transcripts. They enable analysis of codes and data early in the process of research, require thought about ideas that have arisen, and can prompt future questions to address within the data (Charmaz, 2006). Below is an example of a memo written early in the analysis process which prompted me to think about different sorts of knowledge and how they might be valued:

> *A big thing is, are they [key strategists] seeing knowledge in quite a formal way? Are they seeing the mother’s knowledge of breastfeeding within this*

> *context flowing back to them from their peer supporters? This sort of knowledge is not really formally recognised or valued. It seems to be more about 'how can we give them (mothers) the 'right' information in a non-directive way so mum makes her own decision?' NOT about 'what have we (as the peer supporter and the organisation) learned through this encounter about what it's like to breastfeed in this context?'* (extract from memo written on 13.2.17).

Constant comparisons

Constant comparisons are used during grounded theory analysis to '*establish analytic distinctions'* (Charmaz, 2006, p.54) within the data. Initially comparisons of incidents and statements within each transcript are made. Later comparisons are made across transcripts, and memos written about the comparisons. Making these comparisons can enable codes to be linked together into groups. For example, all codes that seemed to concern the individual encounter between a peer supporter and a mother were grouped together and comparisons within and between them made. This helped me explore how these codes might be theoretically linked. The constant comparison technique can help to build theory because codes and their classifications within groups are repeatedly compared to other codes and their classifications (Flick, 2014). The material (i.e. interview data) is thereby '*continually integrated'* (Flick, 2014, p.496) into the process of comparison and theory development. During the analysis I made iterative comparisons until coherent theoretical ideas emerged. Making comparisons can spark new theoretical ideas and new questions to be asked of the data (Charmaz, 2006). Below is a memo written while making comparisons of instances of individual peer support. The memo led me to compare how different participants portrayed the role of the mother, and through those comparisons, I theoretically linked codes about individual peer support, to codes about the way different organisations view breastfeeding itself;

breastfeeding as an individual choice, or breastfeeding as a deeply embedded socio-cultural practice. This provides an example of theory development. It reveals how a memo can, via constant comparisons, lead to two groups of codes becoming theoretically linked:

> *I am just making comparisons across transcripts within the code 'making knowledge available' and need to make a memo about this comparison; Carrie (Org D) says that parents don't know where to go for quality information. The parent's job seems to be weighing up information and making the 'correct' decision. Listen to all, then decide. Carrie is assuming this is the stance of the parents. Mother 'as manager'. Don't just accept what you are told, got to investigate and decide what to do. Weigh it up. Are all the participants expecting mothers to adopt this stance? Is this accepted as the norm? This is just so pronounced in the way Carrie talks. I wonder, do any of the participants cast mothers in a different role? What might this be? Why might there be differences in assumed role?* (Memo made on 22.2.17 while making constant comparisons).

When new theoretical ideas arose during analysis, I did not automatically accept them. Instead I explored them and looked for disconfirming cases. An example of this is provided in chapter 7 (Phase Two Design, section 2.2). Throughout the analysis process I paid attention to my own reactions and feelings both during interviews and when undertaking comparisons. I noticed how I was feeling and stopped to reflect. I was able to intertwine reflection and analysis to increase awareness of my impact on interpretations:

> *Participants are very conscious of not stereotyping, and of not saying the wrong thing. What is this telling me? Why is Carrie (Org D) happy to say 'this is how we reach these people', and 'this is how we reach these other people', but not any kind of generalised difference causing these differences? What is the consequence of a service provider refusing to consider this? I feel uncomfortable too. I feel like they think I want sweeping generalisations – do I? Is that what I want? No. Why does this make me feel so uncomfortable? I feel like it would be very easy to walk away from examining these questions and issues* (extract from reflection written on 13.2.17).

This reflection prompted me to start coding for and undertaking comparisons of feelings of discomfort (both my own discomfort, and times when I sensed a participant's discomfort). It led me to consider participants reactions to thinking about social inequalities and to what extent health inequalities were discussed. Reflective practice considering my own responses and their impact continued throughout and is detailed in section 5 below.

Cross case analysis procedure

Cross case analysis procedures are advocated to break simplistic ways of thinking about the cases (Eisenhardt, 2002). In accordance with Eisenhardt (1989), I juxtaposed pairs of similar and different cases and noted down all the ways in which they were similar and different. Yin (2014, p.168) notes the importance of exploring 'all plausible rival interpretations' during data analysis. The cross-case analysis exercise was helpful in facilitating this. For example, comparing differing organisations C and D, led me to think carefully about the history of the organisations, and the proportion of their BPS practice that had been undertaken in areas of socio-economic deprivation. I had already identified that these two organisations had different ethos' and theorised this might help explain their differing practices. However, the amount of experience each organisation had of practicing in contexts of deprivation formed an alternative explanation which I went on to explore.

As per my analysis plan, I started analysis alongside data collection and followed the analytical steps of grounded theory analysis. I felt overwhelmed at the breadth of the material that had been covered in the interviews, and it was difficult to know how to start organising it. Initially I returned to the aims of phase one and grouped the data around each aim. This approach imposed pre-decided categories upon the data. It also resulted in my constructing five themes which accounted for all the interview data. Each theme was huge. Although all my coding, creation of memos, and comparisons had enabled me to become intimately acquainted with my data, and to form theoretical ideas about the ethos and approach of each organisation, the write up was highly confusing for anybody other than myself to read. This was mainly because I was trying to explain differences between each organisation whilst at the same time covering everything each participant had ever thought or done. Discussion with my supervisory team enabled me to feel confident to put that first effort to one side and return to my data with a focus upon the strategies, developments and adaptions the organisations had made when working in areas of deprivation. I returned to my analysis with renewed enthusiasm. I was able to re-organise my data so that a reader might be orientated to the history and background of each organisation, presented with clear explanations of the strategies each had used, and be informed about what the participants knew about the context of socio-economic deprivation and the political context in which they work.

5.4.7 Member check interviews

Member checking is the practice of returning interview transcripts or analysed data themes to participants and asking them to check and confirm or disconfirm the findings (Birt, Scott, Caver, Campbell & Walter, 2016). It is used to help assess the trustworthiness of qualitative research (Doyle, 2007). Member checking can increase the trustworthiness of findings (Lincoln & Guba, 1985), and can help participants' feel they are not alone when themes resonate with their experiences (Harper & Cole, 2012). However, member check practices may have limited utility because peoples' interpretations of phenomena change over time (Birt et al, 2016), and there is the possibility that participants may feel disregarded if themes do not resonate with their own experiences (Birt et al, 2016). Furthermore, there is the possibility that participants may suppress their own views and agree with a researcher's interpretations, and if only a small number of participants engage with the process, its power to demonstrate trustworthiness is limited (Birt et al, 2016). I considered the advantages and disadvantages and concluded that they would be worthwhile in my study. I felt that if conducted sensitively and carefully I could reduce the potential for participants to simply agree with my interpretations. I prepared feedback sheets for each organisation (see appendix 13). These gave a brief 'pen portrait' of the organisation and outlined my interpretation of the strategies, developments and adaptions it used when delivering peer support in areas of deprivation. Participants were sent the relevant feedback sheets via email, and member check telephone interviews were arranged at their convenience. Of the seven initial participants, one participant from each of the four organisations agreed to undertake a member check interview. The other three participants did not respond to my emails and prompts. Feedback sheets (appendix 13) were used to guide the interviews, which were conducted, recorded, and analysed in the manner described above. Apart from some minor phrasing issues, the member check interviews revealed that the participants felt that the information detailed represented the work of their organisations.

5.4.8 Diagramming

As analysis of both my meta-synthesis and my phase one interviews progressed, I made a succession of diagrams to represent my data. These took several different forms, and I tried to feel free to experiment with different types of pictorial representations (Miles, Huberman, & Saldana, 2014). Figures 2 and 3 at the end of chapter 6 (Phase One Interview Findings) present two such diagrams.

5.5 METHODS DEMONSTRATING TRUSTWORTHINESS INCLUDING REFLEXIVE PRACTICES

Lincoln and Guba (1985) suggest that the trustworthiness of qualitative research is important when appraising its worth. They put forward four components of trustworthiness; credibility, transferability, dependability, and confirmability. A description of each component and methods used are outlined below.

5.5.1 Credibility

Credibility is the extent to which findings can be considered credible (Lincoln & Guba, 1985). In my study, I demonstrate credibility using several of the methods put forward by Seale (1999); I spent a considerable length of time engaged in the process of data collection and analysis. This allowed me to fully immerse myself in my data. I used several different types of data collection, for example, in addition to interviews, during phase one I used grey literature (relevant grey literature was located during my meta-synthesis searches. Although it was not used in the meta-synthesis, I did use it during phase one data source triangulation which is described in chapter 7 section 7.2.2), and during phase two I gathered demographic data from mother and peer supporter participants, made field notes when visiting each case study site, and undertook an observation. I maintained regular communication with my supervisory team including sharing some of my interview transcripts. This enabled me to share any concerns arising from interviews. I asked my supervisors to examine some samples of my data analysis, discussed analytic decisions with them, and maintained dialogue about the research process. When a theoretical idea arose during data analysis, I did not automatically accept it. I ‘tested’ it by seeking disconfirming cases (Yin, 2014). An example is provided in chapter 7 (Phase Two Design, section 2.2). Member checking formed a key way by which I could check my interpretations. Please see section 5.4.7 above.

5.5.2 Transferability

Transferability is the extent to which the findings can be applied to other contexts (Lincoln & Guba, 1985). Because I have gathered socio-economic and contextual data as part of my study, a reader is able to compare my sites with other areas they may know. However, as explained in chapter 4 above, I do not claim the cases I have studied are typical of a larger parent population. Therefore, my findings claim only theoretical generalisation.

5.5.3 Dependability

Dependability is the extent to which the findings could be repeated (Lincoln & Guba, 1985). In my study, a chain of evidence was maintained by way of a weekly research log and a case study database (Yin, 2014). At the end of every week I reviewed my daily research diary and compiled a research log of key decisions, data, and thought development. This was uploaded onto MAXQDA software. I kept a case study database by archiving as much data as possible using MAXQDA computer files and carefully filing paper records.

5.5.4 Confirmability including methods of reflective and reflexive practice

Confirmability is the extent to which the findings are derived from the participants, and not the researcher's own bias or interests (Lincoln & Guba, 1985). In my study I have used reflective and reflexive practices to help me try to continually identify my biases and be mindful of my relations with participants and how they have been represented in the research. While reflection is thinking and writing about my own practice, about what I have done (Cousin, 2013), reflexivity takes this a step further:

> '*To be reflexive is to think about how your actions, values, beliefs, preferences and biases influence the research process and outcome'* (Simons, 2009, p.91).

The need for reflexivity emanates from a study's theoretical underpinnings (Dykes & Flacking, 2016). In chapter 4 I outlined the social constructionist and critical basis of my study, clarified what I accept it is possible to know about the world, and recognised that my values and biases along with my own background experiences inevitably impact upon my work. My methods described here and in chapter 8 (Phase Two Methods), render me the main instrument of the research process, and through them I have '*re-presented'* the experiences of others (Simons, 2009, p.91). I acknowledge that semi-structured interviews are a co-construction and recognise that part of data analysis is attempting to identify my role within such interviews (Mason, 1996). In order to be fair to participants, I needed to track how my own values and judgements affected my portrayal of them. Reflection and reflexivity therefore, became important ethically, as well as being a method of demonstrating quality (Simons, 2009).

Reflection is an active practice used before, during and after a research study (Simons, 2009). Before data collection commenced, I undertook a reflective ‘values’ interview with Professor Fiona Dykes and Dr Karen Whittaker (see appendix 14). This provided an opportunity to explore my preconceptions and values relating to the research question. I also kept a reflective diary and a research log throughout the research process. In the reflective diary I reflected upon my responses to incidents that arose, while my research log was a systematic weekly record of the research process including my general feelings and thoughts (see appendix 14). I paid particular attention to times when I noticed my feelings and emotions making sure I wrote about moments when I wanted to hear more from a participant, times when I wanted them to stop, times when I felt angry, upset or elated. I also adopted an approach whereby different facets of the self, or subjective ‘I’s, are identified through a subjectivity audit (Peshkin, 1985). Like other models, the basic premise is to improve research quality by making plain the impact of the researcher (Peshkin, 1988). However, I found that using this approach did more than this; it helped me locate myself in the research picture (Bolton, 2010), and it helped me understand where my own positions had come from (Cousin, 2013). A subjectivity audit aims to build a rounded picture of the researcher and reveal to the reader ‘study relevant’ information. I systematically reviewed my reflective diary and research log. Each time an emotion or feeling was mentioned I considered what the emotion was and what had evoked it. I worked through my research log which is stored on MAXQDA software, and coded the entries. When I reviewed the coded sections alongside my reflections, I was able to see how my responses formed two main groups; my two subjective ‘I’s. I was then able to use this self-knowledge as the study progressed. Whenever ideas arose which related to my subjective ‘I’s, I recognised I needed to pay attention and consider my impact. I reviewed my reflexive writing and research log at intervals in order to try to identify any new subjective ‘I’s. Appendix 14 provides an account of my personal and professional background, the outcomes of my pre-data collection ‘values’ interview, and explains the findings of my subjectivity audit by outlining the two subjective ‘I’s that it identified. It also provides examples illustrating how their identification helped me identify my potential impact on the study. In addition to my reflective and reflexive practices, I also undertook member check interviews (Flick, 2014) in both phases of the study. These aimed to help me understand to what extent my interpretations resonated with participants and to check the fit of my findings from their perspectives and are described above. I listened carefully to participant’s comments and adjusted my findings in light of them.

In this chapter, I have explained how and why the study has been designed in two phases and the aims and objectives of each phase. I have given an account of ethical issues I have considered for both phases, provided details of the methods used to conduct my phase one interviews, and outlined the methods I have used throughout the study to demonstrate trustworthiness (including my reflexive practices). In the next chapter, I present my phase one interview findings via four themes.

6.0 CHAPTER 6: PHASE ONE INTERVIEW FINDINGS

6.1 INTRODUCTION

In the previous chapter I explained how and why the study has been designed in two phases, gave an account of how I addressed core ethical issues, provided details of the methods used to conduct the phase one interviews, and outlined the methods I used to demonstrate trustworthiness. In this chapter I outline the characteristics of the key strategists who participated in phase one interviews and provide 'pen portraits' of the four participating UK breastfeeding support organisations. I take a critical approach whereby the key mechanisms of BPS interventions and understandings of how they operate are identified. Similarities and divergences in the approaches taken by the different organisations are explained via the following four themes: *'Facilitating access', 'supporting change at the individual level', 'the dual approach to peer support; supporting change at community and individual levels'*, and *'using experiential knowledge of place to forge trusting relationships and meet needs'*. I then provide an outline of the contexts of socio-economic deprivation in which the BPS services work, and the broad societal and political context in which the organisations operate. I conclude the chapter by presenting two diagrams to illustrate the findings.

6.2 DATA COLLECTION

Seven participants from the four organisations took part in six semi-structured telephone interviews lasting between forty minutes and two hours (one organisation requested a conference call interview with two participants). Interviews took place between November 2016 and March 2017. Three of the four organisations provided one participant who worked in a service delivery role in a peer support intervention in an area of deprivation, and one participant who worked in a strategic role. The fourth organisation provided only a participant working in a strategic role, as it provided only telephone based national peer support services, rather than locality-based interventions. Table 12 below provides participant details. It must be acknowledged that the participants interviewed during phase one reflected their own personal interpretations of organisational strategy and action. This means that the theory I generated from resultant data (see page 201-203) forms one interpretation of organisational development. Phase one outcomes drew upon a data set which was wider than this interview data however; phase one findings were composed of three elements (i.e. the findings of the meta-synthesis, phase one interviews, and grey literature identified as part of the meta-synthesis). Chapter 7 section 7.2 outlines how these three data sets were brought together in an analysis process which compared constructs arising across the data sets. This procedure facilitated the establishment of key facts and information about the organisational context and informed phase two study design (i.e. relevant questions to ask in phase two), as well as allowing the development of theoretical ideas.

6.3 PARTICIPANT CHARACTERISTICS

In order to understand participants' background organisational experiences, I asked them to explain both their current and previous organisational roles. These are shown in table 12.

Table 12 Phase One Interview Participant's Organisational Roles

Pseudonym of participant	Code for organisation	Current role within organisation	Previous roles within organisation
Jenny	A	Chairperson, Breastfeeding Counsellor (BFC)	BFC

Yvonne	C	Chief Executive Officer	Project lead for major project within organisation
Sophie	C	Director, supervisor of BFCs	Diverse roles including leading BPS projects, BFC, Trainer and Tutor
Jessie	B	BFC, trainer of other BFCs. (Jessie also works for the NHS supporting breastfeeding women and training PSs).	Peer supporter, trainee for delivering peer support training
Carrie	D	Project lead for a BPS project	Ante natal teacher
Heather	B	BFC and leadership role accrediting BFCs	Many diverse leadership roles within organisation
Daphne	D	BFC and Manager relating to service development	Tutor and Supervisor of BFCs

6.4 PEN PORTRAITS

6.4.1 Pen portrait of organisation 'A'

Organisation 'A' arose from a longer established breastfeeding organisation nearly forty years ago. Small and informal with minimal hierarchy, it was established as a membership organisation running its own telephone helpline, and as somewhere where mothers could obtain breastfeeding training. The voluntary nature of all members ensures adherence to the World Health Organisation (WHO) International Code of Marketing of Breastmilk Substitutes (WHO 1981), and freedom from commercial pressures (i.e. financial pressure to accept sponsorship and advertising is avoided by having no need to pay salaries). The idea at the core of the organisation is that through commitment to the provision of mother to mother support, primarily via a helpline and webchat, women can help each-other. This help fills some of the gaps left by health service provision and contributes to the overall aim that all women might be able to fulfil their own infant feeding goals. Although supporters may also volunteer in local breastfeeding groups where they live, the organisation does not have its own network of breastfeeding groups and is not directly involved in the volunteers' local face to face work. When opportunities arise that align with its aim, the organisation responds. For example, working in partnership with another organisation to run a national helpline, and developing training packages for health professionals. However, commissioned peer support service contract opportunities are not pursued. The organisation strives to train women from all communities, and a fund (derived from membership monies and donations) providing free and reduced cost training has been established. The scope of online support has developed over recent years so that today, a broad spectrum of ever evolving social media platforms are used to help form connections with women from a wide demographic and range of backgrounds.

6.4.2 Pen portrait organisation ‘B’

Organisation ‘B’ was established in America in the 1950’s. The UK arm of the organisation is an affiliate of the broader organisation and has its own strong identity. In the UK, the organisation aims to provide quality breastfeeding information and support to mothers at a community level, to raise awareness of the value of breastfeeding, and to change societal perceptions so that breastfeeding is seen as relational and the norm. The organisation is organised so that specialist areas of knowledge are easily accessible to the organisation’s BFCs, however it is not strongly hierarchical, and everyone is a volunteer. This means the organisation’s integrity is upheld, and there is no pressure to pay salaries. In the past there have been two types of supporter (BFC and PSs); mothers with at least one years’ experience of breastfeeding train to BFC level. Once trained, BFCs run a national helpline and respond to the needs of their communities; running community groups, managing local online support groups (reading posts, monitoring responses from other mothers, providing additional information and specialist support if needed), and providing one-to-one support to mothers. Historically, the organisation set up a separate programme to facilitate the training of PSs who were mothers with at least three months breastfeeding experience who had undertaken a short six to twelve-week breastfeeding training course. Mother to mother support, seen to encompass that given by both PSs and BFCs, is the way the organisation has and does pursue its aims. The peer support programme has been commissioned by health care trusts to provide training to local health professionals in areas of deprivation with low breastfeeding rates, which in turn enabled health professionals to train local mothers as PSs. This acted to raise the profile of breastfeeding within the community. When funding ceased several years ago the peer support programme became financially unviable and the organisation has not been able to continue with this work. However, the strategic decision was taken to continue to seek to provide a community-based resource of mother to mother support in areas where there is none, especially in socio-economically deprived communities where mothers do not have access to support, by enabling local mothers to train as BFCs. When grants are available the organisation seeks to establish new groups in this way. The organisation describes itself as an empowering organisation; it seeks to empower these (and all) BFCs to work collaboratively at a local level and take up opportunities that arise. This is evidenced by the way that such BFCs have sought innovative ways of working to support women in their communities including on occasion continuing to train PSs outside of the main organisation. The strategies described below used in a context of socio-economic deprivation concern the practices of one such BPS scheme.

6.4.3 Pen portrait organisation 'C'

Organisation 'C' arose from a longer established organisation around twenty years ago. In order to avoid all conflicts of interest, and to uphold the international code of marketing of breastmilk substitutes, sponsorship is not accepted. BPS is the organisation's main activity. It has a particular concern for women least likely to breastfeed and ensures that peer support training is free at the point of delivery. The organisation aims to increase awareness about the value of breastfeeding to women, families, and society via: providing quality support and information to women, families and health professionals; positively influencing community attitudes towards breastfeeding; inspiring women to support others in their communities; and by raising awareness about breastfeeding and its work at a national political level. At its naissance, founder members provided voluntary support in their local areas. Over time, they were asked to train health professionals, and commissioned to provide BPS projects in areas of deprivation. Increased commissions, growth in membership, working with another organisation to run a national helpline, and providing high quality infant feeding information for health professionals, have necessitated increased formalisation. Today, resources for commissioned projects are reducing. If a commission comes to an end, or a peer supporter moves to a new area, peer support can continue by way of collaborative working with local health professionals, however, without careful strategic planning of how peer support will fit in with other services (including the roles of PSs trained to work alongside health professionals, and those trained to a higher level able to work more independently with supervision), and some level of ongoing support, the resource of peer support can quickly become lost. The organisation retains its long-term commitment to areas of deprivation and is seeking innovative ways to continue to provide the support that is needed. For example, by looking for ways of continuing to train PSs when less money is available.

6.4.4 Pen portrait organisation ‘D’

Organisation ‘D’ is a large organisation that began in the 1950’s by providing women with information and education about natural childbirth. Since then it has developed by training ante-natal teachers and BFCs, and by becoming a membership organisation with local volunteer branches. Today, the main aim of the organisation is to support parents in their transition to parenthood. This is realised by providing evidenced based impartial information, education, information about available services, and social support. Projects delivering peer support for breastfeeding are just one of the ways in which the organisation seeks to achieve its aim. They form one part of a suite of possible services and interventions the organisation can be commissioned to provide. Provision of BPS is responsive to demand from commissioners and local volunteer branches (which may fundraise in order to pay for BPS training if they feel it is needed in their community). Taking up opportunities to deliver commissions has resulted in the organisation delivering services in areas of social and economic deprivation, although recently this funding has reduced. Over recent years the organisation has become more professional, formalised, and strategically led.

6.5 ORGANISATIONAL CHARACTERISTICS

In this section I provide information about the organisations and their strategies in areas of deprivation. Interview data has been used to construct tables 13 and 14 (see below), which provide overviews of organisational characteristics and the strategies and adaptions participants discussed. I define a woman/mother-centred approach as an approach whereby PSs aim to keep conversations focused on a mother's concerns and desires, use active listening to understand a mother's perspective, and give non-directional support.

6.5.1 Table 13 Overview of organisational characteristics.

Org	Size	Age	Complexity and hierarchy	Involvement in commissioning	Extent to which would continue to pursue BPS if funding removed	How central is BPS to achieving the organisations aims?
'A'	Small	A more recently established off shoot of	Minimal hierarchy	Not involved in commissioning. Everyone a volunteer	100% committed	Central

		another organisation				
‘B’	Medium	Long established	Minimal hierarchy	Not involved in commissioning. Everyone a volunteer	100% committed to mother to mother support (not necessarily through BPS)	Mother to mother support is central, but BPS not always used
‘C’	Medium	A more recently established off shoot of another organisation	Some level of complexity and hierarchy	Involved in commissioning. Some voluntary, some paid posts	100% committed	Central
‘D’	Large	Long established	Complex. Hierarchy present	Involved in commissioning. Some voluntary, some paid posts.	Most BPS would stop if funding removed	Just one of several activities

Table 14: Overview of strategies and adaptions used in areas of deprivation

Org	Present on the ground in areas of deprivation?	Strategies and adaptions
A	No, but seeks to meet the needs of mothers living in these contexts via phone and online.	Facilitating access to individual support by trying to reduce barriers to reactive support (i.e. doing things to make it easier for women to access phone and online support); supporting change at an individual level using a mother-centred approach and utilising the experiential knowledge of mothers by trying to provide a pool of supporters reflective of all women.
B	Yes, in some areas.	Facilitating access to individual support by trying to reducing barriers to reactive support (i.e. doing things to make it easier for women to access group based support); supporting change at an individual level via a woman-centred approach; supporting change at a community level by closely integrating with health services, providing community groups, and by training health professionals so they can signpost to support. Utilising the experiential knowledge and trusted status of local mothers by training local women.
C	Yes.	Facilitating access to individual support via proactive contacting; supporting change at an individual level using a woman-centred approach; supporting change at a community level, and utilising the experiential knowledge and trusted status of local mothers.
D	Yes.	Facilitating access to individual support via pro-active contacting, providing continuity of peer supporter and swift

		booking of subsequent contact; supporting change at an individual level via a woman-centred approach, and utilising the experiences of local women.

6.6 STRATEGIES, DEVELOPMENTS AND ADAPTIONS USED TO DELIVER BREASTFEEDING PEER SUPPORT IN AREAS OF DEPRIVATION

I present four themes that explain the strategies, developments and adaptions the organisations have used to deliver BPS in areas of deprivation. The numbers given in square brackets following the quotes denote the transcription line number. The first theme concerns the issue of service access, and the remaining three themes concern the approaches used once access is gained; supporting at an individual level, the dual approach to peer support (supporting change at community and individual levels) and using experiential knowledge of place to forge trusting relationships and meet needs. I provide very few quotes from Jenny (org A). This is because organisation A provides only telephone helpline support and does not have any ‘on the ground’ projects in areas of deprivation. Consequently, Jenny was unable to provide information about service development strategies in these areas.

6.6.1 Theme 1: Facilitating access

Contacting women an intervention aims to reach is a prerequisite of all change strategies. Participants recognised that many women are reticent to reach out and ask for help with breastfeeding because they don’t want to feel they are ‘*bothering people*’ (Carrie, Org D, [53]). Some participants identified that there may be differential access to services across the social spectrum, meaning that more socially advantaged women may find accessing services easiest:

> ‘*It can be incredibly hard to engage people in real deprivation areas […] to come out to face to face services even at a Children's Centre, you know it is, that is really quite challenging, and those with more resources in terms of confidence and wider experience maybe find it easier to access services'* (Sophie, Org C, [200]).

Less socially advantaged mothers were described as being less likely to approach the organisations themselves whether via a help line, an online platform, or a community-based group. Participants from all four organisations discussed what had happened within their own organisations in order that they might reach out to these women. Reaching out often required additional resources:

> *‘The majority of the volunteers we would get were women who had attended our antenatal courses, to attend an organisation ‘D' antenatal course costs around about £170 per couple, […] the majority of our volunteers were white middle class and well educated […] so we would have a high number of volunteers in affluent areas and no volunteers in other areas so the majority of branch activity took place in affluent areas because that's where the volunteer base was, now that we have commissioned peer support, we've had the funding to number one train peer supporters…'* (Carrie, Org D, [121]).

Efforts to remove barriers to reactive support were described such as ensuring breastfeeding groups were located on a bus route and making sure web-based information was easily accessible from a smart phone (although ensuring the accessibility of the content of web-based information was not mentioned). Online support was seen as a stepping stone to face to face contact allowing mothers to ‘test out' supporters' responses first with less risk to themselves. However, for all organisations proactive contacting was felt to be the adaption most able to facilitate provision of peer support to this group of women. In addition to enabling a connection, sensitive proactive contact was seen to demonstrate a peer supporter felt genuine interest and care:

> *'You're making it very very clear to women that you're there, [...] and you'll listen to what they want'* (Sophie, Org C, [124]).

Timing proactive contact so that it occurs early in a mother's journey was emphasised, so that support is offered '*at the time that they need it'* (Carrie, Org D, [55]). Flexibility ensured the form of contact (i.e. text, phone, face to face) a mother felt most comfortable with could be used:

> *'From working with different groups you tend to learn, what's the best way to engage with them, what are the best communication methods for them, what they prefer, um but yeah, mums under twenty prefer text'* (Carrie, Org D, [100]).

6.6.2 Theme 2: Supporting change at the individual level

In organisation ‘D’ BPS has strong theoretical underpinnings centred upon the person-centred counselling philosophy of Carl Rogers (1951).[9] Participants felt that the mother should initiate, direct, and control the conversation, and that by using this mother-focussed approach, her internal motivation would be fostered:

> *‘Making them feel as though they’ve instigated those conversations that they’ve chosen what they want to talk about that we’re very much on their agenda not our agenda, you know makes them feel that you know, they’re buying into a choice that they’ve made which means they’re more likely to commit to it which means they’re more likely to stick to it’* (Carrie, Org D, [97]).

PSs use active listening skills in order to understand the mother’s concerns in a non-directive manner. The peer supporter then provides relevant evidenced based information to enable woman to make their own choices:

> *‘Here’s the information, here’s the evidence’ ‘these are your choices for childbirth, um, it’s up to you what you do with them’* (Carrie, Org D, [97]).
> ‘*There’s always relatives and family members and friends who have all got opinions on everything, and lots of people will say that their way is the best way to do it, but, how do you find unbiased, evidenced based information? I think that’s what organisation ‘D’ is about’* (Carrie, Org D, [28]),

---

[9] The central idea of Rogers’ philosophy is that all people have the potential for self-understanding and self-determination. This can be facilitated by a therapist who comes alongside the person and sincerely and warmly tries to understand things from their point of view. When a person comes to understand her current situation and decides for herself what to do about it, she is much more likely to follow her decision through than if somebody tells her what to do (Rogers, 1951).

From the approach adopted by organisation D, the mother may be seen to adopt an ‘information manager’ role, seeking out appropriate evidence and using it to make cognitive decisions about parenting. This approach seems to assume that mothers have both a knowledge deficit, and the power and autonomy to make decisions based upon evidence a peer supporter might provide. It also assumes that the communication skills used by a peer supporter during the person-centred approach can facilitate the mother to act as she wishes. There appeared to be tension between the relative importance of the information given to the mother, and the communication skills utilised by the peer supporter among organisation D participants; while as illustrated above Carrie (Org D) felt the provision of evidenced based information was paramount, Daphne (Org D) seemed to privilege the importance of skills:

> ‘*To be a peer supporter […] it’s not about having lots of knowledge in a particular area, it’s about developing those skills, of being alongside a woman when she needs somebody to speak to, so it’s about training people to be active listeners, about making them understand when they may be judgemental, about knowing […] what the boundaries of the role are and where to signpost women on to if they need further support, so yeah, so skills are quite core’* (Daphne, Org D, [28]).

Despite this apparent tension, the ‘active ingredients’ of the approach seemed to be the communication skills and the information rather than anything else about the peer supporter. Although organisation D participants mentioned that local women were trained as PSs, their descriptions of the mother-centred approach did not include a peer supporter sharing information about herself. Because adaption to the unique situation of each individual mother is intrinsic to the mother-centred approach, this approach itself was considered all that was necessary to enable adaption to any context:

> ‘*All or peer supporters are all trained with the mother centred approach which I think again, when you’re dealing with people from different educations different backgrounds, different cultures, if you’re led by the mum, then hopefully the conversation should, should always support that mum shouldn’t it?’* (Carrie, Org D, [100]).

However, the way contact was arranged for young mothers under the age of twenty can be seen as a specific context-related adaption of the mother-centred approach; contact was arranged so that young mothers had continuity in their peer supporter coupled with the swift arrangement of a second contact:

> ‘*We try and just make sure that it’s for them [mums under the age of twenty] that it’s one contact, so for all our mums under twenty they’re immediately referred to our home visit team and a member of the home visit team will call them and try and book a visit on that very first phone call because we quite often find trying to get them back on the phone again later, they tend not to answer their phones’* (Carrie, Org D, [100]).

The importance of a mother being the person to initiate the conversation and the need for proactive contact described above seemed to conflict. However, Carrie (Org D) was able to reconcile these two ideas by a form of compromise; the initial proactive contact made women aware that there were *‘lots of different ways of finding support’.* Once this awareness was in place, control was handed back to the mothers by ‘*putting it* [future contact] *in their control in the sense of 'if you need us text us''* (Carrie, Org D, [107]). Informed decision making and a feeling of being respected, listened to and in control, were the anticipated outcomes of this approach, with increased breastfeeding rates appearing to be a 'given'. This strategy and its underpinning philosophy assume an individualistic view of infant feeding, that it is mainly about the actions and decisions of individual women. It does not provide a scaffold for thinking about the possible constraints women might face.

The approach of organisations B and C to individual support was similar to that of organisation D in that high quality evidenced based information was valued, and the importance of active listening and giving non-directive support to facilitate mothers' empowerment was highlighted. However, organisation C participants overtly mentioned other women's experiential knowledge as important and valuable within one-to-one conversations:

> '*Obviously quite a lot of breastfeeding knowledge is passed from mum to mum and there isn't always a fantastic evidence base […] if we don't know an evidence base for it when we are sharing with mums we'll say something like 'some mothers find this is useful, you know you might like to think about trying that as an option'* (Sophie, Org C, [37]).

Furthermore, participants from organisation C did not mention the importance of the mother instigating the conversation, and descriptions of mothers' decision making included talk of the emotional work of mothers, of the mothers' role of 'balancing' several different people's needs at the same time:

> *'Every women has her own unique situation, she might have a husband, she might not, she might have a mother living with her who is very unsupportive of breastfeeding who didn't do it herself and can't see the point, she might have an aunt nearby who desperately wants to feed the baby a bottle, there are lots of things going on and each mum has to weigh up you know these pressures and what she does about them, we might say [...] the evidence says [...] 'its great for your milk supply to feed regularly and to avoid you know bottles and teats' and she's thinking 'but my mother-in-law really wants to feed this baby, how can I, you know, how can I do this?' work with that?', and so we'll share information that she can think about she can think about her choices about that'* (Sophie, Org C, [56]).

This seemed to reflect an understanding that mothers' power and autonomy within her inter-personal relationships could mean she may not make decisions based solely on evidence. However, the approach avoided placing limits upon a mothers' choices. Adapting the content of peer support training to reflect the reality of infant feeding practices within the communities was described as information about bottle feeding had been added to the peer support curriculum.

6.6.3 Theme 3: The dual approach to peer support; supporting change at community and individual levels

Two organisations discussed similar 'dual' approaches to peer support. In this theme the approach taken by organisation C will be explained first, followed by that of organisation B.

Organisation C has a dual approach to peer support underpinned by a belief in the importance of wider societal and community attitudes towards breastfeeding in facilitating cultural change. In addition to the importance of the one-to-one support a mother receives, it was recognised that the extent to which her community accepts breastfeeding was also of vital importance. Therefore, rather than only trying to facilitate individual level change, the organisation sought broad societal changes in attitudes towards breastfeeding:

> ‘*Key to what the charity is trying to do is increasing more of a positive attitude more of an awareness of breastfeeding right through’* (Yvonne, Org C, [27]).

When working in contexts of deprivation, organisation C aimed to change community attitudes and beliefs, and provide social spaces where breastfeeding is normalised thereby changing the community environment. This happens through the provision of a long term, local, community level resource of mothers with breastfeeding knowledge and skills who are able to share their breastfeeding experiences with other local mothers:

> ‘*The model of creating a peer supporter is about a resource […], mothers with experience is the resource, so actually other mothers can relate to that’* (Yvonne, Org C, [43]).

This community resource can take the form of both virtual and physical community groups. The dual approach marries work towards community change with efforts to effect change at an individual level. Both approaches take place at the same time and re-enforce one another. For example, when a mother has a positive experience of one-to-one support, regardless of the breastfeeding outcome, this is seen to re-enforce changes in community attitudes:

> ‘*The overall kind of aim I guess in terms of the experience* [of individual support], *is to try to get more positive attitudes to breastfeeding, and doing that really by equipping the mother whom we’re offering that support, with the best possible information, that’s balanced and sensitive to her situation and life, to help her make those decisions’* (Yvonne, Org C, [38]).

This dual approach can also result in additional benefits both for individual women and the community at large when women fully engage with support in both its individual and community (social group) forms. Although all the organisations recognised the positive nature of the educational opportunities afforded by a peer support scheme, the wider community benefits of peer support were universally seen as a ‘*by-product’*:

> *‘Some of the by-products of it [individual and community based support] are that mums then become part of a, communal supportive network, that has all sorts of other related benefits by reducing isolation, improving their self-esteem, confidence, and you know helping them to continue to feed for longer if that’s what they’re choosing to do’* (Yvonne, Org C, [38]).

Although both participants from organisation B described seeking to provide individual support and change at the community level, they discussed very different strategies to affect this. Jessie (Org B) explained that in her local area where breastfeeding rates were low, a strategy involving intimate integration with NHS services was used; any mothers initiating breastfeeding were pro-actively contacted by a special NHS support team who visited them in hospital and at home providing one to one support until they were '*up on their feet feeling a bit more confident'* (Jessie, Org B, [137]). Specialist team members then accompanied mothers to community peer support groups and introduced them to PSs who '*just fly with it'* (Jessie, Org B, [33]) and effect *'the normalisation of their world'* (Jessie, Org B, [137]). Specific organisation B groups (both online and face to face) were well attended by both mothers and PSs. Meanwhile, many PSs went on to train as organisation B BFCs and/or become employed within the specialist NHS breastfeeding support team. The project involved Jessie undertaking two roles, one working for the NHS, and another (voluntary) for organisation B. Through training 30-40 mothers as PSs annually in her NHS role (using a course she designed herself but with roots in her own organisation B training), PSs were found to be able to deliver credible breastfeeding information into a community where breastfeeding was unknown, and to shift ownership of breastfeeding from health professionals towards women.

By contrast Heather, the second organisation B participant who was 'higher up' within the organisation, discussed her desire for a different strategy which concerns using BPS to raise the profile of breastfeeding within the community by way of training local health professionals to deliver it:

> '*Breastfeeding isn't always the top of their [health professionals] list and yet […] it would be invaluable for health professionals to generally recognise the value of breastfeeding support and to know how to provide it or where to go to access it for mothers who are out in the community […] to provide our peer support programme again, to Heath Professionals, […]there's a much greater*

> *chance of that breastfeeding approach, and information cascading down to mothers through health professionals.'* (Heather, Org B, [95]).

Heather sees individual support and changes in community attitude as necessary but envisages this happening through health professionals.

The dual approach anticipated the following outcomes; that women would have positive experiences of one-to-one support, feeling respected, listened to, and able to make informed decisions. That the provision of a community level resource of women with experiential knowledge of breastfeeding would cause local community changes resulting in increased community level knowledge and ownership of breastfeeding. That there would be additional benefits for women who engage with community level support such as increased confidence and social support.

6.6.4 Theme 4: Using experiential knowledge of place to forge trusting relationships and meet needs

Organisation C sees the cultural norms of particular geographical places as highly relevant and values the experiential knowledge of PSs and women living within a particular place or community. The other organisations made mention of trust between a peer supporter and a mother arising because of shared experiences, but it was organisation C that operationalised experiential knowledge of place as part of their strategy to effect change within the context of socio-economic deprivation. This theme concerns organisation C's idea that one to one support can be qualitatively different when the mother knows the supporter has experiential knowledge of the social and cultural norms of a geographical area. Breastfeeding in one place might involve very different pressures when compared to breastfeeding in another place. When mothers know that a peer supporter understands the pressures associated with breastfeeding in their particular place, this results in greater trust within the relationship. Training women with first hand experiential knowledge of breastfeeding in a particular place may be seen as an adaption to the context:

> ‘*You’ll get quite different styles of peer support in one area to another […] women living in X* [nearby town A] *had a very, different background and kind of approach to each other to the those in X* [nearby town B], *so in X* [nearby town A] *for example very strong matriarchal society where a mother would live with […] maybe her own mother would be […] a couple of streets away and her granny might be opposite and very strong women […] and so the mothers in there, they understand that and the women who live and work in X* [nearby town A] *understand that the peer supporters understand that, when you get to X* [nearby town B] *very different situation where you get a lot of mums coming in from outside areas a lot of change going on, […] they* [PSs] *still live there and understand the […] area that the women are living in and the pressures of breastfeeding in that area’* (Sophie, Org C, [75]).

The experiences of all community women are also valued, and seen as having the potential to be harnessed to help others:

> ‘*A local area may have the local facebook page for support that mums can join, […] and mums are encouraged to support each other on that as well, […] you will get mums, […] facebook messaging each other in the middle of the night […] this is really joining women up to get support from each other as and when they need it’* (Sophie, Org C, [44]).

When mothers had to deal with a range of other, non-infant feeding issues that challenged at short notice their family’s safety and security, such issues had to be addressed before infant feeding could be thought about. Trust between women who lived in the same locality meant that PSs could provide support quickly including helping mothers deal with other issues. This trust was important because some mothers who lived in conditions that might be seen as less than ideal were described as feeling stigma and potentially a lack of trust in professionals:

> *‘A peer supporter comes to them, and she’s one of them, she’s, you know she lives in the street around the corner, they trust her and she’s there on the spot […] they* [PSs] *would be often dealing with issues that were nothing to do with infant feeding, you know, they’d be getting additional support into that family that […] just hadn’t realised what support that was available to them you know it could have been […] help with making sure they got […] relocated to a flat that was more convenient because the outside steps were, the mother couldn’t get up and down them, you know whatever it is you know all sorts of other things around their lives that, that needed sorting first and infant feeding was kind of like a pretty low priority really, you know the peer supporter would go in do what she could, and then you know, help with the infant feeding’* (Sophie, Org C, [204]).

Sophie (Org C) described her own theory which explained how different aspects of a mother’s own context might interact to impact upon feeding practices. She used

Maslow's (1943) theory of the hierarchy of needs[10] to explain how the basic needs of safety must take precedence over infant feeding concerns. This meant that unstable living conditions may interact with a woman's family culture of infant feeding and associated confidence in breastfeeding to affect practices:

> *'If you're in a culture of […] bottle feeding and you're confidence in breastfeeding is very very fragile, it doesn't take much to knock it, […] and think 'well I, gosh, why am I doing this I can always bottle feed and then my mum can have him when I go and sort out these issues' etcetera, whereas, you know, somebody else it might be different for that person because she's got more confidence in breastfeeding her mum fed her sisters fed, […] its variable really, but I think the basics […] have to be in place for a mum who's fragile about breastfeeding […] probably her faith in breastfeeding is not going to survive many other huge pressures on her, to keep her and her family safe'* (Sophie, Org C, [212]).

In this way the role the mother must adopt is one of 'coper'. The strategies used by organisation C in the context of deprivation were both individual and community based and include the impact of trust arising from shared experiential knowledge of place. Similar to organisation D, they used the person-centred approach (including its theoretical underpinnings), however, greater awareness of the possible constraints acting on women was shown, and the mother was cast in a 'needs balancing' role, with Maslow's theory also underpinning and explaining their practices. This theory may be

---

[10] Maslow's (1943) theory suggests people have a hierarchy of needs which are prioritised. The most basic needs are physiological followed by the need of safety, belonging, esteem, and self-actualisation (reaching one's full potential). People must make sure their most basic needs are met before they can move up the hierarchy and work towards meeting higher level needs.

seen as part of a scaffold that enabled practitioners to think about environmental constraints as well as individual motivation and decision making. The theories organisation C used that explain both individual change and environmental constraints, reflected a more socio-cultural view of infant feeding. This is where infant feeding was seen as a set of highly complex social practices, embedded in the political, structural, social, and cultural context.

6.7 THE CONTEXT

In this section I will outline how the context of socio-economic deprivation was described by participants, and what I have learned about the background societal and political context in which the organisations themselves operate.

6.7.1 The context of socio-economic deprivation

Participants described socially deprived communities as areas that had little knowledge or experience of breastfeeding, where breastfeeding was invisible, and rates were low:

> ‘*In some areas you’ve now got three four generations of bottle feeders and I think people have forgotten what babies do’* (Jessie, Org B, [125]).

Power and status differences and sometimes a lack of trust between mothers and health professionals such that women may anticipate health professionals’ surveillance and judgement were described:

> ‘*I’ve worked with the most fantastic health professionals too but there still is if you’re living in a situation that you know is not entirely* [ideal] *I don’t know, I think there, people are suspicious of ‘are people in authority going to tell me*

> *what to do, or not approve' and I think the health professionals work very very hard to overcome that but never the less there is that, there is that feeling 'am I being checked up on here?''*(Sophie, Org C, [216]).

In addition to power differentials between mothers and health professionals, it was highlighted *'how isolated mothers can be'* (Heather, Org B, [31]), and how power imbalances between women and other family members might suggest some women may have less power within their own homes than might be assumed:

> *'I've supported one lady recently who's from a Bangladeshi background, actually she wants to breastfeed her baby so she can hold her baby. So grandmas from both sides don't take over'* (Jessie, Org B, [185]).

Unstable basic living conditions that could necessitate attention, time and energy at short notice were also felt to affect some women, and difficult living conditions were linked to stress, whereby the impact of *'living in a more stressful environment'* (Jenny, Org A, [53]) and the associated *'cross over between different stresses'* (Jenny, Org A [53]) were recognised:

> '*We know that mums that come from a you know financially difficult situation are more likely to suffer with post-natal depression'* (Jenny Org A, [53]).

6.7.2 The societal and political context

Participants comments suggested that we live in a socially unequal society, and that we may not necessarily be aware of the extent of this. For example, when Sophie (organisation C) first started working in a particular area of deprivation, she described being '*shocked*' and '*amazed*' (Sophie, Org C, [206]) at the issues mothers living in that area sometimes had to deal with before they could think about infant feeding. These could include fire safety hazards, and losing electricity, and contrasted with the concerns of more socially advantaged mothers. Carrie, for example, described a set of very different concerns:

> *'They're* [mothers] *really terrified of maternity leave, cos they know they're gonna have a baby to look after, but they're not quite sure what they're supposed to do with all that time, and where they're supposed to go and 'how do we find out about groups' and 'how do you know where to go for swimming lessons?' and 'how do you know which nursery, nurseries to look at?', 'where do you find this information?', and 'who am I gonna hang out with during the day when all my friends are at work?'*(Carrie, Org D, [152]).

Explicit discussion of addressing health inequalities was very limited, however when it was mentioned, BPS was framed within official policy recommendations as part of broader evidenced based multifaceted interventions to address inequalities:

> '*In terms of how we're working within the health inequalities agenda, […] certainly peer support isn't the whole answer, it's part of a model which we are seeing some erosion to which is about multifaceted approaches and they are the ones in terms of NICE guidelines […] from the evidence […] that are the most effective at increasing rates and supporting, initiation and continued breastfeeding'* (Yvonne, Org C, [109]).

It may be that this official framing serves to inhibit practitioner's own consideration of 'what are we actually doing here?', because consideration of whether they are addressing health inequalities is removed by the official explanation. Implicit mention of working to reduce health inequalities was also limited, but participants implied that the provision of adequate supportive services would enable more mothers to breastfeed, thus reducing health inequalities:

> *'It's short sighted of councils and health trusts to cut the peer support programmes that they have and had, because without it many women would not breastfeed, would not have continued to breastfeed, the evidence is there for the health outcomes, especially with those in the lower socio-economic groups'* (Jessie, Org B, [200]).

There was very limited discussion of infant feeding patterns being one small part of a much broader issue of health inequalities, of the idea that health differences might be socially produced and therefore avoidable and unfair. Differences in behaviours were seen as a cause of health differences, rather than also being a symptom of social inequality. This might be seen more as a failure in the communication of the concepts central to health inequalities rather than as any criticism of the practitioners themselves.

The relationship between commissioners and organisations seemed to be an important one. Its role in facilitating service developments was acknowledged:

> '*I guess the success, the development of commissioning, the response via commissioning within England to create community peer support and also*

> *obviously […] work on wards as well and home visits that really has kind of increased massively'* (Yvonne, Org C, [24]).

Participants described considerable variation between the commissions they had delivered. The spectrum of services included delivering peer support training as a 'one off', providing group-based community services, providing universal services operating across antenatal, hospital, home and community environments, delivering targeted postnatal services, and delivering neo-natal peer support services. It was clear that within the commissioning relationship the commissioners held the power, and that the organisations must deliver exactly what the commissioners want:

> *'It* [what is delivered] *depends on the actual scheme, what's been set up that the commissioner wants cos they are very specific indeed about what they want the peer support to deliver'* (Sophie, Org C, [111]).

The organisations had to align their work to the outcomes desired by the commissioners:

> '*Our priorities are quintile one post codes and mums under twenty, our commissioner has made that quite clear, so when we are busy, priority goes to those mums anyway'* (Carrie, Org D, [166]).

Although the current severe budgetary restrictions within which commissioners must work were acknowledged, some participants felt that their organisations had been 'used' by the current system:

> *‘Because they’ve* [commissioners] *pulled out the funding for peer support programmes, everywhere, not just us* [Org B] *but with organisation X* [org D] *as well, […] they had organisation X* [Org D], *and now they do their own, I think they are still training peer supporters but it’s not from the organisation X* [Org D] *model and its certainly not, they’re certainly not paying the licence to organisation X* [Org D] *for theirs so they’re getting the information from the breastfeeding organisations and then not carrying on with it’* (Jessie, Org B, [149]).

6.8 DIAGRAMS TO REPRESENT FINDINGS

The two diagrams below pictorially represent the findings.

Figure 2 The individual approach of organisation D

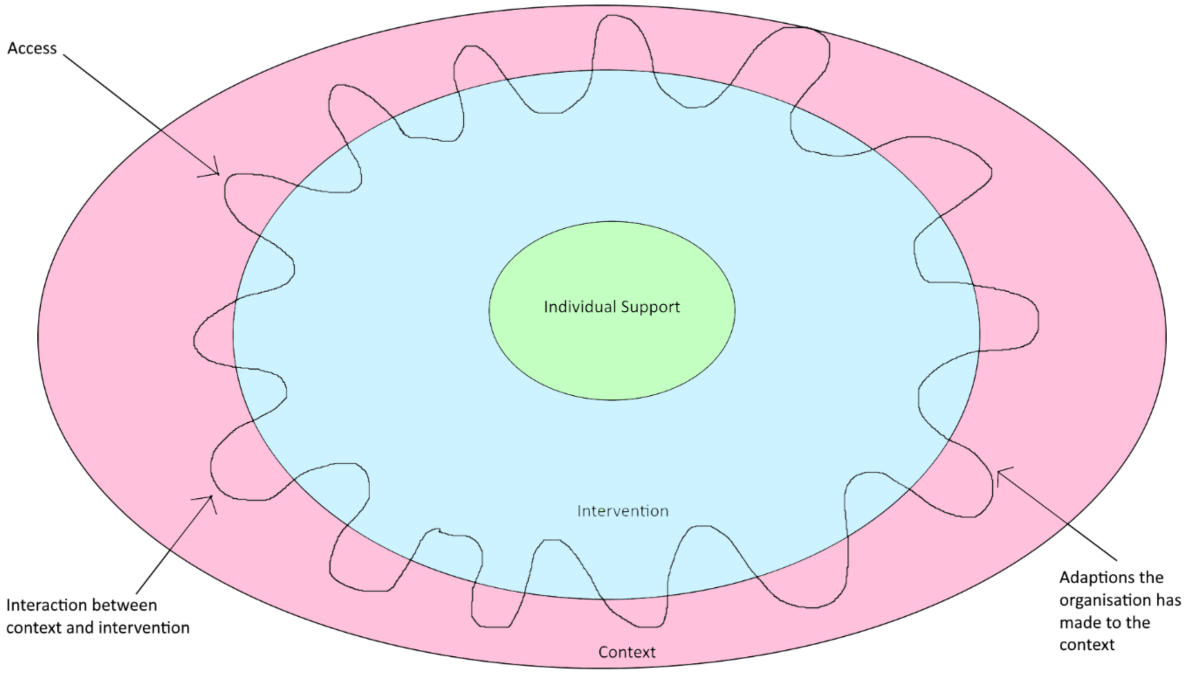
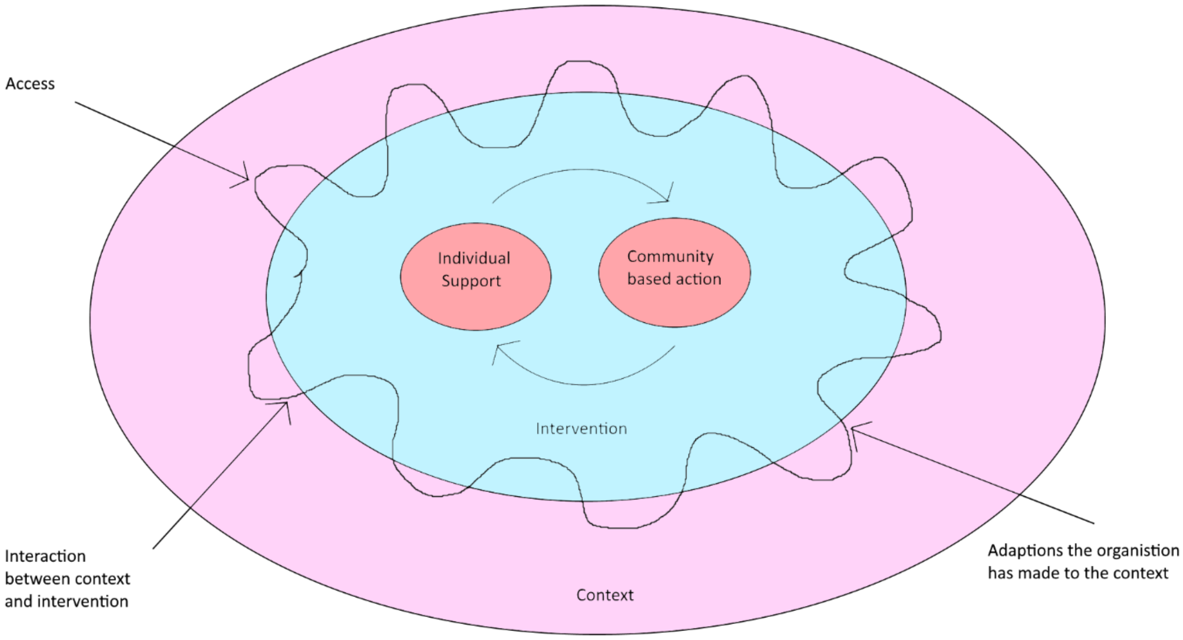


Figure 3 The dual approach of organisations B and C



In the diagrams the background white area, beyond the large light pink oval represents the broad political and societal context within which the organisations must work. This includes the policy of government commissioning, how health inequalities are viewed, and the economic climate. The large light pink oval represents the context of socio-economic deprivation within which the BPS interventions take place. The blue oval sitting within this represents the BPS interventions themselves. Within this blue oval are one or two smaller ovals. These represent strategies used to effect change. The arrows linking the strategies in figure 2 represent the idea that these two strategies might re-enforce and feed into each other. The wiggly lines, or villi protruding out from the blue oval into the light pink oval represent the ways by which the intervention interacts with the context, the adaptions, strategies and developments the organisations have made, and how these reach into the context and at the same time provide opportunities for the organisations to learn about the context. The villi increase the surface area of the intervention oval significantly. This is illustrative of one of the key adaptions to the context; facilitating access by reaching out to women. The villi also extend from the context back inside the intervention oval. This represents the adaption of utilising the experiential knowledge of local women, and how this is enfolded within the intervention. The villi can also represent the listening element of the women centred approach.

In this chapter, I have reported from the perspective of key organisational strategists. I have outlined the strategies organisations have used and adaptions they have made when working in areas of deprivation. In chapter 7, I explain how I used the findings of phase one to underpin, inform and design phase two.

7.0 CHAPTER 7: PHASE TWO DESIGN

7.1 INTRODUCTION

In chapter 6, I presented ‘pen portraits’ of the four participating UK breastfeeding support organisations. I took a critical approach, eliciting key mechanisms of BPS interventions and understandings of how they operate. Similarities and divergences in the approaches taken by the different organisations were detailed via four themes. In this chapter, I explain how I used the findings of phase one to underpin, inform and design phase two. The chapter starts with a re-cap of my research question, phase two objectives, and the phase one findings and data sources used in the design process. I then outline how these findings and data sources were brought together and explain the design process itself.

7.2 DATA SOURCES AND OBJECTIVES

It was important I kept my overall research question and phase two objectives in mind during phase two design. My overall research question was:

- Engagement with the health inequalities agenda: How have third sector breastfeeding support organisations developed their services for delivery in areas of socio-economic deprivation?

My objectives for phase two were to understand:

- The context of the lives of women living in areas of socio-economic deprivation.
- The extent to which the support was acceptable to women.
- The interface between the third sector organisations and women’s lives, including how context-related issues impact upon the work of the organisations.

I used the findings of my qualitative meta-synthesis (Chapter 3), the findings from my phase one interviews (Chapter 6, Phase One Interview Findings), the grey literature identified (but not used) through my systematic literature search undertaken during my meta-synthesis (listed in appendix 5), and my own self-generated data (i.e. my reflective diary and research log described in chapter 5, section 5.5.3 and 5.5.4) as data sources to help me design phase two.

7.2.1 Data source use.

In this section I explain how I brought the phase one findings and data sources together through triangulation of data sources and the use of diagrams.

7.2.2 Triangulation of data sources

In qualitative research, data source triangulation is the use of multiple data sources to build up a comprehensive understanding of a phenomena (Patton, 1999). It has traditionally been used in quantitative research to validate findings (Flick, 2014). However, it may enable exploration of how the meaning of important issues within a qualitative study may change or stay the same across different times, space and persons (Flick, 2014). In this way it is valued as a method of enriching knowledge (Denzin, 1989; Stake, 1995), and helping to establish findings upon a '*more solid foundation'* (Flick, 2014, p.184). It therefore forms a useful strategy for theory building (Denzin, 1989). During data source triangulation important issues to be explored are chosen and analysed across several different sources of data (Stake, 1995). I reflected upon the main issues that had arisen from the meta-synthesis and the analysis of phase one interviews and drew up a list of the issues I considered most important (see table 15 below). These were explored via comparisons across all the data sources.

Table 15 Important issues to be triangulated

Issue	Questions to be asked across data sources
Context	To what extent was the context seen as important? How was the context described? What aspects of the context of socio-economic deprivation were recognised?
Mechanism of action of BPS	How was BPS seen to be working? Through individual support only or also through community change?
Access	Was access to services recognised as an issue?

The grey literature articles identified through undertaking my meta-synthesis searches (see appendix 5), were uploaded onto a MAXQDA file, read and compared to findings from the meta-synthesis and interviews. Memos were written, and codes created in relation to the main issues. I also remained flexible and expanded the scope of the issues if needed. I re-read my own reflective work and research log, comparing and making memos in relation to the key issues. I found this process highly productive as it helped me take a step back and gain a more holistic view of all my data.

In line with the anticipated theoretical benefits of data source triangulation, the process revealed additional information which ‘filled out’ issues I had already identified through the meta-synthesis and interviews analysis. For example, phase one analysis suggested that in organisation D there tended to be a philosophical emphasis on the individual, and a mother may be anticipated to play the role of ‘information manager’, seeking out and weighing up all available information (see chapter 6 section 6.6.2). While re-examining a piece of grey literature produced by organisation D, I noticed that the idea of identifying assets had been interpreted at the level of the individual rather than the community. For example, PSs were described as encouraging individual mothers to identify and make use of their assets such as family members who might be able to help them with other children, or a tongue tie clinic in the local area[11]. I felt the mother's role as 'asset maximiser' seemed similar to the role of 'information manager'. Both placed the mother as active and responsible. This enriched my understanding of what a more individually focussed view of supporting mothers with infant feeding might involve.

Yin (2014) suggests that, as part of the case study analysis process, conscious efforts need to be made to identify alternative interpretations. Incorporating the grey literature through triangulation helped me to do this. For example, in my initial analysis of interview data about being commissioned to deliver peer support I theorised that commissioners were powerful, and organisations must follow exactly what they wanted. During triangulation I noticed that there were differences between the way the organisations portrayed their work within the interview data, and within grey literature which served to 'advertise' their services to commissioners. I investigated these differences using constant comparisons. This analysis led me to adapt my initial theory. My revised theory proposed that although commissioners hold a powerful position, organisations retain their own internal theories about why and how they practice as they do. These may not always align with those of commissioners and may be seen as a form of 'resistance'. I theorised the potential for tension within an organisation between making sure the terms of a commission are fulfilled and working towards the organisation's own internal framework. This theorising also led me to think about knowledge transfer within the organisations, and how different types of knowledge are used and shared within the commissioning relationship.

---

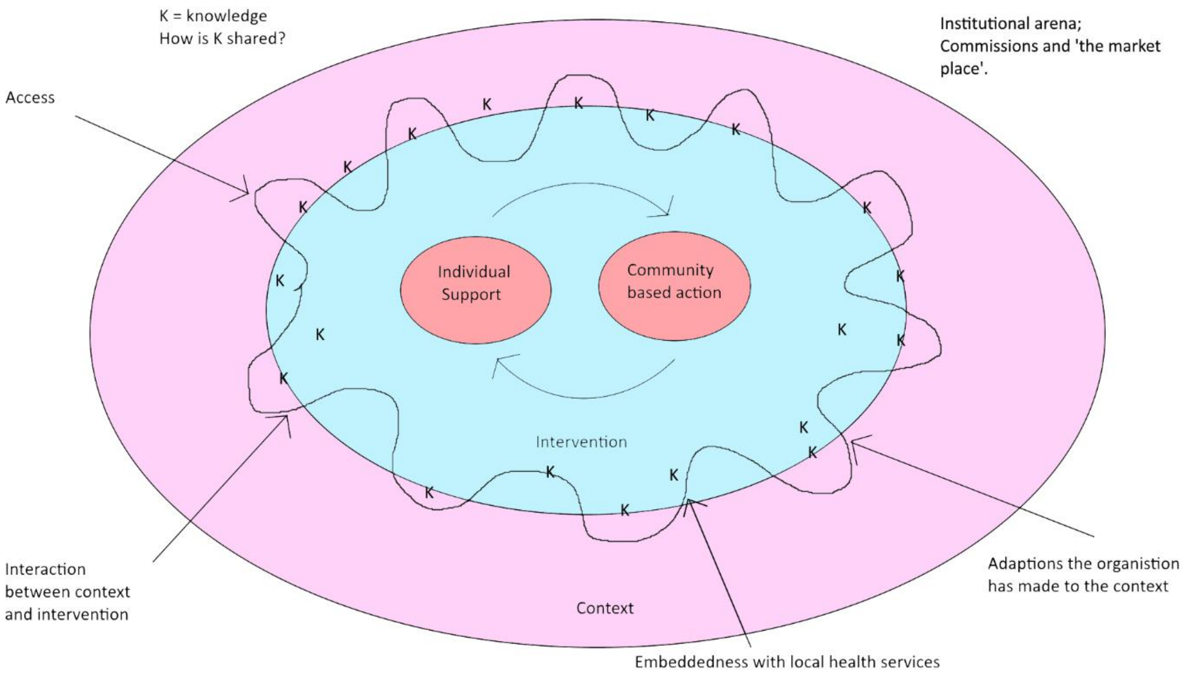
[11] I have not included the reference to this piece of grey literature as it would identify Organisation D.

Overall triangulation helped me to change my focus from organisational practices in the context of deprivation (meta-synthesis), and organisational understandings of their work and practices (phase one interviews), to a view of the organisations themselves as part of a wider political system. I suddenly saw a whole new ‘context’ that I had not properly considered before; that of the institutional context of the relationship between the organisations and commissioners. I realised that when I thought of these organisations and their BPS projects as part of this bigger system, the important issues I had identified through the meta-synthesis and the interviews seemed to be encompassed within the over-arching issue of how knowledge is used both within the organisations, and as part of the relationship between the organisations and commissioners. The organisations had developed services for a specific context, but this development must largely take place within the confines of their commissions. There may be two levels of adaption; overt commission led development, and internal, close to the ground adaptions that practitioners make or want to make. Hence the triangulation exercise resulted in my consideration of whether and how these two levels of adaption might inform each-other and what kinds of knowledge might be used as services develop. I decided to add understanding of knowledge transfer to my list of phase two objectives.

7.2.3 Diagramming

In order to represent how data source triangulation had moved my thinking on, I adapted the diagrams I had created (figures 2 and 3 presented at the end of chapter 6, Phase One Interview Findings). This resulted in figure 4; an adapted conceptual model to help me design phase two.

Figure 4 Adapted conceptual model of phase one



7.3 RESEARCH DESIGN

In this section I describe how learning from phase one was used to underpin and inform phase two design decisions. I explain how I selected the case study sites, and how decisions about methods, participants, and sampling were made.

7.3.1 Case selection

Stake (1995) and Yin (2014) state that case selection needs to link to the theoretical and empirical aims of the research. However, selection decisions also need to be realistic given the time and resources available. I felt it was reasonable for me to study two cases for phase two. The following practical considerations helped inform case selection; a) services must be delivered in a way that would provide opportunities for me to recruit adequate numbers of local women; b) health service and peer support staff at the site must be able and willing to accommodate me; c) only one of the two sites should have a travel time of over two and a half hours from my home.

As explained in Chapter 6 (Phase One Interview Findings), phase one outcomes suggested that two organisations (A and D) tended to focus more on individual level change, while the other two (B and C) incorporated both individual and community level change as part of their underpinning philosophies. This suggested to me that they might have different approaches to service development. The philosophies of organisations D and C contrasted the most, so I was keen to study a case from each of these two organisations in phase two. I asked both organisation D and organisation C to put forward possible cases for phase two in early summer 2017. Organisation C came back with several cases very quickly which I was able to explore. Organisation D took a long time to suggest a case, but eventually one was identified. Using my reflexive practices, I identified a personal preference for the dual individual and community approach of organisation C. I used this awareness to help me avoid bias as I prepared study literature.

Over the summer of 2017 I asked all four organisations to put forward possible study sites and investigated all of them thoroughly. Table sixteen below gives a list of characteristics I considered during this process and table 17 summarises the potential sites identified. Stake (1995 p.6) explains that when selecting cases '*opportunity to learn is of primary importance'*. Given that the type of generalisation I anticipated was theoretical and therefore not based on representativeness, case selection needed to be based not on choosing cases representative of each organisation, or examples of best practice, but upon the extent to which they might provide an opportunity for me to learn about how services had developed for the context. For example, services newly set up might be productive as development would be still happening or be fresh in people's minds. Likewise, services undergoing changes might also prove fruitful. As I considered each potential site, likelihood of useful learning opportunities formed another aspect to my decision making.

For every potential site, I spent time exploring the extent to which it met the core criteria. This meant many phone calls, emails and online research work for each potential site. Once I had gathered all the relevant information, I used a SWOT analysis (analysis of the strengths, weaknesses, opportunities and threats), discussions with my supervisors, and consideration of 'best fit' to make my final decision.

Table 16 Factors considered during SWOT analysis.

Practical/empirical considerations	**Theoretical considerations**
How far is the site from my home? (under 2.5hrs? over?)	What are the philosophical underpinnings of the organisation? (individual / community focus?)
Is their funding secure?	What are the organisations theoretical ideas about how BPS works? (i.e. individual change only, or community/societal change too?)
Is there potential to recruit adequate numbers of women? (i.e. would their systems enable this?).	Is the site in an area of deprivation? Does the service engage with women living in areas of deprivation?
Are organisation and health service staff able and willing to accommodate me?	Is there a good opportunity to learn? (i.e. is service newly set up? Undergoing changes?)

Table 17 Case selection/opportunities.

Org name	**Theoretical considerations from phase 1.**	**Date first approached**	**Sites offered as possible**	**Outcomes**
Org A	Individually focused. Less access to context as does not have any commissioned services	Late summer 2017	No sites offered. Did not offer to ask members if they had a suitable project.	No sites offered.
Org B	Community focused. Limited access to context as does not have any commissioned services.	Late summer 2017	Leadership asked members for possible sites. Three sites offered. One geographically inaccessible, one very small, third site entered my SWOT analysis.	All three sites rejected.
Org C	Community focussed. Theorises BPS to	Early summer 2017	Three sites offered. All three sites	One site chosen.

	work at individual and community/society levels. Runs commissioned services in areas of deprivation so has good access to the context.		entered my SWOT analysis.	
Org D	Individually focused. Theorises individual level change. Runs commissioned services in contexts of deprivation so has good access to context.	Early summer 2017	One site offered which entered my SWOT analysis.	One site chosen.

A brief outline of the two sites chosen for study is provided as follows:

Site one: The project was run by organisation D in an area of deprivation in the north of England. The service was commissioned by the local authority public health department to target mothers living in quintile one areas and young mothers under the age of 20 as part of a universal service of proactive post-natal peer support. In summer 2017 the service had been running for fifteen months. The staff felt confident in their funding for the coming two years. The Index of Multiple Deprivation is the official measure of deprivation in England (Department for Communities and Local Government (DCLG), 2015). It ranks every small area from 1 (most deprived) to 32,844 (least deprived) and small areas are split into five equal portions or quintiles (DCLG, 2015). Quintile 1 areas are those small areas falling into the first (most deprived) of these five portions (DCLG, 2015).

Site two: The project was run by organisation C in the south of England. The service was commissioned by the local authority public health department to target mothers living in particular geographic areas where breastfeeding rates were low. These areas were also areas of deprivation. This targeting was part of a universal service of post-natal peer support. In summer 2017 the service had been running for around a year but was undergoing changes; funding had been reduced necessitating changes to the way the services were delivered, however, staff were confident that the new lower level funding would continue for at least two years.

7.3.2 Use of theory

Before I could move on to designing the exact methods and materials for phase two, I needed to decide how I would make use of theory. I knew that I wanted to generate theory from my study and for theoretical ideas to arise from data. I was keen to continue with the inductive approach of Stake (1995). However, Stake (1995) also recognises that theoretical ideas from outside inevitably play a part in any case study, and no study can be completely inductive. Some case studies make use of external theory to guide them (for example, Aherns and Chapman, 2007). I therefore considered whether to adopt a formal theory at this point. After consideration and discussion with my supervisors, I decided to discount using an external theoretical framework at this point. I resolved to continue inductively, but to be transparent and identify when I was influenced by and made links to existing theories.

7.3.3 Methods and sampling decisions.

Flick (2014) explains that research methods should be appropriate for the subject and research question being studied and should suit the anticipated participants. The data generated must also be the sort of data desired for the study, and the method must fit with the ontological, epistemological, and theoretical position of the study as a whole (Flick, 2014). I kept all these considerations in mind when I made decisions about the methods I would use in phase two.

My objectives for phase two were to understand:

- The context of the lives of women living in areas of socio-economic deprivation.
- The extent to which the support was acceptable to women
- The interface between the third sector organisations and women's lives, including how context-related issues impact upon the work of the organisations.
- How knowledge is shared and transferred.

In order to choose appropriate methods for phase two I used the guidelines suggested by Miles, Huberman and Saldana (2014); using the adapted phase one conceptual model shown above (figure 4) in combination with my phase two objectives, I generated lots of possible questions associated with each research objective. I then considered the questions and reduced their number. Next, I thought about the type of knowledge required to address each question which in turn enabled me to consider appropriate methods and participants. Linking the objectives via question generation helped me to see more clearly the kinds of knowledge I was looking for, the sorts of methods that might deliver it, and the potential participant groups most likely to know about these things. Please see table 18 below.

Table 18 Linking objectives to research design decisions

Objectives	Questions. Wanting to understand…	Type of knowledge	Possible methods that might provide this	Participants who might know about this/have experience of this
To understand the background of the site	The broad social and industrial history and background of the place.	Background	Informal site visits. Local history books and local government reports.	N/A
Understand as far as possible, the lives of the women living in the context.	Women's lived experiences (of feeding, other things going on, inter-personal relationships, community context)	Experiential	Participant interviews	Local women who have initiated breastfeeding and local women who have not. Health professionals and PSs.
Understand how the	How individual			Mothers receiving the services (those

intervention interacts with the context including what aspects of context are important and why.	peer support may work. Was homophily between PSs and mothers important? How community peer support may work. How access to peer support may work. How practices have developed over time.	Experiential Procedural	Participant interviews Demographic data	who fully engaged, and those who partially engaged), PSs delivering the services, mothers who did not receive the services. Peer support co-ordinators/managers. Health professionals, including infant feeding co-ordinator.
Understand how knowledge about the	How PSs learn about the context and	Experiential	Participant interviews	PSs and their co-ordinator/managers. Commissioners.

context and organisational adaptions is shared and transferred.	women's lives. How this knowledge is communicated and used by the organisation.	Procedural and experiential	Participant observations	Peer support supervision sessions

The process described above helped me decide to collect most of my data via semi-structured participant interviews, and to use participant observation of peer support supervision sessions to help me better understand knowledge sharing and service developments. Table 18 (above) also helped me design my observation and interview schedules (please see appendix 12), however by using open questions within the interview schedules I planned to leave opportunities for emic ideas to arise (Stake, 1998). Because I wanted to develop theoretical ideas, I pursued theoretical and purposive sampling, seeking to interview those who would inform me about issues I theorised were important (Charmaz, 2006). Table 18 above illustrates the theoretical links between the participant roles and issues of importance in the study. When constructing table 18, in addition to using theoretical insights, I also used my own reflective practice. I realised it was important for me to interview mothers with a range of infant feeding experiences, those who had engaged with the services, and those who had not. This seemed especially important when I reflected upon the voices which had informed phase one. For example, there were no views from women who had *not* engaged with BPS services within the literature examined for my meta-synthesis. These women may have different experiences and views which would be valuable. I also wanted to gather demographic data about mother and peer supporter participants to explore whether homophily[12] might be important in their relationships. Both the meta-synthesis and the phase one interviews findings suggested that embeddedness within local health services might be a key issue to explore in phase two, therefore I knew it was important for me to include local health professionals as participants.

In this chapter I have provided an account of how the findings of phase one were used to underpin, inform and design phase two. I have outlined both how data sources were brought together, and the design process itself. In the next chapter I provide a rationale and explanation of the methods used in phase two data collection.

---

[12] Homophily refers to the tendency for people to associate more with people who are similar to them as in the phrase 'birds of a feather flock together'(McPhereson, Smith-Lovin, & Cook, 2001). It has been found to be important in the formation of relationships and social networks (McPhereson et al. 2001), so was a relevant concept for my study.

8.0 CHAPTER 8: PHASE TWO METHODS

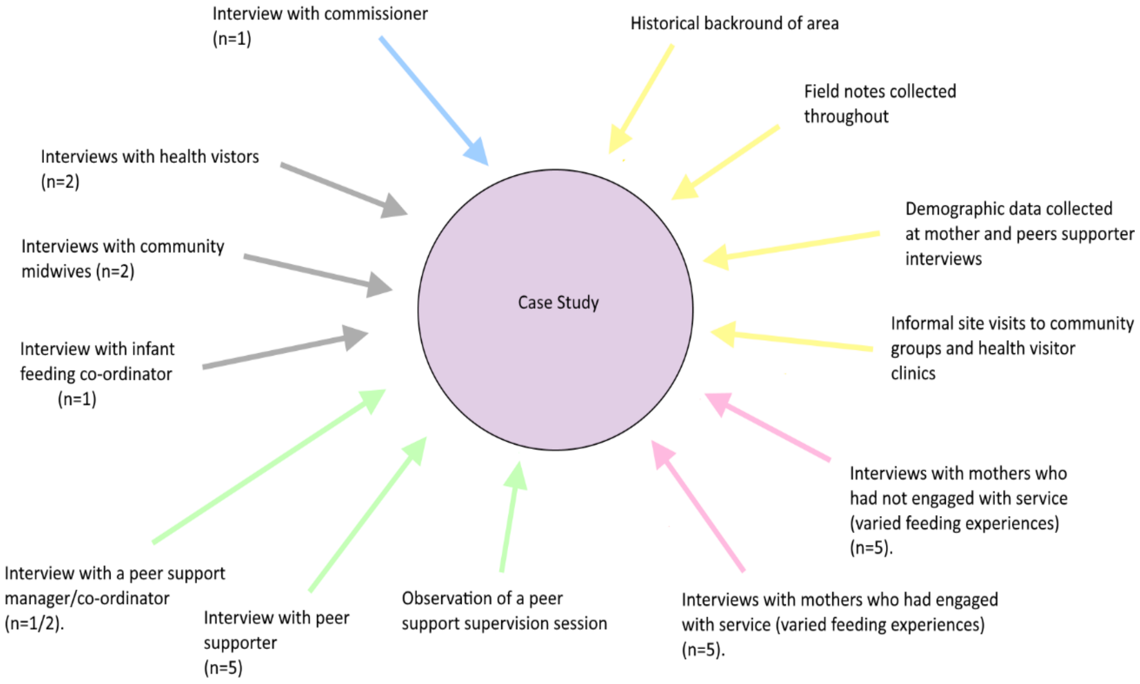
8.1 INTRODUCTION

In chapter 7, I explained how the findings of phase one were used to underpin, inform and design phase two. In this chapter, I provide an account of the methods I used in phase two. First, I use a diagram to illustrate the research activities and participants that comprised phase two. I confirm research was conducted ethically and reflexively throughout. I explain my inclusion and exclusion criteria and the study information I provided. I justify and explain the research activities of making informal site visits, conducting an observation and undertaking individual semi-structured interviews including how participants were recruited and how activities were conducted. Data analysis and member check interviews are then outlined.

8.2 RESEARCH ACTIVITES AND PARTICIPANTS

Figure 5 below depicts the planned data collection activities and participant groups at each of the two phase two study sites.

Figure 5 Research Activities and Participants



8.2.1 Ethical considerations

Gaining ethical permission took longer than expected. A few weeks before I received permission, Organisation D, which was running site 1, learned that their contract had been awarded to another third sector organisation. This meant they would shortly cease providing peer support in the area. I therefore focused on data collection at site 1 first. For full details of the way that ethical issues and reflexivity were attended to, please refer to chapter 5 sections 3 and 5.5.4 respectively.

8.3 INCLUSION AND EXCLUSION CRITERIA

I did not have funding available for interpreters so had to exclude mothers who could not speak English. I also excluded mothers aged under eighteen for consent purposes. In addition, mother participants had to live within the targeted areas or be part of target groups at each site. The project at site one targeted mothers living in quintile 1 postcode areas and young mothers under the age of twenty (for explanation of quintile one areas please see chapter 7, section 7.3.1). Therefore, at site one the mother's address had to be in a quintile one postcode area, and / or they must be aged eighteen or nineteen. Theoretically I could have recruited an eighteen-year-old mother who did not live in an area of deprivation. However, I did not meet any mothers aged under twenty (a senior peer supporter explained that numbers of mothers under twenty in the service area were currently very low), and all mother participants lived within quintile one areas. The project at site two targeted mothers living within defined geographical areas, therefore, at site two mother participants had to live within these areas. All community health professional and peer supporter participants must work within an area targeted by their respective BPS service.

8.4 STUDY INFORMATION SHEETS AND COVERING LETTERS

I tried to minimise the number of different study information sheets as far as possible, however five study information sheets were required (see appendix 8), three information sheets concerned semi-structured interviews, and two concerned observation of a peer support supervision session. Please see table 19 below.

Table 19 Study information sheets

Study information sheet recipient	**Research activity proposed**
Mothers (those who had engaged with the service and those who had not)	Semi-structured individual interviews
Stakeholders (community health professionals, Infant Feeding Co-ordinators, Commissioners, Managers/key strategists/peer support co-ordinators within each third sector organisation)	Semi-structured individual interviews
PSs (interviews)	Semi-structured individual interviews.
PSs (observation)	Observation of a peer support supervision session.
Supervisor of peer support supervision session	Observation of a peer support supervision session the supervisor is due to supervise

8.5 INFORMAL VISITS TO STUDY SITES

To familiarise myself and gather background and historical information about the study areas, I made informal visits (and documented field notes) to both sites. I found and read material about the social and industrial history of each site. As well as providing an opportunity to chat to mothers, these informal visits also provided an opportunity to recruit potential participants. My method of recruiting potential mother participants is described in section 8.7.2 below.

8.6 OBSERVATION

This section details my rationale for undertaking the observations, how I recruited for this activity and how I collected my observation data.

8.6.1 Observation rationale

I wanted to observe some peer support supervision sessions as this might provide an opportunity to observe knowledge sharing and decision-making taking place. Observation has been criticised as being subjective because two different observers of a scene would notice and record different things, and the presence of the observer inevitably impacts upon the observed (Merriam, 1998). However, I did not consider this problematic because my methods included systematic attempts to try to identify and account for my impact on the data (please see chapter 5, section 5.5 for my explanation of trustworthiness, and section 5.5.4 for my account of my reflective practices). An observation offers the opportunity of reporting on a first-hand encounter with the phenomena under study (Merriam, 1998). It involves a planned, systematic approach utilising skills such as recording field notes, separating detail from trivia, and descriptive writing (Merriam, 1998). I thought that undertaking an observation coupled with individual interviews with both PSs and their supervisor might prove useful in enabling me to view supervision from several angles. I aimed to undertake the observations first, and then follow them with interviews. I hoped this might enable me to understand individual perspectives on thoughts and discussions that took place during the observation. I intended to observe one peer support supervision session at each of the two case study sites. I anticipated this would involve up to 10 attendees and one supervisor. However, the service at site 1 was about to cease when my data collection commenced, meaning no further supervision sessions were planned. I was therefore only able to observe at site 2. Whilst observing several sessions may have afforded greater insights, I did not want to over-burden potential participants, had to balance the use of my time in the field, and considered one session adequate to gain understanding of the kinds of interactions taking place.

8.6.2 Observation recruitment

I sent the session supervisor an information sheet and consent form (see appendices 8 and 9 respectively) via email at least two weeks before the supervision date. This explained my proposed observation and encouraged her to contact me if she had any questions. The supervisor was happy for the observation to take place. A letter of introduction, information sheet and consent form (see appendices 10, 8, and 9 respectively) was sent via email to all relevant PSs at least one week before the planned session. The information sheet asked them to contact me if there were any issues and it explained that the observation would only go ahead if all agreed. No PSs contacted me before the date, all nine attendees (eight PSs and their supervisor) had read the information sheet and agreed to be observed, and the session lasted an hour and a half.

8.6.3 Observation data collection

Before the observation date I practiced my observation skills within my own family setting by observing interactions between my children and husband over the course of half an hour (Merriam, 1998). This gave me some experience of trying to write quickly and observe carefully. I prepared an observation schedule (see appendix 12) which outlined the kinds of issues I would be looking for during the observation. However, I remained open to observing new phenomena I had not previously considered. Mason (1996) suggests there are three ways of ‘reading’ or analysing observation data; literally, interpretively, and reflexively. I planned to read my data interpretively, looking for the meaning within it. Because I accepted that I co-constructed the data with my participants, I also planned to read the data reflexively, looking for how I had impacted upon it and the participants. I made sure I recorded my own feelings, thoughts, initial impressions and interpretations as well as what I saw. In order to facilitate these desired 'readings' of the data, I conducted the observation and recorded my data in the following ways; I arrived at the venue early so I could sketch the room (Merriam, 1998) and describe the setting (Stake, 1995). I made a diagram of the room including where the participants, myself, and the furniture and doorways were situated. I sat in an unobtrusive position, but somewhere where I could see and hear all participants. I conducted the observation as per the ethical considerations outlined in chapter 5, section 3 (i.e. informed consent, confidentiality and ethical data storage was adhered to throughout). I recorded what was said and done by whom and left a wide page margin. This allowed me to use a different coloured pen to add my own thoughts and impressions (Merriam, 1998). I also left plenty of space between observations to enable clarity (Merriam, 1998). I tried to maintain my attention at all times, looked for key words in people's remarks, and until I had recorded additional field notes at the end of the observation, I tried to avoid talking to anyone (Taylor & Bodgen, 1984).

8.7 INDIVIDUAL SEMI-STRUCTURED INTERVIEWS

In this section, I outline my rationale for undertaking semi-structured interviews, how I recruited participants for this activity, and how I undertook this data collection.

8.7.1 Individual interviews rationale

I provide a full rationale for undertaking of semi-structured interviews in chapter 5 section 5.4.1. I prepared to undertake my phase two interviews by practicing listening to a friend uninterrupted for five minutes (Simons, 2009), and reading one of my previous interview transcripts to look for places where I could have probed further (Merriam, 1998).

8.7.2 Individual semi-structured interview recruitment

Figure 5 above depicts the different participant groups (and number of participants in each group) I planned to recruit for semi-structured interviews. As my aim was to generate a holistic view of each case, I considered it important to include as many views as possible on the topic (Beitin, 2012). I recruited a wide range of participant groups, and within each group I used purposive sampling to recruit participants with different experiences. Using this approach, I felt that interviewing five mothers who had received peer support and five who had not, five PSs and four community health professionals from each site would enable an adequate range of views to be expressed. For example, I sought women participants with varied infant feeding experiences, and at site two where target areas spanned urban and rural communities, I sought health professionals working in both environments. While I recognise that participant perspectives may not be representative, I felt confident this sampling strategy would afford an in-depth perspective of each case. Based on previous experience of interviewing PSs, I anticipated they may prefer to be interviewed in pairs or small groups rather than on their own. Therefore, this option was offered in the information sheet and an appropriate consent form was prepared. None of the nine peer supporter participants asked for this option however, and all were interviewed as individuals.

Each participant group was recruited in the following way:

<u>Community health professionals (health visiting and midwifery team members), and County infant feeding co-ordinators:</u> The County infant feeding co-ordinator was asked to forward an invitation email to all community health professionals working within target areas, together with a covering letter, participant information sheet, and a consent

form (see appendices 10, 8 and 9 respectively). Potential participants were asked to read the information sheet and consent form and reply direct to me within two weeks if they wanted to participate.

Mothers who had not engaged with the intervention: I visited community-based health visitor clinics and Children's Centres located within the target areas. Health visiting team members and / or Children's Centre staff members introduced the study to the mothers attending, and if a mother was interested, directed her towards me. I provided mothers with a verbal outline of the study and a study information pack (comprising a covering letter, information sheet, contact form (see appendices 10, 8 and 11 respectively), and stamped addressed envelope). I explained (verbally and in the information sheet) that my project was a small study restricted in size to selected areas, that I needed to know their postcode to establish whether they lived in the target area, and that I wanted to speak to mothers with a range of ages. The mother's postcode and age could be indicated on the contact form. The information sheet also explained that if more mothers agreed to participate than intended, an interview may not be organised. In these occasions (and if they lived outside the selected study area), I would send a letter to thank them and give them the option to receive the key findings from the study (this excessive participant letter can be seen in appendix 15). This happened on several occasions at site two.

If mothers were interested in participating, they filled in the contact form and gave/posted it to me. I then called mothers who lived in target areas at least 24hrs later to discuss the study further/answer any questions and if the mother was still interested, arranged an interview.

At site one, all the mothers I met and recruited at a health visitor clinic had postcodes within the target area, and all were aged over nineteen. Although I planned to use health visitor clinics as the route to recruit non-engaged women only, I sought to recruit mothers with a range of engagement experiences. At site 1 while at a health visitor clinic, I recruited some mothers who had minimally engaged with the service alongside those who had not engaged. At site two, I did not meet any mothers who had engaged with the service at health visitor clinics. Appendix 16 shows how each participant was recruited.

Mothers who had engaged with the intervention: I knew that patterns of engagement with BPS services are such that although some mothers engage fully and take up support, many engage at the beginning, but their involvement ebbs quickly away. I therefore established a number of recruitment strategies to enable mothers who had varying levels of engagement to participate. I set up four possible routes to recruitment. First, when I made informal visits to community baby/breastfeeding groups in order to familiarise myself with the study sites, I gave mothers attending study information packs as described above. This proved a useful recruiting channel at both sites. Second, it was intended that PSs would give/send study information to all mothers when they first made contact. At site one, the first contact between a mother and a peer supporter took place when a peer supporter phoned the mother when her baby was around 48 hrs old. At site two the first contact between a peer supporter and a mother could take place at an ante-natal class, on a post-natal ward, or at a community group. If a mother was interested in participating, she would then fill out a contact form (see appendix 11) and post it to me. I would then call her and arrange an interview when her baby was around 4-6 weeks old.

Thirdly, PSs gave mothers study information at subsequent contacts, and fourthly, snow-balling methods were used; I asked mothers who had been interviewed to identify any other mothers in their social networks who may be interested in participating. On these occasions, I asked the mother to share the information sheet, and to ask her friend to make direct contact with me if they were interested. This proved a useful recruiting technique at both sites.

As mentioned above, at site one, by the time my ethical permissions came through the peer support service was about to cease. Hence PSs issued study information to mothers they were currently supporting. Because I had been able to recruit mothers who had minimally engaged via snowball sampling and at health visitor clinics, overall, I was able to recruit mothers with a good range of engagement experiences. When I commenced data collection at site two, PSs were not due to attend any ante-natal classes for some weeks. Consequently, the mother's babies would not be born until after the end of my data collection period. This meant I was not able to recruit any mothers antenatally as I had hoped. Although PSs who supported women in the early postnatal period agreed to give study information to mothers they were already supporting, none of the resulting five interested mothers lived within target areas. All the mothers I met and recruited via my visits to health visitor clinics and non-organisation C community baby groups, and via snowball sampling, had not engaged with the service. This meant that I recruited all five engaged mothers via organisation C's own baby/ breastfeeding groups. These mothers did have a range of engagement experiences; however, they were not as broad as at site one (appendix 16 shows the recruitment methods for each participant).

PSs: An invitation email, together with a covering letter, information sheets and a consent form (see appendices 10, 8 and 9 respectively) was sent by the peer support co-ordinator to all PSs who had experience of working within target areas. Potential participants were asked to read the information sheet and consent form and reply direct to me within two weeks if they wanted to participate.

Key stakeholders (commissioner, peer support co-ordinator, peer support supervisor/manager): I sent an invitation email, together with a covering letter, information sheet and a consent form (see appendices 10, 8 and 9 respectively) to all potential participants. They were asked to read the information sheet and consent form and reply direct to me within two weeks if they wanted to participate.

8.7.3 Conducting semi-structured interviews

During the interviews I wanted to establish rapport with participants so that they would feel at ease and express themselves (Simons, 2009). To do this, I used open questions and active listening practices such as encouragement, reflecting back what a participant had said, making eye contact, refraining from asking questions too early, and trying to '*hear the meaning'* in a participant's account (Simons, 2009, p.47). Beyond initial rapport, I wanted to practice responsive interviewing because it results in the collection of full data with depth containing compelling thematic material (Rubin & Rubin, 2005). To do this, I sought to create an atmosphere of warmth and friendliness, where flexible questions with little confrontation could enable trust between myself and the participant to develop (Rubin and Rubin, 2005). This also acted as an attempt to equalise the power relationship between myself and the participants (Simon, 2009). I found the stage directions for interviewing provided by Hermanns (2004) useful to help me think about the practical things I could do to aid the creation of this environment. Hermanns (2004) imagines the interviewer facilitating the evolution of a drama. ‘Stage directions’ include making sure the interviewee understands the scope of the interview and speaking first using normal speech when the audio recorder is turned on in order to demonstrate a relaxed atmosphere. Thinking of the interview in this way helped me see both myself and the interviewee as actors, both contributing. It was also helpful to think through potential pitfalls before-hand i.e. the danger of agreeing too much with an interviewee and thereby denying them space to reveal different sides of themselves. During the interview I tried to focus on the participant rather than worrying about theoretical concepts (Flick, 2014). I tried to be ready to probe when there was a sense that a participant may have more information to give (Flick, 2014). For example, I tried to use phrases such as ‘can you explain that in a bit more detail?’ ‘what do you mean by…?’ ‘could you give me an example of that…?’ (Flick, 2014). In light of the constructionist epistemology of qualitative interviewing, where participants are seen as ‘*meaning makers’* (Warren, 2011, p.2) and an interview as ‘*an opportunity for active dialogue, co-constructed meanings and collaborative learning’* (Simons, 2009, p.44), I recognised the importance of identifying my own influence upon the co-constructed interview data, and maintained reflective practices (see chapter 5, section 5.5.4 and appendix 14) as interviews progressed.

Semi-structured interview schedules were used (see appendix 12). I asked each participant group about their experiences of the services and the following key issues were explored; with mother participants, their experiences of engaging or not engaging with the services; for mothers who had engaged, their experiences of support including communication strategies; for professional participants, their experiences of service development and adaptions, strategies to engage with the target population, decision-making processes, and inter-professional collaboration. Most interviews took around 20

- 45 minutes to complete. All interviews were digitally recorded following consent (see chapter 5, section 5.3.1 and 5.3.4).

8.8 DATA ANALYSIS

My interpretive approach to the study required me to be open about my role in creating meaning and interpretation through data analysis (Stake, 1995). Roulston (2014) explains that the plan for data analysis is dependent upon the research subject, the research question, and the desired outcomes of the research. I knew that I wanted to understand how third sector organisations have developed their services for areas of deprivation, and that I wanted to develop theories to explain this development. I knew I was using a case study approach to do this and that my methods would draw on the experiences of a number of different stakeholders in order to build a holistic picture of service development. I wanted to build theories about how and why services had developed. By using the data from the various stakeholders, my analysis plan needed to allow me to notice and analyse patterns across the data set, and through doing this, enable me to examine how key ideas might relate to each-other. Roulston (2014) indicates that comparisons are useful as they can enable pattern identification. I knew that I wanted to try to build theory through my analysis (see chapter 4, section 4.5). My methods and research aims both lent themselves to grounded theory analysis techniques. The constant comparisons involved enable the ‘testing’ of ideas and theories in order to evaluate the extent to which they are supported by the data. I therefore decided to continue using the analysis plan outlined by Eisenhardt as described in Chapter 5, section 5.4.6. My explanation of how I conducted phase one data analysis (also provided in chapter 5, section 5.4.6) also reflects how I undertook phase two analysis. However, below I provide an example of how data analysis was informed by my reflexive practice.

As phase two data analysis progressed, I continued to reflect upon my decisions. From undertaking my subjectivity audit (see chapter 5, section 5.5.4 and appendix 14) I knew that I believed in a social model of health. I also knew that it was important I try to identify when and how I might be affecting data analysis. The memo below captures the moment when I first came up with the idea that more socially disadvantaged mothers might be less likely to gain access to peer support because of the effect of aspects of their contexts:

> 1.11.18 Memo: *Woke up this morning thinking about what I had told my friend about my study yesterday – I had told her 'It's like a leaky pipe – at every access point (or joint in the pipe) more socially disadvantaged women are more likely to leak out and not get support than more socially advantaged women'. Ok, so I believe this, why? What evidence do I have for this? What evidence do I have that disproves this theory? I need to analyse my data to explore this idea*

When this idea arose, the self- knowledge I had gained from my reflexivity audit helped prime me to realise this idea could be arising from my own biases. It prompted me to start looking for alternative explanations. I carefully considered my data trying to employ opposing viewpoints. After doing this I concluded that my theory was reasonable. This provides an example of when my reflexive practices were proved especially useful during data analysis.

8.9 MEMBER CHECK

My rationale for undertaking member check interviews is given in chapter 5, section 5.4.7. Member check interviews were conducted in January 2019. As per phase one, I conducted these via telephone. However, synopses of the main themes were provided verbally rather than in written form. Table 20 below details the member check participants. Almost all participants had initially said they would like to be contacted for a second time for a member check interview. However, many did not respond when I tried to contact them. Those who did take part in the member check interviews agreed with the overall findings. Several participants mentioned that it was important to note that their own service was affected by changes to the way other services were delivered such as children’s centres and health visiting. This was an issue that had arisen during data analysis, but perhaps had not been made explicit enough in the findings. Hence, I adjusted my findings to make this clear.

Table 20 Phase Two Member Check Participants

Participant group (n=number of participants in original interviews)	Number of member check participants	
	Site 1	Site 2
Non-engaged mothers (n=9)	2	1
Engaged mothers (n=10)	2	3
PSs (n=9)	2	4
Peer support managers (n=2)		1
Health professionals (n=7)	1 (IFC)	
Commissioners (n=2)	1	
Total	8	9

In this chapter I have outlined the methods I used in phase two. In the following chapter I provide an account of the findings.

9.0 CHAPTER 9: PHASE TWO FINDINGS

9.1 INTRODUCTION

In chapter 8, I provided an account of the methods I used during phase two research activities. In this chapter I introduce the phase two case study sites, explain data collection, present participant characteristics, and outline the theoretical framework I have used to structure my findings. I then present one over-arching theme and four main themes to explain service development. Theme one, is the over-arching theme of *'the transcending influence of society'.* The four main themes are *'the role', 'access', 'embedding'* and *'service management'.*

9.2 THE CASE STUDY SITES

Site 1 is a post-industrial urban part of Northern England. It has an established black and minority ethnic community that makes up between 10-20% of the population with Asian and Asian British people of Pakistani and Bangladeshi origin the most common group. It has a general fertility rate (number of live births per 1000 women aged 15–44) of between 51.2 and 71.2, but overall the rate is above the England average of 63.7. The area comprises large areas of deprivation. Four of the five local authorities are in the fifth most deprived in the country. It has a long history of engagement with the UNICEF UK Baby Friendly Initiative (BFI), with most services BFI accredited. In early 2016 organisation D won a commission to deliver universal postnatal peer support with targeted support for mothers living in quintile one areas and young mothers under twenty. The service was designed to be intensive; PSs were present on the hospital postnatal ward and on the neo-natal unit most days at most times of the year, all women discharged breastfeeding received a telephone phone call at 48hrs. Following this, three PSs worked as the home visit team. They acted proactively, providing a home visit and ongoing text, phone, and home visit support as needed for six weeks including invitation to online and community groups and access to online information (ongoing access to these). It was intended that women forming part of target groups (i.e. young mothers under the age of twenty, and mothers living in quintile one postcodes) would receive more of the peer support resource. Women could also be signposted or referred into the service by health professionals or could self-refer. The core service was provided by paid PSs. Volunteer PSs supplemented this by providing support at the hospital, working alongside a paid peer supporter who made the phone calls at 48hrs, and at community groups. The paid peer supporter who made 48hr phone calls and the paid home visit PSs also volunteered at community groups. As explained in chapter 8 (section 8.2.1), in spring 2018, a few weeks before I received ethical clearance, the contract was re-tendered and awarded to another third sector organisation. Three weeks after ethical permission was gained, organisation D handed over to the new provider. Hence, data collection was rapid and all but one interview was conducted via telephone. I made two, two-day informal visits to recruit, visiting two community support groups and a health visitor clinic.

Site 2 is in Southern England. It is an affluent area in the least deprived UK quintile for overall deprivation for unitary and county authorities. Consisting a mix of urban and rural communities, it has a small black and minority ethnic population, a lower than average general fertility rate of 59.6, and there are pockets of urban and rural deprivation. Hospital and community health services are BFI accredited. Organisation C has been providing peer support at site 2 since 2012. In autumn 2017 it won the latest contract to provide a universal service with targeted support for women living in specific areas of deprivation with low breastfeeding rates. These areas were identified by the first three or four characters of their postcodes. The service was not designed to be intensive. The universal service offered to all women including those living outside target areas consisted of reactive peer support whereby women could call or text local PSs or organisation C’s national telephone helpline or online forums, or visit local community based and online support groups. On top of this universal offer, women living in target areas who signed up to the service received proactive text support for the first six weeks. PSs could also telephone these mothers if needed, but they only made home visits in extreme cases. Women living in target areas could sign up for this proactive post-natal text support when meeting PSs at an ante-natal class. They could also be signposted towards the text service by a health professional or could self-refer. If women living outside target areas signed up at ante natal classes, it was intended that they should receive one encouraging text message detailing how to access peer support. Although one peer supporter made a short weekly visit to the hospital postnatal ward to sign up target women to the texting service, the vast majority of women did not meet her in hospital and overall uptake was such that PSs did not meet most women initiating breastfeeding. Three PSs provided the early text support. These PSs were paid for a small number of hours per week, however, they provided support for several hours per week on top of this as volunteers, and two of the three also volunteered at community groups in their areas as well. Volunteer PSs attended antenatal classes where target women were signed up to the text support service and also worked in community groups. Most of the service was provided by voluntary peer support. Table 21 below summarises the key features of each site.

Table 21 Key features of each case study site

	Site	
Features	1	2
Location in England	North	South
Urban/Rural	Urban	Urban and Rural
Deprivation	High number of areas of deprivation	Low number of areas of deprivation
BME population	High	Low
Birth rate	Higher than England average	Lower than England average
BFI accreditation of health services	Most	All
Peer Support service intensity	High	Low
Peer supporter presence in hospital	Present	Not present

9.3 DATA COLLECTION

Data collection took place in spring and summer 2018. At each site I made informal site visits to community groups and health visitor clinics (see chapter 8, section 8.5). At site one I visited two community groups and one health visitor clinic. At site 2 I visited five community groups and two health visitor clinics. At site one I was not able to observe a supervision session because, as explained above, by the time my ethical permissions came through, the service was about to cease, and no further supervision sessions were planned. At site two I was able to observe a supervision session which took place at a community centre. However, because it took some time to arrange, I had already undertaken three (of my five) individual interviews with PSs before it took place, and only one peer supporter present at the supervision subsequently undertook an individual interview. Individual interviews took place either over the telephone or at a suitable public community venue such as a children's centre, neighbourhood centre, library or other community venue (as preferred by the potential participant) during office hours. I adhered to my lone worker policy throughout (see appendix 17). Seven of the forty interviews were conducted face to face, the rest via telephone. A table showing how each participant was recruited and their interview mode (face to face or telephone) is given in appendix 16. Table 22 below shows interview participant roles.

Table 22 Interview participant roles

Participant Role and the intended number per site	Number interviewed	
	Site 1	Site 2
Mothers who had not engaged with service (n=5)	5	4
Mothers who had engaged with service (n=5)	5	5
Peer supporter (n=5)	4	5
Peer support service manager/peer support co-ordinator (n=1/2)	1	2
Community midwives (n=2)	1	0
Health visitors (n=2)	2	2
Infant Feeding Co-ordinator (n=1)	1	1

Commissioner (n=1)	1	1
Total	20	20

9.3.1 Demographic characteristics of mother and peer supporter participants

As discussed in chapters five (section 5.5.4) and seven (section 7.3.3), I asked all mother participants and PSs to complete a demographics form. Resulting data enabled me to assess the similarities (or differences) in socio-demographics between the PSs and the mothers they support (although no individual pairing of PSs and mothers was explored). The following demographic information was recorded; ethnicity, educational attainment, postcode, infant feeding history and current practice, marital status, work status including number of hours and type of job, and age. Please see table 23 below. Other participant groups were asked about their job role and length of time in post. A table showing this information is provided in appendix 18.

Table 23 Demographic characteristics of mother and peer supporter participants

Site 1

Participant role	Participant code	Age	Parity	Postcode IMD Quintile	Highest qualification	Ethnicity	Marital Status	Employment status	Infant feeding history
Peer supporter (PS)	S1PS1	33	2	2	Degree (D)	White British (WB)	Married (M)	27hrs/week. Most paid, some voluntary	Exclusive breastfeeding, some mixed feeding until 14 months.
PS	S1PS2	40	4	2	D	WB	M	Employed 31hrs/week. Most paid, some voluntary.	Exclusive breastfeeding to 6 months all. Continued breastfeeding until 15-30 months.

PS	S1PS3	30	1	3	D	WB	Single (S)	Paid -casual at café. Volunteers for 4hrs/week.	Mixed fed till 7 months, now breastfeeding with solids at 24 months.
PS	S1PS4	49	3	5	D	WB	M	21hrs paid, 3 voluntary /week	Breastfed for 6-12 months.
Mother who had engaged with service. Engaged Mother (EM)	S1EM1	34	5	1	D	WB	Separated	Nursery Nurse 40hrs/week. Maternity leave now.	Range from mixed feeding for 3weeks to full breastfeeding at 6 months with current baby.
EM	S1EM3	35	2	1	D	White European	M	Factory packer.	Breastfed for 3 years, now breastfeeding at 1 month.

								20hrs/week. Maternity leave now	
EM	S1EM4	29	2	1	A Levels	WB	M	Nursery teacher. Maternity leave now.	First child: 5 months exclusive breastfeeding. Continued breastfeeding until 10 months. Now: exclusive breastfeeding at 1 month.
EM	S1EM5	28	3	1	College (C)	WB	S	No employment outside home	First 2 children bottle-fed. Several weeks breastfeeding 3rd child.
EM	S1EM6	23	1	1	C	Asian British - Pakistani	M	Self-employed 2hrs/week now.	Expressed for 3 months.
Mother who had not engaged	S1NEM1	25	2	1	C	WB	M	Nursery worker 32.5hrs/week.	Bottle-fed from birth.

with the service. Non-engaged Mother (NEM)								Maternity leave now.	
NEM	S1NEM2	23	1	1	A Levels	Asian British - Pakistani	M	Nursery Worker 40hrs/week. Maternity leave now	Breastfed for 2/3 days.
NEM	S1NEM3	39	6	1	Some High School.	WB	Separated	No employment outside home.	Bottle-fed from birth all babies
NEM	S1NEM4	31	2	1	C	WB	S	Nursery Worker 40hrs/week.	Breastfed 1st child for 7 months and 2nd child for 4 months.

NEM	S1NEM5	21	1	1	C	WB	Partner	Nursery worker 40hrs/ week. Maternity leave now.	First breastfeed only

Site 2

Participant Role	Participant Code	Age	Parity	Postcode IMD Quintile	Highest Qualification	Ethnicity	Marital Status	Employment Status	Infant Feeding History
Peer supporter (PS)	S2PS1	43	2	Quintile 4 (in target area).	Some college (NVQ)	WB	Married (M)	Paid for Org C 3hrs, voluntary 7 hrs /week. Also, 3hrs/week voluntary breastfeeding support for another third	Exclusive breastfeeding for 6 months then continued till 2.5 years.

								sector organisation.	
PS	S2PS2	38	4	Quintile 3 (in target area).	D (PhD)	WB	M	3.5hrs/week for Org C. Plus varied extra voluntary.	First baby expressed for 4 months (premature), other children breastfed till 2.5, 3.5 years. Child 4 still breastfeeding at 21 months.
PS	S2PS3	31	1	Q4 (in target area).	D (PhD)	WB	M	Part time civil servant 18.5 hours/ week.	Exclusive breastfeeding for 6 months. Then with solids. Currently breastfeeding at 2.5 years.
PS	S2PS4	29	2	Q3 (in target area).	D	WB	M	3 part time jobs; 10 hrs paid (3hrs for Org C), 2hrs	Exclusively breastfed both children. Currently breastfeeding

								voluntary /week for Org C.	second child at 10 months.
PS	S2PS5	48	1	Q1 (in target area).	D (PhD)	WB	M	5 hours paid, 1.5 hours voluntary/week for Org C.	Exclusive breastfeeding then continued for long time.
Engaged Mother (EM)	S2EM1	23	1	Q2 (all mother participants lived within target areas)	D	WB	M	Full time nurse. On maternity leave now.	Exclusively breastfeeding now at 3 months.
EM	S2EM2	23	1	Q2	D	WB	Single (S)	Maternity leave now. Care assistant 30hrs/ week.	Exclusive breastfeeding initially, then expressed, now at 10 weeks direct breastfeeding plus some formula.

EM	S2EM3	36	1	Q3	D	WB	M	Paid half time, plus some voluntary.	Exclusive breastfeeding until 6 months, now continues alongside solids.
EM	S2EM4	37	2	Q3	D	Asian British - Bangladeshi	M	Full time Art Director. Maternity leave now.	First baby mixed fed for 5 months, then breastfed with solids till 18 months. Current baby exclusive breastfeeding at 6 months
EM	S2EM5	35	1	Q3	D	WB	M	Full time for NHS. Maternity leave now.	Mixed feeding now at 7 weeks
Non-engaged Mother (NEM)	S2NEM2	20	1	Q1	Some college	WB	S	Support worker for autistic adults 26hrs/week	Exclusive breastfeeding from birth. Now alongside solids.

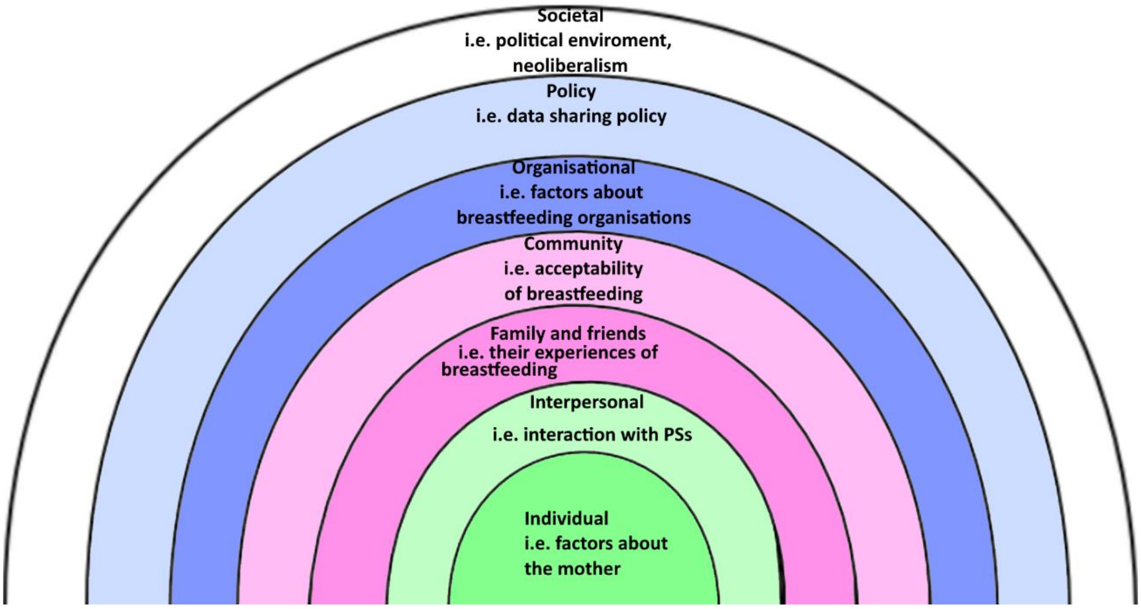
NEM	S2NEM3	25	1	Q2	Some College	WB	M	Maternity leave now. Care work 64 hrs/week.	Bottle fed from birth.
NEM	S2NEM4	28	2 (twins)	Q3	College (NVQ)	WB	M	Maternity leave from Care home 37.5 hours/week	11 weeks prem. Breastfed exclusively till now at 5 months. Some formula recently.
NEM	S2NEM5	35	3	Q2	Some college	WB	M	Fitness instructor. 2-10 hours/week.	Baby 1 breastfed for 5.5 months then formula. Baby 2 breastfed till 4 months then formula. Baby 3 (now 4months) breastfeeding and some formula.

As table 23 shows, site 2 women and peer supporter participants were more socially advantaged than those at site 1. However, at both sites, PSs lived in houses with higher quintile postcodes than mothers (i.e. suggesting lower levels of socio-economic deprivation). At site 2, although all PSs lived within target areas, their postcodes had higher quintile levels than the mothers. At both sites, PSs were more highly educated than mother participants, and non-engaged mothers had lower levels of education than those who engaged. PSs were also older than mothers. At site two once maternity leave was over, mothers would be returning to jobs with longer hours than those of PSs. At both sites PSs shared ethnicity with most mothers.

9.4 THEORETICAL FRAMEWORK

I identified the social ecological model (SEM) as a suitable framework to structure my findings because it aids consideration of different levels of context from individual to societal. In my findings I found that contextual issues operating at these different levels interacted to affect service development. The model uses concentric semi-circles to depict the different levels which do not make interconnectivity between the levels obvious. In my data contextual issues at different levels seemed intertwined in complex ways rather like a bird’s nest. There are several versions of the SEM: for example, McLeroy, Bibbeau, Steckler, and Glanz (1988), Sweat and Denison (1995), and Dahlgren and Whitehead (1991). Figure 6 below shows my own version inspired by these.

Figure 6 Adapted version of the social ecological model.



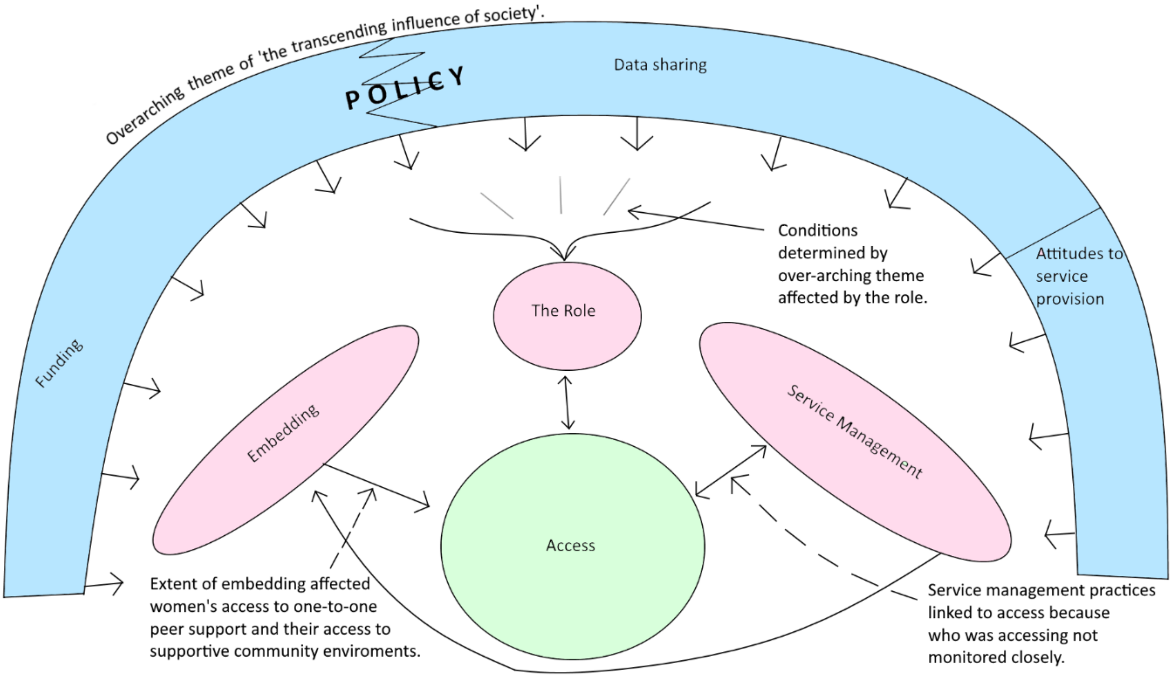
The model depicts the different layers of context in terms of the issues my study was concerned with. I used this version of the SEM to help me make sense of the data. It helped me to identify and track the many different factors affecting service development that arose from all the different layers of context identified in the model. Some important issues in my data concerned policy level factors, organisational level factors, and factors at levels closer to the individual. Using this model helped me to keep in mind the impact of the very outer levels of context at the same time as recognising inner levels.

9.5 INTRODUCTION TO THE THEMES

In this section I introduce the themes that explain service development. Figure 7 below provides a visual representation of the themes. The over-arching theme, *'the transcending influence of society'* is about the importance of policies and the wider cultural and political levels of context. The theme comprises three influences; the bureaucratic influence of society, the possible relationship between service design and

PSs contextual knowledge, and underlying social attitudes about service delivery. This theme is important because it explains the conditions in which further service development took place. *'The role'* is the first main theme. It explains that at both sites the peer support role was acceptable to mothers, and that it operated on three levels; at the level of the individual through one-to-one support, at the level of the social group, and at the level of the community. This theme also explains how the background conditions set by factors discussed in the over-arching theme led to the role developing differently at each site. The second main theme is *'access'*. This theme outlines how access presented as a problem at each site, how services developed to better enable women's access, and concludes by explaining how social disadvantage may affect access. The third main theme is *'embedding'* which is linked to service access and concerns how PSs can become trusted and integrated within health professional practice and the community resulting in cultural change. The fourth main theme is *'service management'*. This theme outlines how the scope of service management was affected by funding levels, and how the management practices of having time for regular communication with many different people and using different knowledge sources impacted service development. Throughout the themes there are examples of instances when factors that form part of the outer levels of the SEM interact with inner level factors in complex ways to affect service development.

Figure 7 Visual representation of themes.



9.6 OVER-ARCHING THEME: THE TRANSCENDING INFLUENCE OF SOCIETY

This theme illustrates the impact of the outer levels of the SEM upon service development across the two sites. Outer level issues comprise three influences; the bureaucratic influence of society, the relationship between service design and PSs contextual knowledge, and underlying social attitudes about service delivery. Together, these influences underpin the four main themes that follow.

When I use participant quotes, participant identification codes comprise four parts. First, the site; S1 refers to site 1 and S2 refers to site 2. Second, the participant group; EM refers to an engaged mother; NEM to a non-engaged mother; PS to a peer supporter; PSCOORD to a peer support co-ordinator; MAN to a peer support manager; IFC to an infant feeding co-ordinator; MW to a midwife; HV to a health visitor and COM to a commissioner. Third, for participant groups with several participants, the participant number is given. Fourth, the number given in square brackets refers to the transcript line number from where the quote has derived. My transcribing conventions used underlining, i.e. to indicate voice emphasis, and * to indicate a one second pause.

9.6.1 The bureaucratic influence of society

The bureaucratic influence of society is about how policy level factors influenced service development. Three policy level issues were influential. The data presented below demonstrate how the policy of proportional universalism, the impact of data sharing policy, and the funding available for a commission (resulting from government policy affecting council funding), came together to influence service development at each site.

Historically, at both sites, peer support started as reactive support available at breastfeeding support groups. This was recognised to result in more socially advantaged women getting more of the resource, despite groups being provided in areas of deprivation:

> *‘Middle-class white mums were coming to the group […] but the women from the more deprived area, […] although the group was right next to that area, those mums weren’t attending […]. They* [public health commissioners] *started asking the questions and kind of evaluating were the groups actually effective at helping more mums breast feed? And […] they weren’t really making the impact that they wanted’* (Penny S2PSCOORD [145]).

In response to this, commissioners at both sites developed services focusing on early one-to-one support to address local and national patterns in breastfeeding rates whereby many mothers stop breastfeeding soon after birth:

> *'The commissioning is very much around one-to-one support on the post-natal ward and at home'* (Joanna S1IFC [39]).

At both sites, resource access became important to service delivery as commissions followed principles of proportionate universalism whereby universal services were delivered at an intensity and scale proportionate to need (Marmot, 2010) (see chapter 2, section 2.5). Commissions aimed to deliver more resource to mothers living in areas of higher deprivation to meet need, and maximise health impact:

> '*The evidence shows that those are the mums that perhaps need that more support, younger mums, […] families living in quintile one areas, […] when we've looked at breastfeeding status previously over the years with trends we've found that in those areas there is more bottle feeding rather than breastfeeding, and because we are looking at increasing breastfeeding rates that's where we wanted that support to be'* (Cathy S1 COM[28]).

However, the extent of targeting differed between sites. At site 1 women from target groups received a similar service to other women. Commissioners asked PSs to *'focus on a little bit more'* on target groups. They wanted to use key performance indicators (KPI's) to *'see that they're actually delivering services'* in the quintile one areas and *'giving more'* (Cathy S1 COM [6]) one to one support to target groups. Meanwhile, at site 2 targeting was more pronounced, providing *'a very targeted offer but with a universal element within it'* (Mary S2COM [5]) intending only target women receive proactive peer support.

Data sharing policy interacted with these proportionate universal aims to influence the extent to which they could be achieved. At site 2 the commission intended all women living in target areas to have the opportunity to receive early proactive text support. However, despite year-long extensive inter-professional working including development of a data sharing pathway, the requisite data sharing agreement that would have allowed midwives to sign up women for text support without the women having to meet a peer supporter face-to-face, remained elusive:

> *'We still can't set up a data sharing agreement with the trust and that's more about [...] the new data regulations and people covering their backs [...] it's quite frustrating because we're almost tied up by bureaucracy, when we could actually be doing more for more women so there are other impediments to actually what we're trying to do'* (Janine S2PS5 [112]).

Further, in general data sharing policy dictates transfer of minimum information only. Because at site 1 the hospital trust did not provide PSs with women's postcodes, they were unable to target support towards women living in quintile one postcodes at the crucial contact opportunity of the first phone call:

> *'Cos of information governance we didn't have people's post codes then we didn't* know *when we got the discharge data who was a quintile one post code and who wasn't. The only way we could find that out is if we could get them on the phone and ask them for their post code'* (Jackie S1 MAN [22]).

The extent to which proportionate universalism aims could be enacted was also affected by funding. Participants at both sites recognised funding levels affected how intensive and universal a service could be, and that sufficient funds were necessary in order *'to get those* [target] *families to engage'* (Jenny S2IFC [14]):

> *'If one could just say 'we need a hundred thousand' like [...] in [another area] and we can reach every mum, we can give them a call [...] they* [PSs] *are completely integrated, they are seen as that universal service'* (Melissa S2MAN [131]).

The type of contact provided by the PSs also depended on funding, with home visiting the costliest, and perhaps most effective in enabling expression of needs:

> *'Midwives, we're cutting down the home visits now ** down to clinic appointments which is just 15 minutes half an hour, so in that time we're not able to offer the women all the time or full support that maybe they need, you know, they might not open up the same way whereas if X* [org 'D'] *are on the phone or going round to visit them at home, they're more likely to get that extra bit that they [...] needed'* (Tash S1MW1 [30]).

Home visiting also afforded otherwise unobtainable insight into women's wider social context:

> *'It's opened my eyes to [...] a lot more of the struggle that locally, mums are facing and there's families that only live a few streets away from me, and I never knew how bad it was for them'* (Kerry S1PS1 [105]).

While PSs might have *'preferred to go out and visit the women'* (Tash S1MW1[46]), staffing constraints limited this at site 1, and at site 2 funding levels almost completely precluded it. Hence, while service intensity and universality were governed by funding, in turn they influenced the ease with which PSs could learn about women's contexts.

9.6.2 The relationship between service design and PSs contextual knowledge

At site 2 PSs' face-to-face contact with women was limited to clinics or community groups. This seemed to provide fewer opportunities for them to learn about target women's wider contexts when compared to site 1. When asked what they knew about the contexts of women living in target areas, site 2 PSs demonstrated limited knowledge particularly at the intra, inter-personal and society SEM levels. The peer support co-ordinator (also a voluntary peer supporter) provided the majority of contextual information at these levels, feeling target women might have lower confidence resulting in reduced service access:

> *'I think it's about confidence as well and being able to ask for help and get the support they need'* (Penny S2PSCOORD [61]).

She considered that the women her service was targeting might be less likely to seek formal information, be more likely to accept knowledge from social contacts, have family members unsupportive of breastfeeding, and have little experience or knowledge of breastfeeding and breastfed baby behaviour:

> *'In the [rural area] you know they tend to still, [...] it's still quite close knit communities so they might, [...] the mum* [grandma] *might live near, down the road and they're the ones giving them the support so they're the ones that [...] if*

> *their experience hasn't been breastfeeding, they then say, […] 'why are you still breastfeeding?', 'why don't you give them a bottle?'* (Penny S2PSCOORD. [61]).

Other site 2 PSs had limited knowledge of women's contexts; however, they were able to provide some information about the community context within target areas. Several, such as Verity, felt that some women found public breastfeeding a barrier e.g. *'I think that's* [breastfeeding in public] *definitely a big barrier for a lot of people'* (Verity S2PS4 [9]) but also that breastfeeding visibility had recently increased which was slowly making breastfeeding more socially acceptable. For example, Bridget explained that *'I don't think anyone gets put off breastfeeding around here - no it's okay'* (Bridget S2PS2 [25]). Although mothers expressed a range of experiences of breastfeeding in front of other people, several mothers, such as Cerys, seemed to experience breastfeeding in front of others (inside their own homes and in public) as more problematic than PSs identified:

> *'I hated it* [breastfeeding outside own home] *at the beginning I was really scared and I didn't want to do it, and it was just a bit, I panicked about it until I felt like it made me ill'* (Cerys S2NEM2 [13]).

Several site 2 PSs suggested that all services for mothers and babies had reduced due to recent cuts to Children's Centre services, and that public transport was poor which meant it could be difficult or impossible for women living in rural areas to access community services. Several also felt that breastfeeding mothers need a supportive community, but that in areas of deprivation breastfeeding is not normal and rates are low. They felt this may mean ideas about a good baby who sleeps for long periods from a young age are more prevalent. This means, for example, that when a baby exhibits normal breastfed baby behaviours, such as wanting to breastfeed frequently and not sleeping for long periods, women might be more likely interpret such behaviour as a sign that something is wrong with breastmilk supply. Mothers might also be more isolated:

> *'I can't imagine how mums must feel at three months if they don't know anybody else who is breast feeding'* (Nina S2PS3 [37]).

However, the contextual information supplied by mother participants suggested that some communities within target areas were more supportive of breastfeeding than others. For example, while both were target areas, Brooke lived in a suburb of the main city where she experienced several incidents when negative comments were made towards her, or people moved away from her while she was breastfeeding in public. These experiences sat alongside comments from her family and friends such as:

> *"Oh you have got to get her onto a bottle soon otherwise she's just going to […] use you to fall asleep and you are never going to be able to leave her'* (Brooke S2EM [15]).

Naziha, on the other hand, lived in a rural village:

> *'We've got a community that's very much into breast and babywearing and re-useable nappies as well which is a good thing'* (Naziha S2EM4 [6]).

Many site 2 PSs did not seem to recognise this heterogeneity because most talked about target areas in generic terms, with only Nina highlighting contextual differences within target areas:

> *'I think everyone has different experiences because different bits of X* [rural target area] *are very different... So, I live in the south of X* [rural target area] *in a little village which I think is probably a bit different to being in X* [larger town in rural target area]' (Nina S2PS3 [5]).

Site 2 PSs demonstrated limited understanding of other wider social contextual issues which might affect women living in target areas such as difficult housing conditions, poverty, or having to cope with multiple young children. This was in contrast to some site 2 health professionals who highlighted the impact of these things on infant feeding experiences:

> *'I've certainly been to see some families where […] there's more than one family living under one roof, and maybe just sharing kitchens and lounges but having their only own space is a bedroom so that might be challenging, especially if there are other young children within the family as well'* (Jenny S2IFC [10]).

Site 2 PSs did not seem to realise that many women living in target areas stop breastfeeding very early. They did not mention the need for early support, rather, they wanted to establish more community groups which in reality were only usually accessed when babies are six weeks or older. Being less aware of wider contextual barriers seemed to be in tension with assumptions underpinning the aims of the commission, and highlighted a lack of appreciation of the contextual challenges that these women may face:

> *'You know I think breastfeeding it doesn't matter really whether you're-you're affluent or not [laughing] [...] I think they still face the same challenges'* (Penelope S2PS1 [45]).

By contrast, site 1 was better resourced. The PSs demonstrated in-depth knowledge of target women's contexts which concurred with but extended beyond that demonstrated by site 2 PSs. Site 1 PS's contextual knowledge mostly coincided with information given by site 1 mother participants across all SEM levels, although they too underestimated the extent to which many mothers found public breastfeeding problematic. It is important to note that there was an educational disparity between PSs and mothers, such that PSs had a higher level of education (see table 23 above). Several site 1 PSs felt target women might be more likely to find social situations difficult, particularly value experiential knowledge, and feel doubtful about their own abilities to breastfeed:

> *'I think the doubts around breastfeeding are perhaps more prevalent and in communities, quintile ones, where there's not a lot of breastfeeding'* (Ellen S1PS4 [77]).

One site 1 peer supporter felt that some women may be struggling to secure the basics of life such as food. At the inter-personal level, several site 1 PSs felt mothers might be more likely to experience language barriers, struggle with literacy, lack social support, and feel a health professional is powerful:

> *'Cos I think a lot of mothers feel that their health professionals know better than they do'* (Sarah S1PS2 [64]).

At the family level, site 1 PSs felt women might be more likely to have to care for other children and / or older family members at same time as their new baby, and that some women might breastfeed because they could not afford formula, rather than by choice. At the level of the community they identified that areas of deprivation may feature unemployment, crime, violence, and poverty, and emphasised the rarity of young mums breastfeeding, and older babies being breastfed. At the level of society, Kerry for example, voiced the negative impact of cuts to benefits and other services:

> *'The lack of government funding now is making a huge impact for those mums, benefits being cut, less intervention from social services, um, yeah Children's Centres again'* (Kerry S1PS1 [97]).

The universality of site 1 PSs *'experience of supporting mums in all areas'* (Jade S1PS3[151]) appeared to help them assume a population level view, recognising *'lots of different areas'* including *'pockets of very affluent areas and also areas of extreme poverty, almost on each other's door steps'* (Jade S1PS3[131]). Within this whole, they noted two infant feeding cultures; South Asian women who may have social support for breastfeeding, and white women who may not:

> *'There's two aspects to the community, there's the quite a large South Asian community, and breastfeeding socially is more acceptable in that community, but as a British white woman, very little support for breastfeeding mums, socially it's not accepted'* (Kerry S1PS1 [12]).

The ability to provide an intensive service to all women that adequate funding and good data sharing arrangements allowed, seemed to result in appreciation of the importance of a mother's context:

> *'I think that's (getting a PS home visit early, regardless of expressed need) really important again because those of deprivation, the ones that are least likely to have that social mobility and the sort of the family and friends around them that would be more supportive of their choices to breastfeed, so I think it's more important for those mums in those areas, who might be feeling that social isolation as well'* (Kerry S1PS1 [55]).

One interpretation of all the data for the subtheme 'the bureaucratic influence of society' is that the delivery of proportionate universalism[13] can be influenced by funding levels and data sharing policy to determine whether PSs are able to proactively contact target women early in the postnatal period. The funding available may dictate the intensity and universality of a service, affecting the extent to which PSs may learn about women's contexts and take a population view. However, it must be noted that at site 1 PSs estimated quintile one areas formed 30-40% of all postcodes, while at site 2 target areas were to some extent heterogeneous with regard to social deprivation so that pockets of intense deprivation formed a smaller proportion of the whole.

In addition to the influence of the policies discussed here, beliefs and assumptions about service provision may also influence policy enactment and are discussed as follows.

---

[13] Proportionate universalism is an approach whereby policies are designed to respond to local health needs and direct additional action and resource to communities where deprivation levels are higher (IHE, 2018).

9.6.3 Underlying societal attitudes about service delivery.

Valuing equality of opportunity, desiring a universal approach that is responsive to individual need, and wanting to avoid categorising women, are ideas about service delivery that influenced service development. Rather than being imposed via policy, these ideas seemed to arise from within participants. Although my main focus was with PSs, these ideas were also present in other participant's accounts, for example, a public health commissioner, health visitors and women.

At both sites many PSs and some health professionals showed discomfort through reticent speech when asked about the lives of women living in target areas. This made it awkward to talk about their contextual knowledge, and at times it was as if differences noticed between groups should not be there. For example, in the quote below (which is presented verbatim) Suzie one of the health visitors at Site 2 stated:

> *'Erm… I wouldn't, I mean it is difficult I would say in my particular area it is difficult for some of the mums who are, you know, sort of live in the more deprived areas hhh- and from sort of the lower sort of social backgrounds it can can be difficult to engage them in that sort of group, I must admit'* (Suzie S2HV2 [21]).

Several PSs who felt it was, e.g. '*really horrible to kind of clump them* [women] *together'* (Sarah S1PS2 [64]), were keen to make sure the complexity of contextual issues was clear, and that any kind of grouping of women living in deprived and non-deprived areas doubtful:

> *'So, it is really individual I don't think you can ever put anybody into a category who would fit exactly into that category'* (Kerry S1PS1 [92]).

When asked whether they adjusted support for women in target areas, PSs at both sites explained they treated all mothers the same - as individuals:

> *'I think our training is quite comprehensive as in… I mean it's very much about working within the group and… it's about treating mum as individuals really'* (Penny S2 PSCOORD [185]).

Asking such questions at times generated feelings of defensiveness such that the idea of responding differentially to women based on any kind of grouping seemed to call into question and conflict with the core desire to treat everyone fairly:

> '*We have the same approach with everybody […] Yes, we're a non-*judgemental *service'* (Penelope S2PS1 [163]).

At both sites PSs felt strongly they were *'there for every mum'* (Penny S2PSCOORD [63]), and being able to *'take a very much blanket approach'* (Sarah S1PS2 [140]) to service delivery was appealing to many participants including this commissioner:

> *'The changes that I would like to see is that, […] we don't need to focus so much on just the, […] highest quintile of deprivation, […] if we can create a culture shift in the community then we wouldn't need to target in that way […] so we can have a more universal service'* (Cathy S1 COM [85]).

Another service provision ideal was to give everyone an equal chance to receive the service:

> *'All mothers will follow the same pathway and have the same opportunity for support, or not'* (Sarah S1PS2 [56]).

These ideas seemed to affect PSs attitudes towards targeting so that individual need rather than population group needs formed the focus:

> '*We are measured on those target areas, and our commission is based on those areas but I think our general aim is to give mums universal support rather than making it any more different for one mum because she lives in one postcode compared to another, so it is just on the needs of those mums we speak to'* (Kerry S1PS1 [88]).

At site 2, although some PSs followed the commission and provided proactive peer support only to target women because *'they're entitled to get that one-to-one support'* (Janine S2PS5 [174]), other PSs such as Bridget, pointed out they were paid for only a small proportion of their supporting time. They chose to spend their volunteering time providing the same proactive text support to non-target women and, despite recording postcodes for commissioning reporting purposes, often did not mentally note women's target status:

> *'I'm not going to sort of not help a mum because they're not in my certain postcode'* (Bridget S2PS2 [85]).

It is possible that the awkwardness I often sensed during interviews when PSs talked about differences between women’s contexts, and their desire to avoid categorising women, may have inhibited their discussion of their contextual knowledge at other times too (during supervision sessions for example). Seemingly at variance with the underlying thinking behind the commission, the desire for a blanket service and to provide equality of opportunity could move focus towards individuals and away from a population view. These beliefs about fairness may combine with the bureaucratic issues discussed above to influence whether early proactive contacting, service intensity, and service universality were possible, and to further affect the attainment and application of contextual knowledge. This theme has explained how factors from the outer levels of the SEM set the conditions in which PSs were working in at each site. The next theme explains how services developed in response to the basic conditions they found themselves in.

9.7 MAIN THEME 1: ‘THE ROLE’

This theme explains the acceptability of the peer support role among women participants, defines how the role of the PSs operated at different levels at both sites, and demonstrates role development in terms of ‘the scope of the role’ and ‘being a peer’.

9.7.1 Role acceptability

Mothers from both sites who had received peer support liked it and reflected that they appreciated the different ways the PSs had supported them. Several mothers like Kiera valued the practical support the PSs had provided:

> *'I was like literally ready to give up cos of her not latching and she just weren't doing […]so she* [peer supporter] *showed me how to do it so she could feed and that was the first time that she fed properly without screaming her head off'* (Kiera S1EM5[30]).

Several other mothers mentioned they appreciated the emotional support which could be experienced one-to-one or, like Carrieann, through a supportive group environment:

> *'It's not just breasfeeding support, it's emotional support, someone else to talk to, just have a bit of time out the house. It's sort of essential really else you'll go a bit crazy'* (Carrieann S2EM2[138]).

The encouragement and affirmational support provided by the PSs was mentioned by several mothers. Tahmina who was on a neo-natal unit with her premature baby when she received support from her peer supporter reported:

> *'She* [peer supporter] *goes 'you're doing really good', so the way she was spoken to me, the way she was explaining to me, the way she was calming me down, I think that was really helpful'* (Tahmina S1EM6[42]).

Several mothers discussed how they valued the informational support the PSs gave them, whether information was delivered verbally, via text or phone call, or in Brooke's case, using written materials when she met a peer supporter at an antenatal class:

> *'They give you leaflets to take away with day one, this is what breastfeeding should look like. Day two, this is what nappies should look like things like that'* (Brooke S2EM1 [79]).

Many mother participants expressed how they appreciated the PSs availability. For example, Tracey was worried about her baby's weight gain. Her peer supporter demonstrated she was present and available by discussing the situation fully face to face and following this up with proactive online messages:

> *'But X* [peer supporter] *was really good she like went through the reason why and messaged me on Facebook and stuff like that'* (Tracey S1EM1 [159]).

Such proactive contacting was acceptable to all mothers who received it. Several mothers appreciated their peer supporter being non-judgemental. For example, Carrieann was mixed feeding. While she was initially worried the PSs at the breastfeeding group would judge her use of formula milk, her fears were unfounded:

> *'They* [PSs] *sort of turned around and was like 'well actually like well we've got mums who are bottle feeding and trying to get back on the breast' and from then I just, I stopped caring like if she wanted to feed off me she did, if she didn't I was happy to give her the bottle there* [at breastfeeding group]. *Um so they just make you feel so much better about it'* (Carrieann S2EM2[128]).

Being non-judgemental fitted in with another aspect of PSs support which many mothers valued, that PSs focused upon their needs and desires. For example, when her baby was first born Lauren was not able to directly breastfeed. She felt her midwives disregarded her desire to breastfeed, and that they seemed to feel; *'right, well baby's fine and putting on weight, you're fine, great''* (Lauren, S1EM4 [51]). By contrast, Lauren's peer supporter listened as she '*explained what was going on'* so much so that Lauren felt '*she* [the peer supporter] *seemed to understand my need to breastfeed'* (Lauren, S1EM4 [53]). The manner by which the PSs communicated with mothers was also appreciated by several mothers. For example, Cara explained that in her experience, a health professional would tell her *'how things are'*. This made it *'very difficult'* for Cara to *'say to a professional, "hang on a minute this isn't actually working out for me"'* (Cara S2EM5 [133]). Likewise, when Tahmina's baby was born extremely early, a doctor told her what to do. Tahmina explained '*I was getting very worried because the doctor said '" I [doctor] need my [Tahmina's] milk", and "you need to do it [express]"'* (Tahmina S1EM6 [42]). In contrast, Cara appreciated how the PSs were non-directive and communicated in such a way as to allow her room to try several different approaches when feeding her baby:

> *'They are very open to [...] 'there's a lot of different things that you can try', and their one experience isn't how everyone else is going to be'* (Cara S2EM5[133]).

Many women who had not engaged with peer support lacked the opportunity to do so, and most women interviewed who had not received the service appreciated the idea of peer support, especially valuing the idea of the PSs experiential knowledge:

> *'If another mum's experienced something like that and* she* [new mother] *could talk to somebody who's actually gone through it, it'd be like better than speaking to a midwife that has * learnt it off, like, paper'* (Carrie S1NEM1[20]).

However, one mother who was socially isolated was unable to contemplate feeding in public. This made breastfeeding a non-option and peer support irrelevant. For another, formal knowledge that breastfeeding might be healthier for babies held no sway. This mother did not want to meet others and struggled to see value in peer support:

> *'I suppose for some people that might help. That might help people who are like, I don't know, I'm just very independent, I like to do things on my own or try and do things on my own. I try to work something out'* (Paige S2NEM3 [75]).

9.7.2 Different levels within the role

Spanning several SEM levels, at both sites, PSs were seen to perform different functions at different time points along a mother's journey. Initially at the individual level PSs provided one-to-one support in the manner described above. This support was ongoing, so the peer supporter was alongside a mother as her journey progressed:

> *'They* [mothers] *always said I've just managed to text at the right time when something was awful and they said they can't go on [...] and then they get this text from me going, "Hi, how you doing? Is it okay? Can I help?" And it's just like 'YES!'* (Janine S2PS5 [57]).

Site 1 peer supporter Ellen explained that at the intra-personal level her role was to facilitate expansion of a mother's social network by enabling her to access an online or community group:

> *'The continuity of breastfeeding, I think does depend in terms of it […] becoming a bit more of a norm for them,[…] if they're going to group regularly and they're meeting other people who are breastfeeding it gives a bit of balance I suppose, that it can be normal to breastfeed a baby beyond, you know, up to six weeks'* (Ellen S1PS4 [62]).

Finally, PSs were seen to contribute to culture change at a community level. This aspect of the role developed differently at each site and is explained in theme three 'embedding'.

9.7.3 Role development.

Despite the similarities discussed above, data suggests that the role of the peer supporter developed differently at each site in relation to *'the scope of the role'*, and *'being a peer'.* The role developments explained below form examples of how outer levels of the SEM influenced the strategies PSs adopted. In turn such strategies interacted with organisational and inter-personal level issues to influence service development.

'The scope of the role'

As explained above, site 1 PSs held extensive knowledge of women's contexts and were able to home visit. Phase one of this study aimed to establish background information about the organisations and therefore collected a limited number of accounts, however, phase one findings suggest that organisation D purports to have a strong theoretical focus on being woman centred (see chapter 6, section 6.6.2), PSs wanted mothers to feel *'they've got someone on their side'* (Ellen S1PS4 [90]), and that PSs cared about them and their situations:

> *‘That’s what it is for me, it’s about making mothers feel valued’* (Sarah S1PS2 [98]).

Much of site 1 PSs time was spent supporting women *‘through what is normal’* (Jackie S1Manager [77]). Their basic work concerned preventing complications, encouraging, reassuring, and dealing with difficulties occurring during the normal course of breastfeeding. However, sometimes more complex issues arose:

> *‘As well as trying to provide enough information so, she can do the best she can […] we’re speaking very much about, […] positioning and attachment, hand expressing, growth spurts, how do you know your baby’s getting enough, is our kind of bread and butter stuff and then the other stuff is being that link so they can get the right information and the right support’* (Ellen S1PS4 [87]).

PSs wanted to understand what was troubling women, whether this related to baby feeding or not. For example, mother’s worries about how to introduce a new baby to their other children, or concerns about benefits, housing, or food security:

> *‘It was a little bit of a blinkered vision before-hand of what the peer support was about, I thought it was just for breastfeeding support, but quite often it is going to those families, and sort of asking them more, they’ll open up and tell you about what’s happening’* (Kerry S1PS1 [105]).

Several site one mothers recounted stories of times when health professionals appeared to have disregarded their views, or *‘didn’t really seem to bother’* (Carrie S1NEM1 [4]) with their situations. For example, over many months Kiera had tried to explain to health professionals that she feared her new baby had the same allergy as her other children, but they would not take her opinion seriously. When I said that this must have been hard for Kiera, she replied: *'I'm, I'm used, ** well they won't listen to me'* (Kiera S1EM5 [55]). Sometimes women told me such stories when I met them face to face, but did not repeat them in detail during an interview. For example, when I met experienced mum of six Alana at her Children's Centre, she told me all about her baby son who had been crying and not sleeping from birth, and how she had taken him to several different health professionals repeatedly over several months, but no one would listen to her concerns. It was only when her baby aspirated and required hospitalisation that reflux was diagnosed.

Many site 1 PSs recognised women sometimes felt less powerful than health professionals and within their families and there were examples of PSs advocating for mothers. For example, Kiera explained that while she was in hospital her baby was struggling to feed and a nurse wanted her to use formula milk. Kiera's peer supporter acted to support her desire to breastfeed:

> *'The nurses like, they weren't listening, they were like just like 'just feed her however you can feed her', and this woman* [peer supporter] *were like 'well no, we'll try* [breastfeeding] *first, and if it don't work, <u>then</u> we'll give her a bottle''* (Kiera S1EM5[40]).

Site 1 PSs also sought to facilitate mother's access to health professional services:

> *'I think we are a stepping stone as peer support between a mother, whatever her situation, and what the, you know, the health profession'* (Sarah S1PS2 [64]).

As detailed previously, site 2 PSs had less contextual knowledge, their service did not include home visiting (instead they communicated mainly via text and met women either at health clinics or community groups), and they could not reach everyone. In common with site 1, they also had a woman centred ethos, but although their role was *'quite wide ranging'* (Penelope S2PS1[61]), they saw it as bound within support for parenting:

> *'It's kind of actually taking a holistic approach to supporting a new mum with a baby rather than just looking at how the milk is going in and what milk they are getting, it's actually seeing that feeding a baby is part of a much bigger picture of how you parent essentially, so supporting mums with that'* (Nina S2PS3 [25]).

Within this, and in the same way as at site 1, site 2 PSs also did a lot of reassuring, normalising, encouraging and dealing with normal issues of breastfeeding:

> *'Just coming to the group for reassurance, you know because most of it is reassurance [...] that it's normal, that's what babies do in the early days'* (Penny S2PS COORD[78]).

However, feeding difficulties seemed to hold a greater focus when compared to site 1:

> *'We can help with anything… to do with breastfeeding. So, it might be engorgement or blocked ducts or mastitis or it could be a case of thrush. Baby could have tongue tie [...] anything to do with infant feeding in general [...] so that includes formula feeding as well'* (Penelope S2PS1 [57]).

This greater focus on difficulties seemed to relate to the circumstances in which PSs were able to meet mothers. The commission at site 2 required PSs to sign up a certain number of target women per quarter. Although PSs sought to sign up pregnant target women at antenatal classes, they were not able to sign up enough women via this route to meet the commissioning requirements. This meant that more target women had to be 'found' postnatally. To try to reach women, site 2 PSs used a strategy of 'piggy backing' onto other services. For example, (in addition to going to ante-natal classes) they attended a midwifery drop-in clinic at the hospital and community health visitor weigh in sessions:

> *'Plugging in with the weigh-ins has been really good [...] and I think you know weight gain and feeding go hand in hand so I think that is really useful to have that link together'* (Nina S2PS3 [73]).

Although this strategy facilitated contact, it meant they met mothers in an environment controlled by health professionals, which may already be problem focused. Mothers might be attending because a difficulty had already arisen. Janine explained that this meant that a PSs main concern was to help with that issue:

> *'Because I'm* <u>mainly</u> *doing the... like the more intensive supporting at the hospital* [Saturday morning midwifery clinic] *hh- it's literally 'let's deal with your issues, let's have a chat, let's give you some support'* (Janine S2PS5 [176]).

The strategy of 'piggy backing' helped organisation C meet target women and thereby fulfil their commission. However, it may have influenced the development of the peer support role so that providing information early (thereby preventing problems or issues arising) tended to form a smaller part of their role, and dealing with difficulties tended to form a larger component of the whole.

‘Being a peer’

Several site 1 mother participants discussed interactions with health professionals in which they had felt undermined and dismissed (see section 9.7.3 above). Their accounts suggested they frequently felt less powerful than health professionals. In contrast to this power differential, Avisa explained that *‘when it’s just another mum [i.e. a peer supporter] who you can relate to, you don’t feel inferior’* (Avisa S1NEM2 [22]), stating that:

> *‘When it’s a midwife you feel a bit kind of intimidated because they’re very like, well educated’* (Avisa S1NEM2 [22]).

Other site one mothers recounted behaviour which, although not reflecting intimidation, resonated with Avisa’s situation; they described times when they had not demanded help or attention. For example, Tahmina wanted to start directly breastfeeding her pre-term baby for whom she had been expressing, but she did not ask for help feeling that *‘there was no-one to help me’* (Tahmina S1EM6 [73]). Further, talking about breastfeeding could involve using medicalised language which for Alana seemed to be ‘owned’ by health professionals:

> *‘She* [Alana’s twenty-year-old daughter] *wanted to breastfeed, she did the very first, is it the colostrum or whatever they call it, whatever’* (Alana S1NEM3 [54]).

As previously mentioned, several site 1 PSs were aware of such power imbalances and some felt it was important women saw PSs as non-professional and non-powerful. To counteract this, they consciously sought to come across as mothers rather than '*mini-health professionals'*:

> *'There's certain lines that you wouldn't cross […] for example writing in white notes or doing that kind of documentation in people's books […] when you start writing in notes for women, […] it perhaps moves you slightly away from the peer supportness, you do become like a little mini health professional or it can feel like that for the mum'* (Ellen S1PS4 [108]).

Several site 1 PSs referred to how they wanted to avoid mothers feeling that breastfeeding required a lot of knowledge:

> *'If you're a breastfeeding supporter and you come across really knowledgeable and have all that wealth of training and you're making that overtly obvious to the mum then I think it makes it more challenging for the mum to think, […] 'I have to do all that training, I have to know all this stuff to be able to breastfeed', I think it's much more empowering for the mum if the peer supporter doesn't know everything but she still managed to breastfeed her baby'* (Ellen S1PS4 [85]).

Ellen was a senior site 1 PS with some management responsibility. She was guided by her awareness of the importance of power relations and perceptions within the mother – peer supporter relationship as service development decisions were made. Part of site 1 funding came from the Stop Smoking service. This meant PSs were expected to have conversations with mothers about smoking cessation; '*they want us at every visit to ask 'are you, are you a smoker' and 'if you are a smoker, you know, would you like information on stop smoking'* (Ellen S1PS4 [96]). Although the commissioning arm of organisation D was keen for this to go ahead, Ellen worked with managers higher up the organisation to reconcile the terms of the commission with the role of the peer supporter. The solution Ellen and her managers devised enabled a mothers' autonomy, control, and power within the mother – peer supporter relationship to be maintained, and the peer supporter to avoid coming across as a mini-health professional, whilst at the same time allowing PSs to discuss smoking as per commissioning requirements:

> *'We devised […] a choose and chat card thing, so, on it there would be a few different, topics that […]aren't necessarily breastfeeding but maybe relate to breastfeeding so, Vitamin D, […] cos that's often a question that comes up, we had kind of safer sleep […]but we also had smoking on there, […] so there were about four or five things on them so the idea was then that, you would hand the mums, like, the cards and you could say something a bit like, […] 'is there anything from here that you want to chat about?''* (Ellen S1PS4 [102]).

This forms an example of how policy, organisational, intra and inter-personal levels of the SEM interacted to influence service development.

Among site 2 PSs there was no mention of the way their breastfeeding knowledge might be perceived by mothers, and exceptional breastfeeding knowledge was valued among PSs:

> *'She's* [peer supporter]*, she's really good, she's got really good knowledge'* (Verity S2PS4[32]).

At site 2 there was a desire to train PSs from within target areas. Melissa, the site 2 manager explained how: *'we want them to be as diverse looking like the community that people live in'* (Melissa S2MAN [77]). As demonstrated in table 23 above, most site 2 mothers and all site 2 PSs were white. Only one site 2 PS, who was much older than most mothers, recognised she was *'the wrong demographic'* and *'not part of that* [target] *cultural group'* (Janine S2PS5 [89]). Feeling uncomfortable, she worried her volunteering at ante natal classes may be perceived as lecturing. However, at both sites, when I asked mother participants whether it was important PSs were like them, neither women who had or had not received peer support expressed the need for PSs to resemble them in any particular way beyond being another mother. Although the role differed at each site, the way peer support was delivered was acceptable to participating mothers. However, at both sites there were many women who would have liked the service who did not get it. This is explained further below.

9.8 MAIN THEME 2: 'ACCESS'

The most significant issue regarding service developments at both sites concerned access. This theme outlines how access presented a problem at each site, how services developed to better enable women's access, and concludes by explaining how social disadvantage may affect access.

9.8.1 The problem of access

At site 1 PSs were able to attempt to contact all women discharged home breastfeeding because they had contact data transferred to them by the hospital. This meant the main problem facing site 1 PSs was how to keep as many women as possible in their service. At site 2 there was no data sharing agreement and the PSs only opportunity to sign up target pregnant women to their texting service was at antenatal classes. This meant the main problem facing site 2 PSs was how get as many women as possible into their service.

9.8.2 Service developments designed to facilitate access

Below I explain that while PSs at both sites made efforts to facilitate better access, such efforts were commonly designed for all women without keeping the particular needs of target women in mind. I also highlight that sometimes special pathways designed to facilitate the access of target women were set up, but that they were often undermined.

While different strategies were used by the PSs at both sites to facilitate access, they often did not appear to be focussed on encouraging access amongst the target population. For example, at site 1 although PSs had established which mothers lived in target postcodes (by asking them during the initial 48hr phone call), PSs developed their access pathway by sending extra texts to all mothers when babies were 2-3 weeks old. This development, described by Jackie the site 1 manager below, was adopted without analysing its impact across target and non-target groups:

> *'We added, a text at 2 – 3 weeks to the women to remind them how to access breastfeeding support cos that's the point where paternity leave tends to be over for a lot of partners, and it's at the point where women are suddenly on their own at home with a baby so we added after, at the end of year 1, we added an extra text in at 2 – 3 weeks to say 'this is where we are, this is how you contact us and this is where our local breastfeeding groups are if you want to get out and about''* (Jackie S1Manager [20]).

In addition, the thinking underlying this development seems to be more suited to the contexts of middle-class mothers. This was because it assumed that mothers would have a partner who had been able to take leave, and that mothers would be likely to access services as a result of a text requiring them to react. In a similar way at site 2, some of the adaptions PSs put in place to better enable access were not designed with target mothers' situations in mind; as explained in theme one (section 9.6.3), and as required by the commission, site 2 PSs recorded the postcodes of all the mothers they met or came into contact with. However, as mentioned in theme one (section 9.6.3), some PSs who were paid to give ongoing text support offered this kind of support to all women whether they lived within a target area or not. When such PSs adapted their practice to try to enable better access, they applied their adaptions to all women. They did not think of the women they were supporting as being either target or non-target women and therefore could not analyse the impact of their innovations on the access of these different groups of women. For example, Bridget developed a strategy to help women fully engage that involved encouraging them to come to a group rather than visiting them:

> *'What I do now is try and get them to the group […] usually it means then at least the mum will come back and get further support, quite often if you do a home visit, * that tends to be like the only contact […] then […] you might not see the mum again'* (Bridget S2PS2 [174]).

Bridget did not seem to have considered whether accessing a group might be more difficult for target mothers as opposed to non-target mothers. At both sites PSs tended to treat all women in the same way with regards to new developments designed to facilitate better access, and new developments did not seem to take target mother's wider contexts into consideration. Despite this, there was one occasion when a service development was felt to be important to encourage access for target and non-target women, but for differing reasons; at site 1, from the project outset, the PSs who made home visits knew as *‘an innate thing’* from their own experience *‘that kind of regular contact is of value’* (Ellen S1PS4[54]). For more socially advantaged women with family and friends who had successfully breastfed, ongoing pro-active text support may avoid the necessity of women identifying themselves as needing support for something they may perceive others found easy. However, for women living in quintile one areas, it was felt to be important for different reasons. Ellen described how for women who had no family or friends who had breastfed, and who had heard many stories of women who could not breastfeed, when breastfeeding did not proceed as they expected, understandably they automatically assumed they too could not breastfeed. There then seemed little point seeking help for something that could not be changed. Ongoing proactive text support could intervene at the point when women’s breastfeeding was not proceeding as expected, and act to normalise those experiences:

> *‘Sometimes they think ‘well, it’s just not working out for me, you know, it’s not going to work out because I can’t breastfeed, […] or my baby can’t breastfeed’ or, if they’re feeling then it’s something that can’t be changed, why would you sit and google something to find out or ring people if you feel that it’s just, […] they’ll probably hear quite a few stories from their peers, ‘I couldn’t breastfeed because,[…] my baby wouldn’t attach or I couldn’t breastfeed because I didn’t have enough milk’* (Ellen S1PS4 [75]).

This example suggests that different means to encourage access for target women may not always be necessary. However, special pathways tailored to the needs of target women had sometimes been set up. When the site 1 project started, the PSs used the same methods of contact for all mothers. However, this was found to be ineffective for young mothers, as identified by Sarah - *'we found we were losing those* [young] *mums'* (Sarah S1PS2[32]). As data about mother's age was transferred from the hospital, the service decided to construct a specific pathway to help keep young mothers in the service. For example, all contacts were made by the same home visiting peer supporter:

> *'The first call they get, the first person they chat to is the same person that's going to come in the door, it's the same person that might meet them at group, it's the same person that will follow them up for as long as they need, and we found that much better, rather than let's build a little bit of a rapport, let's get to know you a little bit and then I'll give you to somebody else'* (Sarah S1PS2 [28]).

The schedule of contact attempts was adjusted creatively to include use of an online chat bot,[14] or to *'start a text conversation, maybe send them stuff about groups or whatever'* (Ellen S1PS4 [120]). Ellen explained that she found the young mother's mother often acted as gatekeeper making it difficult for her to communicate directly with the young mother. However, Ellen and Jackie the site 1 manager felt that text messaging could enable direct communication with the young mother and enable her to access links to other sources of information. A gift bag was also used as a mechanism to enable access as through it Ellen tried to facilitate face to face meetings:

---

[14] A chat bot is an artificial intelligence app through which a mother can conduct a conversation via text. It gives the kinds of answers a human might give providing access to up to date information.

> *'If we were on the phone they were saying "Oh we're doing Ok my mum's here to support me" […] we said "Well we're in the area we'll drop off, we've got a goody bag for all mums […] can we drop one off with you, we've got some information in" - so at least you can - give them something so then they might think about contacting you or just[…] perhaps if they've seen your face […] at the door, they might think well actually she looks OK'* (Ellen S1PS4 [120]).

This young mothers' pathway was designed to help ensure young mothers accessed their fair share of the resource.

There was also evidence that specially designed pathways could become compromised; at site 1 the pathway by which quintile one mothers were supposed to receive the extra support required by the commission was unclear. The manager felt that once quintile one mothers had been identified (when they gave PSs their postcodes at the 48hr phone call), they *'were prioritised for a first visit and a follow up visit'* (Jackie S1 Manager [22]). One of the PSs who provided home visits discussed making special efforts to maintain contact with quintile one mothers by e.g. *'booking a visit while we're still there sort of thing, say, "Well, shall I come back out on Friday, you can always cancel it if, […] on Friday morning, if you don't need it but shall I book it in?", sort of thing'* (Ellen S1 PS4 [58]). By contrast however, another PS who also provided home visits, felt this strategy had been changed so that one visit was now standard:

> *'We did have a process where we were booking mums in for a standard follow up for those* [quintile 1] *area codes, but with three part time people working a massive area of X* [county] *sometimes it just wasn't workable with the amount of visits that were being requested and we were then finding that we wouldn't have*

> *time to visit other mums because we'd got the follow on visits booked, so it's trying to make that balance'* (Kerry S1PS1 [67]).

None of the site 1 engaged mother participants interviewed had received more than one home visit.

PSs at site 2 were first asked to target particular geographical areas in 2012, and over time set up several different pathways or strategies to that end. Initially, they used paid PSs to work in the hospital to sign up target mothers for ongoing text support post discharge. However, the hospital's insurance limited the work they could do:

> *'They* [PSs working in the hospital] *couldn't give any clinical support so they couldn't actually support mums to breastfeed while they were here in the unit […] they* [mothers] *were asking for support with feeding, but […] because of insurance and things […] because they* [PSs] *are not employed by us, there was only limited things that they could do'* (Jenny S2IFC [47]).

Signing up adequate numbers of mothers proved difficult, and the specific pathway was compromised:

> *'What we found is we wasn't getting enough mums from just the X* [target city centre postcode area], *so we expanded it to the whole of X* [main city]*'* (Penny S2PS Co-ordinator [163]).

The data in this section suggests that at both sites new developments to help facilitate access could be applied to all mothers without consideration of target mothers' wider contextual situations. It also suggests that although specific pathways could be developed, they could also be undermined.

9.8.3 The impact of social disadvantage on access

Table 23 (demographic characteristics of mother and peer supporter participants) above illustrates that while all site 1 mother participants were socio-economically disadvantaged, at site 2 some of the mothers, although living in target areas, were more socially advantaged (i.e. had quintile 3 postcodes, were older, married, had degrees and professional jobs) than others. As explained in section 9.2 above (section introducing the case study sites), it must also be noted that the Black and minority ethnic population at site one was significant (10-20% of the population), while at site two it was small. These community demographics were reflected in my study sample; at site one two mother participants of South Asian ethnicity and one of Eastern European ethnicity participated, while at site two, one mother of South Asian ethnicity participated (see table 23). Analysis of women’s access experiences suggested there were factors in more socially disadvantaged women’s contexts which I theorise, negatively impacted on access making them more likely to drop out of the service at site 1, and less likely to get into the service at site 2. My data provides limited opportunity to compare the access experiences of women with differing social advantage. However, considering the manner by which developments to help facilitate access had developed at both sites discussed above, one interpretation of the data is that social disadvantage systematically impacts access at a gradient so that at all points of potential contact or access, more socially disadvantaged mothers may be less likely to receive the resource. Contextual factors influencing access across a mother’s journey will now be explained.

As described previously, being single, caring for all their children alone, and having no transport (as was Kiera’s situation) could make mothers’ community group participation more difficult:

> *‘I didn’t come back* [to group] *cos it was a bit of a while away from my house ** and my little girl finishes nursery at the same time as it starts so I didn’t get back to it’* (Kiera S1EM5 [48]).

However, there were many contextual factors that affected mothers’ access. At site 2 several of the more socially disadvantaged mother participants did not access ante-natal classes, therefore missing the opportunity to sign up for text support (and therefore receive early pro-active support). Classes did not appeal as women felt *‘not interested’* (Carrieann S2EM2[142]), or that *‘I don't want to go’* (Cerys S2NEM2[29]). Furthermore, if they did want to attend, rather than their own midwife signing them up, they were required to make a phone call themselves. For Kizzy, attending would also have also required her to arrange for someone else to care for her older children, and the organisation of transport to the hospital which was some distance from her home. This resulted in non-attendance:

> *‘She* [midwife] *said “Then they do a one at X* [main city], *you have to contact the hospital” and all this sort of stuff and I was like “Oh” but, so yes, I was really kind of bummed out a bit because I really wanted to do some antenatal classes but - [...] It’s really seems hard to come by’* (Kizzy S2NEM5[111]).

More socially advantaged women participants did not find ante-natal education culturally inappropriate, or struggle to arrange transport and someone to care for older children in order to attend.

While in the hospital environment more socially disadvantaged women seemed especially vulnerable and to have low levels of power. For example, Carrie had thought she would breastfeed her first baby, but she was very concerned about breastfeeding in front of other people and he was taken to special care. This meant she could not directly breastfeed him and would have to express. In the unfamiliar hospital environment, she was not in a powerful position, and decided it was easier to bottle feed:

> *'I just like chose not to, 'cos he was in an incubator and stuff like that* and *I couldn't hold him so I'd have to express and do it that way, I would have rather have done it me and him'* (Carrie S1NEM1 [16]).

At site 1, of the five non-engaged women participants, three initiated breastfeeding, and of those, two stopped in hospital before seeing a peer supporter. Kristi was having her first baby aged 20 and came from a family where nobody had put their baby to the breast. Kristi had had a positive conversation about breastfeeding with her health professional antenatally, and gave the first feed when the midwife was with her, but did not *'have a clue really'* (Kristi S1NEM5[35]). Lacking confidence, she could not continue unaided:

> *'When I were giving birth and I had the midwives there they were really good but when you went down into the ward there were no, no help at all, at all really so'* (Kristi S1NEM5[27]).

To feel able and confident to put her baby back to her breast for the second feed, Kristi needed a supportive person like a peer supporter with her. At site 1 when PSs were supporting in the hospital their work was guided by the midwives, and the midwives understandably prioritised the need for mothers to see ‘someone’ before they were discharged. There was no evidence that very early peer support was prioritised for mothers such as Kristi. Although mothers could be discharged rapidly after birth, if they were not, prioritising the need for support before discharge may have resulted in PSs meeting women nearer the end of their hospital stay, rather than as early as possible. This may have made it more difficult for them to meet the support needs of a mother such as Kristi:

> *‘Sometimes it’d be, they* [midwives] *would have a list of people who were breastfeeding who needed support, or were being discharged that day’* (Jade S1PS3 [13]).

One site 1 peer supporter working in the hospital environment explained that she felt that white middle-class mothers ‘*will ask for help and be more receptive to help’* (Jade S1PS3 [19]) compared to less socially advantaged women and women facing language barriers. Indeed, many site 1 mother participants found it difficult to ask for help in this environment. For example, Avisa was aged 23, she lived in a quintile one area, and had A level education. Avisa expressed her feelings of anxiety about asking for help in hospital:

> *‘They do say if you need help you can, but it’s a bit nerve wracking asking sometimes’* (Avisa S1NEM2 [8]).

Several site 1 mother participants either did not pick up their 48hr phone call, or for some reason did not receive it. Maggie, for whom English was a second language, did not like to answer the phone when her husband was not there to help her, and her husband did not have time off work when their baby was born:

> *'My husband work[s] in the morning[s] so nobody can answer the phone'* (Maggie S1EM3 [57]).

Tahmina was still in hospital looking after her preterm baby and did not feel confident to call the peer supporter back after missing her 48hr phone call. None of the site 1 women knew to expect a phone call. None of them mentioned friends who had received the service. They also had no idea how to access support themselves:

> *'I had no idea where to turn to next […] so, I was trying to think, of what we could do, whether I could get back in contact with her* [lactation consultant seen at hospital] *or, - I didn't know, I wasn't too sure what to do next'* (Lauren S1EM4 [73]).

Similarly, at site 2 some of the more socially disadvantaged women participants did not know other mothers who breastfed, with several having no friends who had used the service able to tell them about it. Further, the non-engaged site 2 mothers did not attend any community baby groups where they may potentially meet PSs, and when peer support groups were verbally mentioned, this did not often translate into attendance. For example, Gemma was told about groups by her health visitor, but despite this she had *'never really gone to one'* (Gemma S2NEM4 [41]). The more socially advantaged mothers at site 2 were more likely to access a group as a result of verbal signposting. They also expected to have to work to find help, as reflected by Jane:

> *'Well you have to do your own research nowadays which is fine but my knowledge grew from just, someone just mentioning it in passing really'* (Jane S2EM3 [82]).

In comparison with more socially disadvantaged women, these women seemed more comfortable asking for help from PSs and from other sources, to approach health professionals, and to access a wider range of support from health services. For example, seeking support from a GP and specialist lactation services:

> *'I was quite concerned by it* [low supply with previous baby] *so I contacted a lactation consultant* [during the antenatal period] *at X* [main city hospital] *and she was really great, she kinda gave me some information'* (Naziha S2EM4 [12]).

The data presented above does not prove that more socially disadvantaged mothers are less likely to receive peer support than more middle-class women at all access opportunities. However, it does demonstrate how a diverse range of contextual issues affected the access of mother participants in this study. The contextual issues operated at different time points in a mother's infant feeding journey and in different locations from the antenatal period, through the hospital environment to home again.

9.9 MAIN THEME 3: ‘EMBEDDING’

‘Embedding’ is linked to service access and concerns how PSs can become trusted and integrated within health professional practice and the community resulting in cultural change. At both sites, participants identified networking as the key mechanism to enable such developments.

9.9.1 Health professional embedding

PSs, managers and health professional participants at both sites felt that positive relationships with health professionals developed trust. At both sites several individual PSs made special efforts during the normal course of their work to have personal contact with the local health professionals where they were working. They felt this fostered trust in them as individuals:

> *‘I spent a lot of my time, […] if I was in the Children’s Centre I would always stick my head in and make small talk with the health visitors or midwives […]and I would* <u>*make time*</u> *to talk to them’* (Janine S2PS5 [190]).

In addition, senior PSs at both sites often had long working histories within various local support and health services such as maternity services and children’s social care. At site 2 the peer support co-ordinator took on a new job as a maternity support worker alongside her co-ordinator role. This was anticipated to enable her to ‘*be that link between all the systems’* (Verity S2PS4 [79]). The fact that ‘*they know me’* (Janine S2PS5[196]) and PSs felt they had *‘good maternity links’* (Sarah S1PS2 [22]) was considered to enable greater access to women. At site 2, such trusting relationships with health professionals enabled PSs to access ante-natal classes in order to sign up women, and at both sites they led to more women being referred or signposted into the service:

> *'If we work closely with the health visitors […] and they see our work **and they feel we're on their side, I think they're ** more likely to **signpost women in, less likely to be gatekeepers of the women they're more likely to feel open to say **[…] I'll give Ellen a ring'* (Ellen S1PS4[132]).

In one case at site 1, trust between health professionals and PSs led to increased social support for particularly vulnerable mothers:

> *'Last year I had two quite young teenage mothers that were on 'Child in Need' plans and their social workers bought them to XXX (pregnant and new mum's group) as part of their care plan'* (Sarah S1PS2[22]).

As well as this informal, ground level communication, at site 1 PSs regularly communicated on a more formal basis with health teams, the IFC and wider partners about how the service was going:

> *'We try to visit the health teams quite well once every 6 months go round the all the different health teams just to chat to them *** talk about the service, maybe kinda things that have gone well, things that we're finding challenging *** and also trying to really encourage at our infant feeding meetings if any of the health visiting teams have […] feedback from mums that they weren't happy about in terms of what we did, going in to talk to teams about it face to face and being openly, 'sometimes we don't always get it right, sometimes we might overstep boundaries' or whatever but I think having that open discussion'* (Ellen S1PS4 [132]).

Although some site 1 health professionals still desired more communication with PSs, the BPS service was felt to have become *'embedded within their* [health professional] *tool kit'* (Sarah S1PS2[134]). In comparison, at site 2 there was no systematic formal communication between the peer support co-ordinator and the health teams:

> *'We've got a contact number*- that I can't remember the ladies name but we've got the contact number and details* <u>*we*</u> *call if needed or signpost on to parents but no there's no regular sort of meetings or calls, you know, or sort of any sort of contact like that, that I'm aware of'* (Suzie S2HV2 [287]).

As reflected by Suzie above, site 2 health professionals desired increased communication, and referral to PSs at site 2 remained unusual:

> *'It's not a service that I see that much in my area. Well, kind of it doesn't, it's not kind of built in to our daily role'* (Suzie S2HV2 [307]).

As described in theme 1 (section 9.7.3), site 2 PSs used 'piggy backing' onto health professional services to access women. They also hoped to contact target or any women through increasing general levels of service awareness. Unfortunately, such awareness levels among health professional and mother participants were not high. For several women, finding out about the service appeared to rely on chance as they *'sort of-sort of stumbled across it'* (Jane S2EM3 [82]), and several site 2 non-engaged women participants would have liked peer support, but did not know it was available. For example, Kizzy explained: '*they* [health professionals] *didn't mention about it'* (Kizzy S2NEM5 [107]). Several women and the health professional participants were more aware of the group-based part of the service, but some non-engaged women felt groups would not suit their needs, and as demonstrated by Suzie, a health visitor, awareness of the text support element of the service was lacking:

> *'I wasn't aware of the text service, so [...] I'm not aware of actually* - *some of the services that are available to them* [target women]*'* (Suzie S2HV2 [217]).

The targeted nature of the service and the location of the target areas was not well known among site 2 health professionals. One health visitor, Maria, explained that it seemed to be *'a real hit and miss who's got the information* [about the text service] *and who hasn't'* (Maria S2HV1 [17]), so that she had *'no idea'* (Maria S2HV1 [20]) why some women received text support, while others did not. The lead health visitor for infant feeding was unclear about the location of target areas, and the health visitor participants did not realise the PSs worked in target areas. Several site 2 PSs realised that general levels of awareness about their service were low, and wanted to raise awareness among mothers and health professionals. For example, Penelope, sought to publicise the service among all women and health professionals:

> *'So, it's important really that… we make ourselves [laughing] even more visible, even though we feel that we're-we're doing [...] as much as we can to flag that up. It's obvious that in certain instances we're just not getting to the people that we [...] we need to get to'* (Penelope S2PS1 [393]).

In order to facilitate the access of all women several site 2 PSs attended various community-based groups and distributed *'flyers'* and *'leaflets'* (Nina S2PS3 [59]) via health professionals. However, the differential impact of such strategies which, given the contextual issues that may affect women living in target areas, may be less effective for more socially disadvantaged women, were not analysed.

At both sites there were challenges to embedding whereby PSs perceived that some health professionals held negative attitudes towards them:

> *'The X* [town A] *midwives team seemed to be more reluctant t-to get to-for us to be involved* [with ante-natal classes]. *The X* [town B] *team were always very good'* (Bridget S2PS2 [216]).

At site 2 there was evidence from some women, PSs and health professional participants that at times the service could be unreliable. For example, Janine mentioned how the PSs could find it difficult to *'get to all of'* (Janine S2PS5 [9]) the antenatal classes, and two of the mother participants who gave PSs their phone numbers did not receive any follow-up, feeling e.g. *'they forgot to contact me'* (Carrieann S2EM2 [55]). The IFC emphasised that this could negatively impact upon health professional trust in and referral to the service. Several participants acknowledged that having to rely on volunteers to deliver a large proportion of the service could result in such difficulties. Jenny the IFC stated:

> *'There's not a lot of paid time for peer support and that in itself to me is a challenge […] if they're* <u>*purely*</u> *volunteers then […] if some things in their life is happening at the time that they would normally volunteer then maybe, maybe rightly so I don't know, they can put that first cos it is volunteering but for mums who are breastfeeding I think if there's a lack of consistency of support, can be one, can be a challenge'* (Jenny S2IFC [18]).

Some PSs and manager participants at both sites felt the process of re-tendering for peer support services could damage embedding. This was because health professionals may be less likely to invest time in making peer support work, especially if the contracts were short. Kerry expressed how some health professionals may view peer support as a *'short-term gimmick'* and wonder *'what's the point?'*:

> *'In terms of the health visitors I can understand that completely because the way that the process in tenders works [...] is that you can have somebody supporting in that area building up a really good network of contacts with health visitors with the local mums who spread the word about the support that they provide, and that they have benefitted from it, and that's taken away on a re-tender and it all changes again'* (Kerry S1PS1 [122]).

Furthermore, some participants at both sites emphasised that frequent re-organisation and re-configuration of other related services such as health visiting and Children's Centres formed another negative influence on embedding both through disruption of trusting relationships, and the time and effort that change requires. For example, Mary, the site 2 commissioner pointed out the impact of recent changes to Children's Centres:

> *'Some of the groups, [...] mums and babes groups that the peer supporters used to go into to support mums, were moving from those Children's Centres but were no longer being delivered by Children's Centre staff, and [...] they've* [PSs] *had to develop new relationships with different groups to try and ensure that they get the coverage in the areas of deprivation'* (Mary S2COM [79]).

9.9.2 Community embedding and culture change.

At both sites commissioners had commissioned services that focused on early one-to-one support. However, in this section I explain how at both sites PSs valued the idea of peer support affecting wider community contexts.

At site 1 two PSs explained that they felt that through the continued presence of their service, gradually greater links were made with the community, resulting in increased effectiveness. For example, Sarah felt that *'the longer a service runs for and the more embedded it becomes within the community, the more effective it can be'* (Sarah S1PS2[134]). As a by-product of one-to-one support, women receiving the service were seen to change their own community culture via networking:

> *'When I'm visiting mums they might say 'oh you visited my friend' and 'my friend told me about this' and 'my friend said it'd be really good if I saw somebody' and they spread the word that way [...] because they've been successful at breastfeeding and they've overcome the issues they go on to help other mums, you know 'it might be difficult right now, but here's what might help' and they've taken the information away that we've given them and passed it on to other mums, so it has a ripple effect, so you might see one mum, but that might affect three mums outside of that, and might affect other mums as well'* (Kerry S1PS1 [128]).

However, there was no evidence that social change was expected to result from site 1 PSs actively networking within their own social networks outside of formal volunteering/working hours; the site 1 manager's main focus was to recruit volunteers who could supplement paid PSs to provide support in the hospital. Such volunteers *'needed to commit to do a shift on the post-natal ward every week'* (Jackie S1 MAN [69]); they needed to be reliable. The recruitment process was complex and required high levels of written English. Furthermore, living within a target area was not part of recruitment criteria.

At site 1, the process of embedding with the community was disrupted when the peer support service provider changed during my final data collection visit. This was demonstrated when Tracey, a mother who had engaged with peer support expressed confusion as to which organisation was now providing the BPS service in her area. In addition to being unable to tell any friends who the new provider was, she would also now have no direct experience of the new provider to relate to others:

> *'I've just heard well I've seen something on today that something changed like changed over but it's kinda saying that it's* [incomp] *when I looked at it it's a different support instead of XX [Org D] it's through something else instead [...] but I don't really know what what that is'* (Tracey S1EM1 [218]).

At site 2, there was evidence that women who had received peer support brought non-breastfeeding friends to community groups and talked about breastfeeding with other women in the target community. Brooke lived in an area where breastfeeding was unusual. Acting like a breastfeeding pioneer in her community, she reported that she had discussed her breastfeeding experiences with several friends and acquaintances as exemplified below:

> *'Another mum that I was speaking to, her little boy is six months old. She lives next door to my Mum and she was like "Oh my God. You're <u>still</u>*

> *breastfeeding?" I said "Well yes. Like why not?" and she was saying like "Oh yes but it really hurts though, doesn't it?" 'and they just feed on you constantly' and I was like "You've got the wrong information." You know, so she obviously didn't get- but now after she's on about having another child and she was like "Yes, I'm going to try it. Definitely"* (Brooke S2EM1[75]).

However, at site 2, the idea of embedding to engender cultural change was not constrained to passive networking by mothers, rather it assumed a more active form and was a large part of the underpinning theoretical ideas about how peer support might work and of organisation C's ethos:

> *'To promote and… change the perceptions of breastfeeding make it more acceptable, I think really the wider picture is definitely'* (Penny S2PS COORD [63]).

At site 2, PSs actively sought to embed themselves within target communities by attending various community groups, so that by talking to mothers, and breaking down any potential barriers, they might start to change attitudes and make breastfeeding a possibility:

> *'It's very much about volunteers […] being there […] weekly in the local communities where mums are, […] sort of giving mums that kind of… access to support, […] just building friendships really and then from that, you think, 'oh actually the peer supporter's quite a nice person', you know 'I might try breastfeeding'. It's kind of those drip drip drip bits of information'* (Penny S2PS COORD [63]).

Melissa, the site 2 manager, explained that it was intended that through their training PSs learned how to talk about breastfeeding with family and friends and so challenge community ideas about breastfeeding from within:

> *'You are changing the culture aren't you? They are not just doing peer support at a group then, whatever they are doing we are teaching them how to talk to people you know and how to not judge so when they are at home they are using all of those counselling skills for their family members'* (Melissa S2Manager [81]).

The theory that by training PSs, permanent advocates within communities able to effect present and future cultural change could be created was demonstrated when a non-engaged mother participant explained how a family member had supported her:

> '*My auntie in particular she used to part of a breastfeeding support group. She was one of the ladies who used to run it and she's given me a lot of advice'* (Gemma S2NEM4[25]).

At site 2 PSs attempted to promote change in any way they could. For example, at the supervision session observation, one of the PSs who worked for the local mental health trust discussed how she planned to ensure mention of BPS within upcoming peri-natal mental health training to be delivered to health professionals. There were also examples of PSs trying to change work place culture as Nina explained:

> *'In my work place we have a women's network and a new parents network... and there was kind of, cos I work in the civil service there was one department that had a breast feeding network has now extended into more departments and I support through that so I'm also supporting mums with returning to work and breast feeding through work so.. And that is something that kind of I have been able to draw on what I've done with Org C'* (Nina S2PS3 [49]).

This emphasis on cultural change was recognised as a long-term effort as reflected by Penny, the peer support co-ordinator who stated: *'It's taken a long time to actually see any change'* (Penny S2PSCOORD [67]), however, Penny felt the work was now paying off:

> *'We've definitely had an impact, you know in all the groups that we've done over the years in changing people's perceptions and the kind of culture around breastfeeding and attitudes, you know, it's more, definitely more positive'* (Penny S2PSCOORD [65]).

Given the constraints on access to target women at site 2 explained above, this community approach enabled Org C to go into target communities and pursue wider cultural change.

9.10 MAIN THEME 4: 'SERVICE MANAGEMENT'

This theme outlines how the scope of service management was affected by funding levels, and how the management practices of having time for regular communication with many different people and using different knowledge sources impacted service development.

9.10.1 Funding and service management

At site 2 the peer support co-ordinator was paid for a small number of hours per week, yet worked many more voluntarily in order to fulfil management duties and to support women. She volunteered at the Saturday midwifery clinic, ante-natal classes, community infant feeding groups, and answered the local Organisation C phone support line. She led peer support supervision sessions, was available to PSs via phone, attended multi-professional meetings, and worked on data sharing protocol plans with the IFC. As explained in theme 3 'embedding' (section 9.9.1) above, she did not have time to regularly personally communicate with on the ground health professionals. The site 2 manager realised there was *'quite a lot'* required of her, and recognised the impact of her '*very small hours'* (Melissa S2Manager [148]) and minimal management time:

> '[PS co-ordinator] *is on six hours* [per week] *you know, for what she does [...] it is not going to be perfect, there are going to be holes'* (Melissa S2 Manager [107]).

The tight budget meant much of the site 2 service, including fundamental tasks like attending antenatal classes to sign women up for text support, was delivered by volunteers:

> *'We do a lot more voluntarily than you know the paid hours to support the paid support'* (Penny S2PSCOORD [40]).

By contrast, at site 1 the core service was delivered by paid PSs and the management of paid and volunteer PSs was shared between three people, all of whom had sufficient management time. For example, Ellen supported mothers and managed PSs:

> *'I do twenty-one hours so I have [...] six hours a week that I kind of, to help with the team management and team quality control and sort of team wellbeing I suppose'* (Ellen S1PS4[4]).

9.10.2 Having time for regular communication with many different people

At site 1 management time was used for systematic (regularly arranged), open (both sides feeling able to point out negative aspects as well as positive) communication with a number of different stakeholders. This enabled ongoing monitoring of the quality of the service. In addition to regular communication with both health professionals working in local teams and managers of other services at infant feeding partnership meetings (see theme 3 'embedding' section 9.9.1 above), Jackie, the site 1 manager explained that regular feedback was also obtained from women:

> *'At the 6-8 weeks point, we did a X* [online survey provider] *survey basically we text, texted out all the women and they could feed back on, what they found good, what they'd like more of, and that kind of thing as well as checking their feeding status at the same time'* (Jackie S1 Manager [14]).

Routine communication with PSs via online and face to face meetings enabled site 1 managers to ensure consistency; *'we're all working to the same sort of ethos, and standards in terms of BFI'* (Ellen S1PS4 [3]). Meetings were organised fortnightly, but the *'support network'* was available '*as and when you need it'* (Ellen S1PS4. [9]) ensuring PSs were not left waiting to discuss experiences, helping them feel supported:

> '*We very much support each other, so I have had phone calls* [with mothers] *that have either resonated with my personal experience or made me feel a bit useless and awful* […] *I messaged X* [supervisor] *and said ' X* [name of PS] *, I need to chat to you'* (Sarah S1PS2 [100]).

At site 2 the commissioner re-convened the infant feeding strategic partnership[15] meetings at the start of the current commission. This was considered to have improved communication between the peer support co-ordinator and the managers of other related services which enabled better fulfilment of the commission and the following positive outcomes; the profile of PSs within the wider health community was raised:

> *'There's dialogue across the system, people aren't working in silos. ** An example being that the sort of the infant feeding pathway that the CCG produced now includes the contact and, part of the pathway is the breastfeeding peer support ****offer. **Whereas previously it wasn't. That wasn't included in the pathway'* (Mary S2Commissioner [17]).

The partnership also enabled Organisation C to '*connect and network with the rest of the breastfeeding system',* which proved *'invaluable'* (Mary S2 Commissioner [5]) as the commission required increased capacity via training more PSs:

---

[15] The Infant Feeding Strategic Partnership Group was a regular meeting of all strategic partners involved in infant feeding work. For example, leaders from midwifery, health visiting, public health, the Clinical Commissioning Group, local charities and Org C. Such meetings had ceased some years before the new commission began in 2017.

> *'One of the discussions* [at strategic partnership] *was […] how can we help X [Org C] recruit more volunteers? […] to become peer supporters because we were really struggling with numbers on the training courses so… So now it goes, now all the people* [at strategic partnership meeting] *distribute […] a leaflet. So, it goes far and wide'* (Penny S2 PSCOORD [126]).

This increased management level communication and resource sharing enabled organisation C to train more PSs and use them to reach more women. However, increased capacity required more management time to optimise impact, and as described above and in theme three 'embedding' (section 9.9.1), the site 2 peer support co-ordinator had minimal management time. The site 2 manager used organisation C reserves to fund two volunteer co-ordinators to assist the peer support co-ordinator. The new volunteer co-ordinator role involved communicating with PSs about a range of issues. Melissa, the site 2 manager explained:

> *'They have been really amazing in sort of supporting the supervisors I suppose, so they might have to chase up requirements for their* [PSs] *registration, you have got the admin side of it that we support them with, so 'has their DBS come through?' 'oh there is an issue with it' 'Do we need to do it again'? All really boring stuff that holds them up volunteering'* (Melissa S2Manager [83]).

Volunteer co-ordinators facilitated communication between PSs via organising social events to e.g. *'just to build that kind of team morale'* (Verity S2PS4 [58]), they chatted with PSs in order to help to find the new recruits suitable placements and prompted them to attend mandatory supervision sessions which resulted in improved monitoring of standards and support for PSs. The new volunteer co-ordinator role, alongside having ‘*experienced supporters in the different* [county] *areas’* (Melissa S2Manager [83]), eased the burden of management responsibility and communication upon the peer support co-ordinator to some degree. However, capacity to deliver monthly supervision sessions remained an issue and a new system of ‘*online, distance supervision’* (Melissa S2Manager [83]) was planned to address this. At site 2, in addition to the limited communication with ground level health professionals discussed in theme three, (section 9.9.1) ‘embedding’ above, there was also no systematic feedback from mothers regarding their ante-natal session or BPS service experiences. This seemed to limit the peer support co-ordinator’s awareness of and ability to address some service issues, for example the occasional unreliability outlined in theme three above (section 9.9.1).

9.10.3 Making use of different knowledge sources

The overarching theme ‘the transcending influence of society’ outlined how PSs at both sites had some level of contextual knowledge, including the idea that women living in target areas may find accessing services difficult (see section 9.6.2). Themes 1 (‘the role’) and 2 (‘access’) provide examples of how that contextual knowledge was used by PSs to develop services tailored and acceptable to local women (i.e. section 9.7.3 role development at site 1 and section 9.8.2 the young mums’ pathway). However, no participants at either site voiced formal discussion of such contextual knowledge at supervision sessions. At both sites, supervision was seen to help ensure standards, enable feedback, and facilitate ongoing learning and wellbeing. Consequently, although contextual knowledge was present to some extent at both sites, there appeared to be no organised process to gather and apply it.

Managers at both sites used a number of different data sources such as peer support activity logs, group attendance logs, supervision feedback, and at site 1, mother’s survey feedback, in order to report quarterly on various key performance indicators (KPIs). Jackie, the site 1 manager explained:

> *'There was a huge number of, KPI's to report on […] so, things like […] the number of 48 hour calls we made to women in a quarter, number of home visits, number of home visits to under 20's, number of home visits to quintile one post codes'* (Jackie S1 Manager [9]).

It must be recognised that at times managers did not have the data sources they needed to be able to determine to what extent they were reaching target women. For example, at site 1 mangers did not have access to baseline data for the number of quintile 1 mums initiating breastfeeding. This meant they could not determine whether PSs failed to contact more quintile 1 mothers at the 48hr phone call compared to other women. However, at both sites the potential of hard data sources to assist service development was not fully realised. When new developments designed to improve access were introduced (as discussed in theme 2 'access', section 9.8.2), their impact upon the access of target and non-target women was not evaluated at either site. There were also other opportunities to use hard data that were missed. For example, at site 1 PSs working in hospital obtained women's postcodes, but they did not use this information to target their attempts to contact women by telephone once the mothers had been discharged home. When PSs received contact information from the hospital (which did not include postcode data), they did not cross match this with the postcode information they had gathered from women on the ward. At site 2, although PSs collected postcode data for all women engaging with the service, they did not scrutinise it to establish whether more advantaged women living within target areas were more likely to engage than those living in higher deprivation postcodes. Some site 2 PSs routinely provided intensive text support, texting *'three times a week'* (Penelope S1PS1[173]) in the early post-natal period compared to others who would *'send a text within the next week'* (Bridget S2PS2 [91]). Engagement records were not used to investigate the efficacy of each approach. Furthermore, although some site 2 PSs provided text support to all women regardless of target status, differential impacts of intensive text support for target and non-target women were not explored.

For PSs on the ground at both sites, formal data sources enabled commission fulfilment. They were not viewed as tools to help them evaluate, improve or develop services:

> *'From our perspective on the ground, yes there's X* [manager of project] *that writes the reports and she's interested in where these mother's live and how old they are [...] because that's what, that's what the KPI's are, that's, that's what the commissioners asked for, but I think for the rest of us on the ground it doesn't actually make any difference'* (Sarah S1PS2 [56]).

In order to design services commissioners used local breastfeeding data, good practice and stakeholder insights alongside *'specifications from* [other] *areas where good practice, ** had been, put in place'* and services were *'achieving good results'* (Mary S2Commissioner [31]) as well as national evidence:

> *'Nice guidance, the bfi guidance, from UNICEF, the public health outcomes framework, lots of places, mostly national, national guidance that's available'*. (Cathy S1Commissioner [54]).

Mary, the site 2 commissioner, felt that using an organisation with experience delivering BPS in similar contexts in other parts of the country ensured her service would fit the needs of local mothers:

> *'Mums in X [site 2 county] aren't necessarily that different from mums in other areas of deprivation [...] the issues are very similar to that which X [Org C] has a lot of experience in their training, to support their volunteers to be able to meet mum's needs'* (Mary S2COMM [47]).

Although commissioners managed services via KPI's and used qualitative data and informal discussion of services when meeting senior PSs at infant feeding strategy meetings, there appeared to be no formal gathering of contextual knowledge from PSs. For example, at both sites commissioners did not require feedback about how services had developed in response to local needs. This may have made it harder for services to develop to become better attuned to local contexts despite the site 2 commissioner's desire to *'really be sure'* services were meeting *'local mums needs'* (Mary S2Commissioner [67]). When I undertook member check interviews, I asked participating PSs about their experiences of ongoing development in response to local needs. Ellen, an experienced site 1 peer supporter, highlighted that although she felt such development was not necessarily expected, she felt it happened *'inside my head'* (Ellen S1PS4 Member check interview). Contextual knowledge seemed 'invisible' within management practices at both sites which may have impeded service development.

In this chapter, I have introduced the case study sites, explained my data collection, presented participant characteristics, and outlined the theoretical framework I used to structure my findings. I then presented one over-arching theme and four main themes to explain service development. The over-arching theme was ‘the transcending influence of society’. The four main themes were ‘the role’, ‘access’, ‘embedding’ and ‘service management’. Figure 7, presented above, provides a visual representation of the themes. In the following chapter, I summarise the findings and contextualise them by relating them to theoretical insights from the wider theory and literature base. I consider the extent to which my findings support or refute other literature and discuss the implications of my study for research, policy, and practice, and its strengths and limitations. Consideration of the study’s unique contribution to knowledge is followed by a conclusion.

10.0 CHAPTER 10: DISCUSSION AND CONCLUSION

10.1 INTRODUCTION

In the previous chapter, I presented one over-arching theme and four main themes to explain service development at the two phase two sites. In this chapter, I summarise the findings from both phases and explain how third sector breastfeeding support organisations have developed peer support services for areas of deprivation. I contextualise the findings by relating them to theoretical insights from the wider theory and literature base and consider the extent to which they support or refute other literature. I then discuss the implications of the study for research, policy, and practice, and its strengths and limitations. Consideration of the study's unique contribution to knowledge is followed by a conclusion and closing reflection.

10.2 SUMMARY OF FINDINGS

Phase one of my study involved four national third sector breastfeeding organisations referred to as Organisations A, B, C, and D. Phase one findings showed they had self-help origins and sought to help all women. Without external funding it was difficult for them to provide peer support in contexts of deprivation, and some had taken up peer support commissioning opportunities to do so. They saw such involvement as helping to address health inequalities by enabling more mothers to breastfeed. Although the findings of my meta-synthesis (chapter 3) and phase one interviews with key strategists (chapter 6) identified that a woman centred non-directive approach, and proactive contacting were potentially important practices in this context, the key strategists had differing ideas about how peer support interventions might effect change in contexts of deprivation. Within one organisation (D), peer support was seen to be working at an individual level, while in two organisations (B and C), individual, group and community level action were important.

In phase two I identified how service intensity, universality, and the extent to which initial early proactive contacting was possible were determined by the funding available for a commission in combination with data sharing arrangements. In turn, this affected how much PSs were exposed to information about women's contexts and were able to assume a population level view. During interviews PSs found discussing differences in women's socio-economic contexts uncomfortable. They wanted to help everyone and liked the idea of equality of opportunity and responding to individual need. Although the service commissions followed principles of proportional universalism (see chapter 2, section 2.5) requiring resource for all and more for target women where there was greater need i.e. those experiencing socio-economic disadvantage, PSs did not always enact this.

At both phase 2 sites which were run by organisations D (site 1) and C (site 2), the peer support role formed three parts; provision of one-to-one support, facilitation of social contacts via online or physical groups, and community culture change through networking. Women found the peer support role, including proactive contacts, acceptable. They appreciated the practical, emotional, affirmational, and informational support provided which was delivered using a woman centred, non-judgemental, non-directive approach. At site 1 (Organisation D), PSs sought to prevent issues from arising, to be perceived as mothers rather than mini health professionals, and to 'be there' for women. At site 2 (Organisation C), PSs lacked access to women and 'piggy backed' onto other services to meet them. This led to a more solution-focussed role. Access formed the biggest contextual challenge, and a desire to improve access prompted PSs to make several adaptions to their services. Such developments were not always focussed on target women, and target women may have been less likely to receive peer support at all potential access opportunities. Embedding services with health professionals and within the community enabled better access and aided cultural change. Service management was affected by the funding available for a commission. More funding enabled more time for managers to communicate with and receive feedback from health professionals, PSs via supervision, and women. Discussion of mother's wider socio-economic contexts did not form part of peer support supervision sessions. Meanwhile, managers used available data sources to fulfil commissioning reporting requirements but did not use them to evaluate impacts of service developments upon the engagement of target and non-target women.

10.3 CONTEXTUALISATION WITH WIDER THEORY AND LITERATURE

In this section I contextualise my study findings with wider theory and literature. I adapt Levesque, Harris, and Russell's (2013) theoretical conceptualisation of access and use it to discuss my findings. This discussion demonstrates that access forms the central issue of my study.

10.3.1 Rationale for my theoretical framework

After reflecting on my phase two findings, I realised that the issue of access to BPS services forms the central issue of my study; findings suggest that early proactive access by PSs provides the foundation to learn more about women's contexts and develop services to better suit them; access was an issue throughout a peer support relationship; and PSs sought to enable women to have access to positive individual, social and community environments. This realisation led me to decide to structure my discussion chapter using a theoretical framework of access. I considered using Dixon-Woods et al.'s (2006) candidacy theory as it is based on studies of people living in socially deprived areas. Candidacy theory explains access as the relationship between health care services and individuals; it views candidacy as '*a continually negotiated property of individuals'* which is *'subject to multiple influences'* (Dixon-Woods et al., 2006, p1). However, reflection had also led me to realise that through undertaking phase two, I had started to think about peer support being delivered to a whole population. My view had expanded outwards from seeing an individual mother, to seeing a whole population. Dixon-Woods et al.'s (2006) candidacy theory is an individual level theory which did not fit this population level view point. I therefore chose to use Levesque et al.'s (2013) population level access theory which will be explained below.

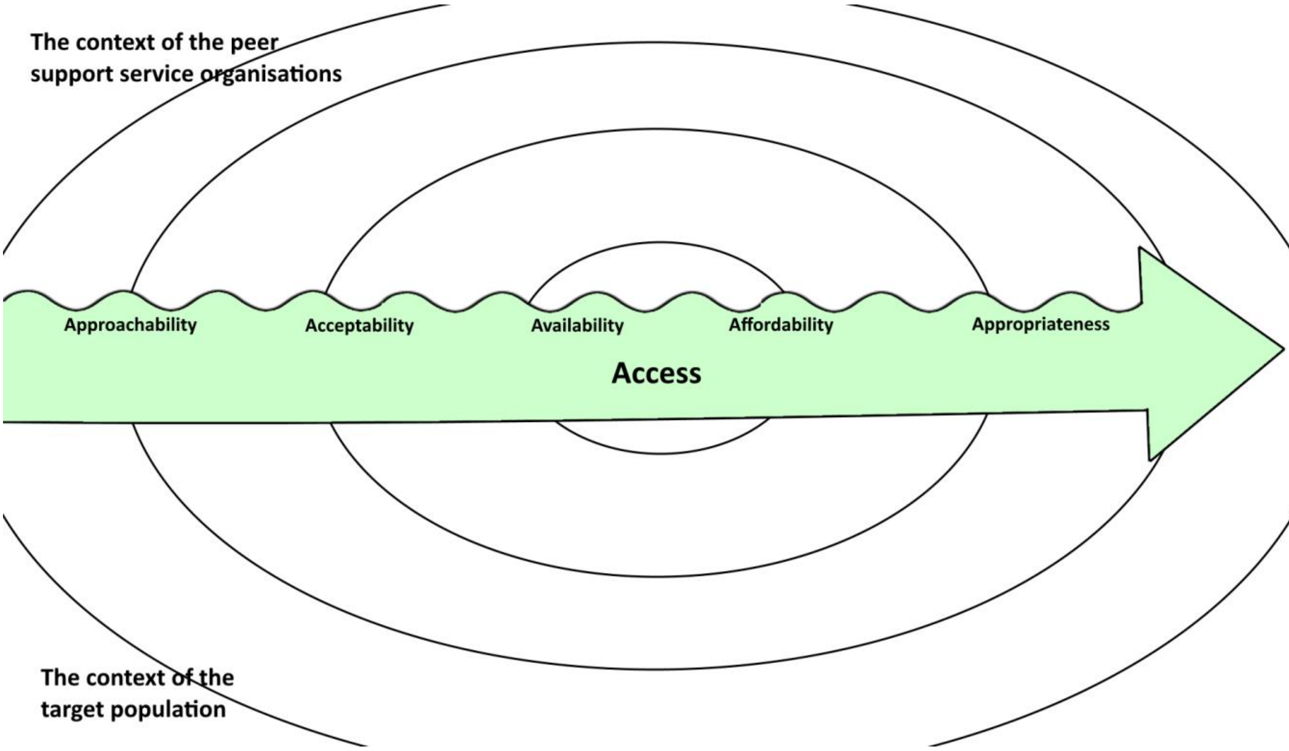
10.3.2 Utilising Levesque et al.'s (2013) Model

There are many different definitions of service access in the literature (Levesque et al., 2013), and the concept is recognised as complex (Gulliford et al., 2002). At its most elementary, '*having access'* concerns a population's potential to use services if required, while '*gaining access'* concerns initiating the process of using a service (Gulliford et al., 2002 p.186).

Interpretative synthesises of the published literature concerning service access reflect access as a dynamic complex of contextual barriers or facilitators (Dixon-Woods et al., 2006; Levesque et al., 2013). Barriers or facilitators affect both the ability of the target population to access a service, and the ability of a service to develop to fit the context (Dixon-Woods et al., 2006; Levesque et al., 2013).

Levesque and colleagues' (2013) theoretical framework presents access as a continuum of the sequential dimensions of approachability, acceptability, availability, affordability and appropriateness. I decided to simplify and adapt Levesque et al.'s (2013) model (figure 8 below); in chapter nine, I used the Social Ecological Model (SEM) to help structure my findings. In order to represent a continuation of this approach, I have used concentric semi-circles to represent the multi-level contexts of the target population (i.e. the concentric semi-circles underneath the central arrow) and of the organisations delivering the services (i.e. the concentric semi-circles above the central arrow). In the following discussion, I first explain the concept of the degree of fit between services and their populations (in figure 8 the degree of fit is represented by the wavy line of the central arrow). This is because Levesque et al.’s (2013) model offers an explanation of the degree of fit between the service and the women’s needs. I then explain each of Levesque et al.’s (2013) five dimensions, and relate them to my findings.

Figure 8 Adapted version of Levesque et al.’s (2013) model of access



10.3.3. Degree of fit

There may be barriers preventing people who have access to a service from using it, and Penchansky and Thomas (1981) were the first to put forward the idea of the importance of the degree of fit between a population and its services. As my study is about how third sector organisations have developed their services for areas of deprivation, the fit of services to their population is of primary concern. The following findings suggest that improving the fit between the peer support services and the population of target women did not form a central focus of the services' activities; PSs did not always recognise the value and relevance of mothers' contexts; some service developments did not take mothers' contexts into account; organisational processes did not facilitate the acquisition and use of contextual knowledge; and identification of aspects of the context affecting target women, and service developments responding to such issues, did not form part of commission reporting requirements. This is important because the policy of service decentralisation theorises that local actors are closer to communities, more sensitive to local conditions, and better able to respond to local needs (World Bank, 1997) (see chapter 2, section 2.11). Since the early 2000s and up until the present, third sector organisations' supposed special knowledge of local communities, has been used to justify their role in service delivery (Buckingham, 2009; Cabinet Office, 2011; Department of Health, 2016; Milbourne, 2013; VCSE, 2018). However, there is little evidence to demonstrate the existence of such special knowledge (Dickinson et al., 2012), and critics point out that during decentralisation, while local knowledge is championed, simultaneous centrally imposed targets and accountability practices render the autonomy of local actors a fallacy (Mifsud, 2016). My data suggests some kind of balance. On the one hand development in response to context was not the central focus of organisational activities. On the other hand, there was evidence that services did develop in response to contextual issues to some degree, sometimes in ways that were not prescribed by commissions (i.e. work to enable women's access to more supportive social and community cultures).

10.4 Levesque et al.’s (2013) five dimensions

Each of Levesque et al.’s (2013) five dimensions of approachability, acceptability, availability, affordability and appropriateness will be explained and related to my findings.

10.4.1 Approachability

Approachability is about how well known a service is. It describes how the degree to which a service is known well and understood, interacts with the population’s ability to perceive and seek care (Levesque et al., 2013). The finding that few women would seek out peer support of their own accord suggests that in this context, BPS services needed to be more than approachable; indeed, in order for a BPS service to make initial contact with most women, at a time when it was relevant for the women (i.e. early in their infant feeding journey), it needed to be able to proactively contact women in a systematic way. Several other studies of BPS in areas of deprivation have also reported similar non-help seeking behaviour (i.e. Fox et al., 2015; Graffy et al., 2004; McFadden & Toole, 2006); Trickey et al.’s (2018) realist review of experimental one-to-one peer support reported the same issue, identifying lower motivation and lower confidence to explain this (see chapter 2, section 2.10.4 for overview of Trickey et al.’s (2018) review). My findings offer context specific insights that expand upon Trickey et al.’s (2018) explanations. My findings highlight that constraints services faced (for example, poor data sharing and low funding) could prevent them adopting a systematic approach to early postnatal contact. In turn this affected the development of the peer support role.

In my findings, although context led development did not form a central concern, there were times when PSs used their contextual knowledge to inform the way they developed access pathways for target women. Levesque et al. (2013) explain that in order to consider seeking care, people must perceive that a service could provide care capable of helping them. At site 1, PSs felt that because target women often had no social contacts who had breastfed, when normal breastfeeding issues arose, rather than prompting a call for help or a search for information, they served to indicate that, like everyone else the women knew, they too could not breastfeed. PSs responded by proactively contacting women repeatedly. This enabled them to identify issues early, normalise them, and give appropriate support. This finding resonates with other studies such as Ingram (2013), Thomson et al. (2012) and Thomson et al. (2015) in that they too found PSs valued early proactive support. It also links with Hoddinott et al.'s (2012) study which identified 'pivotal points' in women's breastfeeding journeys when support was particularly necessary. Hoddinott et al. (2012) found that the early post-natal period was a key time when pivotal points triggering change in feeding method arose, and that timely interventions could enable families to continue breastfeeding. Trickey et al.'s (2018) realist evaluation suggests that the provision of one-to-one peer support, as an external motivation factor, may be insufficient to increase women's own internal motivation to continue breastfeeding after peer support had ceased. My findings provide a context specific explanation which expands upon this explanation; findings emphasise the nature of women's social environment and the timing of information provision interacting with motivational elements of an interaction.

Continuity of peer supporter was another practice used to facilitate ongoing access to peer support in my study. Achieving continuity through contact with the same peer supporter was felt to increase trust and make it more likely that engagement could be sustained. This finding is similar to that of Thomson et al. (2012) who found that ongoing proactive face to face contact (facilitated by the giving of gifts) enabled the ongoing engagement of especially vulnerable women. The value of continuity of supporter is reflected in other studies such as Schmied et al. (2011). One interpretation of the need to carefully build trust is that it may reflect women’s low power and status within society. Groleau, Sigouin, and D'souza (2013) use Bourdieu’s (1989) theoretical ideas of habitus and field[16] to explain that power is an important concept to consider when exploring the infant feeding experiences of women living in areas of deprivation. Their work indicates that women’s power may change depending upon the social space they are occupying. This has relevance in my study when the spaces and places in which PSs were able to meet women are considered. My findings suggest the work of site 2 PSs, who were commonly providing support in health care venues, was more issue focused. Similarly, Hoddinott et al. (2009a) (who’s study involved breastfeeding groups facilitated by health professionals), found that clinical issues were discussed when groups were provided in health centre venue’s, and social and experience-based issues were discussed when they were provided in community venues.

Levesque et al. (2013) suggest that because it is generally easier and quicker to change a service than to change the contextual conditions of a population, most developments to facilitate access will be expected to involve changes in the context of the services themselves. However, my findings suggest that the organisations sought to effect change to women’s social and community contexts. At both sites, PSs felt that the absence of a knowledge of breastfeeding within the community culture and by social contacts, negatively affected women; they saw women gaining access to more supportive social and community environments as a valued outcome of their BPS

---

[16] Bourdieu rejects the idea that people’s daily actions occur only as a result of individual decision making, and also that they are determined only by social structures (Williams, 1995). His concept of habitus bridges these two ideas as habitus is seen as a learned system of dispositions that generate action (Williams, 1995). Bourdieu sees society as composed of autonomous ‘fields’ networked together (i.e. education, politics, lifestyle). Each ‘field’ has its own internal logic and structure which both produces and is the result of the habitus appropriate to it (Williams, 1995).

services. This is in line with a large body of literature (for example, Brown, Raynor & Lee, 2011; Negin, Coffman, Vizintin & Reynes-Greenow, 2016; Vari et al., 2013). There are currently few theories underpinning community level BPS (Thomson & Trickey, 2013; Trickey et al., 2018), although Dykes (2003) mentions informal networking as a potential mechanism, and networking was the mechanism PSs in my study recognised.

10.4.2 Acceptability

Acceptability is about the relevance of the social and cultural acceptability of a service including service providers' values (Levesque et al., 2013). Such factors determine whether the population find a service acceptable (Levesque et al., 2013). Similarly, Dixon-Woods et al. (2006) explain that people living in areas of deprivation may feel intimidated by the social distance and power dynamic between themselves and health professionals, and that this can inhibit help seeking behaviour. At site 1 (organisation D) in particular, several women recounted experiences of feeling disregarded by health professionals, with one mother even using the word 'intimidated'. This could have prevented them from asking questions or seeking support. PSs had a strong presence on the post-natal ward where they sometimes acted as women's advocates, and the peer support role developed to ensure women saw them as other mothers rather than mini-health professionals. In order to fully 'be there' for women it was also important women felt able to discuss anything with PSs including issues unrelated to infant feeding. Part of the peer support role therefore, involved referring women to other services and at times acting as a bridge to health professionals. These findings suggest power and status inequality might be an important factor underlying service development, and that the peer support role may have developed to help bridge a gap between the power and status of women and that of health professionals. This finding resonates with those of

Thomson et al. (2015) who note power differentials and report PSs acting to enable women to access additional, non-infant feeding services. It also suggests that this gap had wider significance and affected women's use of other services. In phase 1 key strategists from Organisation D (site 1) felt the woman centred approach was important because it increased a mother's internal motivation to breastfeed. These findings suggest that in this context the woman centred approach might have been important because it enabled provision of a sense of social support, and enabled more of women's wider (non-infant feeding) needs to be met. However, clear understanding of how these outcomes may affect and interact with women's infant feeding experiences lies outside the scope of this study. Trickey et al.'s (2018) realist review sought to identify underpinning theories explaining how BPS interventions work. In their review having PSs being mother focussed was seen as a mechanism to enable mothers to keep breastfeeding. There was no mention of other issues that might get in the way which PSs might need to help women with. My findings provide a context specific insight that expands upon Trickey et al.'s (2018) findings (i.e. by suggesting a more complex relationship between a PSs woman centred approach, women's wider contexts, and breastfeeding practices). My findings also juxtapose to some degree with the findings of Copeland et al. (2018), who, in their study, suggest the need for the PSs to maintain the focus of their conversations with mothers upon breastfeeding.

10.4.3 Availability and Accommodation

The dimension of availability and accommodation is about whether services have the capacity, resources, and flexibility to meet people's needs (Levesque et al., 2013). In this section I explain how my findings relate to this dimension in two parts; first in relation to the policy environment in which the organisations found themselves which governed their funding and data sharing arrangements, and second, in relation to PSs attitudes towards the targeting of resources (i.e. their attitudes towards accommodation). Levesque et al. (2013) suggest that barriers to access are sequentially structured (i.e. one barrier leads to another barrier), and this was demonstrated in my findings. The amount of funding available for a commission combined with data sharing arrangements, governed whether PSs were able to proactively contact all women or not. In turn, this affected whether they could then learn about women's contexts, which was a prerequisite for further service development to facilitate access. The amount of funding affected the time available to build relationships with health professionals so that peer support might become embedded within health professional services. In turn, activities to facilitate such embedding further affected access via increased health professional referrals. Other studies examining the implementation of BPS interventions have also highlighted the importance of adequate funding and staff time, including time for interdisciplinary communication (Dykes, 2005; Hoddinott et al., 2009a), and the importance of good relationships with health professionals to support effective working of peer support projects (for example, Aiken & Thomson, 2013; Thomson et al., 2015).

At site 1 (organisation D), PSs were provided with the names and phone numbers of all women discharged who were breastfeeding. This provided opportunity to proactively contact all women, enabling them to more easily see the population as a whole and learn about women's contexts. However, because data sharing law requires sharing of only the minimum personal data (Information Commissioners Office, 2018), PSs were only provided with women's names and phone numbers, and not their postcodes. Therefore, they did not know what proportion of the whole population was made up by target women. This prevented them from specifically attempting to contact target women, and from tailoring such attempts to women's needs. Despite the intention of the policy (which was based on proportionate universalism and thus required that more resource reach target women), data sharing law prohibited the kind of data sharing that would make the mechanisms of a proportionate universal approach feasible. At both sites women who were uncontactable became invisible to PSs, and protection of the individual (as exercised via data sharing law) took precedence over the needs of target women as a group. There is little research evidence examining the implementation of interventions that cross organisational boundaries (Lyon et al., 2018), and I have not been able to identify any studies discussing the impact of data sharing on equity of access. However, Collins, McCartney and Garnham (2016) urge public health researchers to look to the political determinants of health inequalities in order to identify the actors and forces driving them. Neo-liberalism is a dominant discourse and political project founded upon individual rationality (Bourdieau, 1998). It is associated with various cultural practices, policy decisions and economic interests (Undurraga, 2015), but key principles include individualism, market fundamentalism, privatisation, and decentralisation (Macgregor, 2001) (please see chapter 2 section 2.11). Restricted spending on public services such as BPS services for new mothers, delivering such services in a devolved, localised way via third sector organisations, and having strong data sharing laws protecting individuals over groups, are examples of policy level out-working of these principles. Within neo-liberalism, the individual is valued above the group or collective, individual success is valued in terms of work and consumption, social justice comprises equal treatment for all individuals with no preferential treatment, and focus lies with the individual (Macgregor, 2001). My finding, that the policy outworking of individualism (i.e. data sharing law) affects resource allocation even when a proportional universalism policy has been adopted, provides an empirical example of just how entwined political ideology is with practices and outcomes.

As explained above my findings suggest that the issue of access was not limited to the need for a pro-active first contact. They coincide with the findings of other studies suggesting women face *'powerful social and emotional barriers to help seeking'* (Trickey et al., 2018, p.14). In my study, PSs made several developments to their services that concerned access in some way which suggested that access was an ongoing issue for them. As discussed in chapter 2 section 2.5, Tudor Hart (1971) was the first to describe the inverse care law whereby because the more socially advantaged are better at taking up available care, those with the greatest need paradoxically receive the least care. Marmot (2010) also emphasises that people living in more socially deprived situations may be less likely to receive services, and Dixon-Woods et al. (2006) highlight that being less assertive, articulate, and less likely and able to express themselves, people living in more socially deprived situations may receive a lesser service when they do access. My analysis of women participant's access or non-access pathways suggested that their contexts impacted on their access and utilisation of services in many different and complex ways. Factors at the outer level of the SEM could interact with organisational, family, and individual factors to affect access at all possible opportunities. This led me to the idea that the context of deprivation may systematically affect access to peer support, and that without close monitoring, as per the inverse care law, this could lead to more socially advantaged women taking up more than their fair share of the resource. Other authors have also reported times when more socially advantaged women have taken up the resource of peer support (Anderson & Grant, 2001; Fox et al., 2015; Hoddinott, Britten & Pill, 2010; Trickey et al., 2018). In my study, the peer support systems of accountability did not require the proportion of the resource that was delivered to target women to be monitored. Commissioners at site 1 required mangers to report the numbers of target women contacted and at site 2 managers were required to make contact with a certain quota of target women.

However, at neither site were managers asked to monitor contacts with target women as a proportion of the whole. Furthermore, at site 2 there was no requirement to monitor the quintile banding of the postcodes of those target women who engaged. This suggests that the systems of accountability were not robust enough to establish whether target women received the desired proportion of the resource. Although PSs at both sites recognised several barriers to access particularly affecting target women, they did not express the idea of a systematic link. It was not possible to examine data that could have established whether more socially advantaged women were taking up more than their fair share of the resource, making verification of the validity of this theory outside the scope of this study. Trickey et al. (2018) found that PSs were more motivated when their work was appreciated, and that they were more responsive to mothers who actively sought their support. They suggest that this may drive the trend for more socially confident and advantaged women to receive more peer support because socially confident mothers are better able to assert their needs. My findings expand upon this explanation, suggesting that when the barriers to access affecting women, combine with peer supporter's and their organisation's genuine desire to help everybody without reference to context, and tendency to adopt an individual level view, this may result in access inequity.

10.4.4 Affordability

Affordability is about people's economic ability to spend resources and time using services (Levesque et al., 2013). Although all BPS services were free to women, indirect costs associated with using them formed barriers for mothers. For example, the pressure of having to care for other children could mean time was not available to access services. This dimension links back to the first dimension of approachability. This is because approachability concerns how the degree to which a service is understood and known well, interacts with the population’s ability to perceive and seek care (Levesque et al., 2013). Factors such as lack of time affect the ability of women to seek and use services. As explained in the approachability section above (section 10.4.1), in order for mothers to have access to the BPS services at an appropriate time for them, the services had to come to them via proactive contacting.

10.4.5 Appropriateness

The final dimension of Levesque et al.’s (2013) model concerns service appropriateness. It outlines that service quality, including technical and interpersonal skills and adequacy of care, forms an important dimension of access because utilisation of a poor-quality service does not constitute equity of access (Levesque et al., 2013). My findings suggested that the peer support services were of good quality. At both sites commissions sought to provide early, one-to-one peer support so that women could be supported at the most appropriate time. My findings suggested that those women who received such peer support found it appropriate. They appreciated the practical, emotional, affirmational, and informational support PSs provided, and they liked their woman centred, non-judgemental, non-directive approach. The literature base suggests that women like and find these approaches to support helpful (Graffy & Taylor, 2005; Hoddinott et al., 2006b; Rossman et al., 2011; Schmied et al., 2011; Scott & Mostyn, 2003; Thomson et al., 2012a).

Perez-Escamilla and Sellen (2015) state that if social justice in breastfeeding is to be realised, all people must have fair access to *‘the multilevel intersectoral infrastructure needed to protect, promote and support breastfeeding so that individuals, families and society can partake in the numerous benefits derived from breastfeeding’* (p.12). My study findings suggest third sector peer support services are playing their part in achieving this aim. Services have developed to work towards trying to enable access to supportive environments at the individual, social group and community levels, and also perhaps, access to other services where wider social needs may be met. However, my study findings also suggest that there are strong countervailing influences preventing this both within the contexts of the target population and the services themselves.

In this section I have contextualised key findings of my study by relating them to theoretical insights from the wider theory and literature base and have considered the extent to which they support or refute other literature. In the following section I discuss the implications of the study for research, policy, and practice, and its strengths and limitations. I then consider my study's unique contribution to knowledge.

10.5 IMPLICATIONS FOR RESEARCH, POLICY AND PRACTICE

In this section, I first consider the implications of my study for research, and then for policy and practice.

10.5.1 Implications for research

My study proposes the idea that in contexts of deprivation it may be important that women can discuss issues other than infant feeding with PSs and that part of the role includes helping women to access other services. In phase 1 (Chapter 6, section 6.6.4), one of the organisation C participants put forward the idea that issues such as housing problems and food insecurity sometimes had to be addressed first before infant feeding issues could be considered, and having a peer supporter on site quickly who was able to help with such other issues was important in this context to help enable breastfeeding continuation. The data I gathered during phase 2 showed the peer support role at site 1 included speaking to mothers about wider issues such as benefits and housing, as well as acting as a bridge to health professional support. However, I did not see any evidence of PSs having to help with wider issues before infant feeding could be dealt with. My study was not specifically designed to explore this aspect of the peer support role in depth. However, it may be that power imbalance between myself and the women participants, coupled with my data collection methods which did not allow much time for trust to be built, meant that women did not feel able to talk with me about other issues they were dealing with because they did not know me very well. From my data it remains unclear exactly what form interactions between PSs and women concerning other issues take. What do these interactions look like? How common are they? Under which circumstances do they take place? What issues do they commonly concern? How do PSs react and help? How do these other issues impact upon infant feeding? How do such interactions relate to the work of health professionals such as health visitors? These are important questions about how issues to do with the social determinants of health interact with infant feeding, and where the peer support role fits in. A qualitative study, perhaps using a realist approach could examine this question. Such a study could explore the experiences of key participants (such as mother recipients of services, senior PSs, and health visitors) of times when wider issues have been discussed as part of BPS services. Resulting data could be analysed to identify context-mechanism-outcome configurations which could be formed into vignettes and ‘tested’ for cogency with mothers who had received peer support. Such a study would require methods that enable trusting relationships with mothers to be built over a longer time and could involve co-production methods whereby women and or PSs could be involved in gathering and analysing data themselves.

The social ecological approach (Mclaren & Hawe, 2005) could form the theoretical basis upon which an action research study could be undertaken. Such a study could involve working with third sector organisations and commissioners to develop a tool to help them focus on, collect and use contextual knowledge. The study could also explore the use of contextual knowledge within third sector organisations, not just at the level of the PSs, but also up through the organisation. For example, it could explore how such knowledge could be used to inform advocacy. Before and after attitudes towards the relevance of context could be measured, as well as the impact of resulting service developments on service utilisation by target women.

Despite not being specifically designed for use with socially disadvantaged populations, the service access model by Levesque et al.'s (2013), introduced in section 10.3.2 in this chapter, proved a useful framework which helped me to better understand my findings. Dixon-Woods et al.'s (2006) candidacy theory (see section 10.3.1 in this chapter) is an alternative theoretical framework of access that was developed through critical evidence synthesis using published evidence of access relating only to areas of deprivation. However, the Dixon-Woods et al. (2006) theory takes an individual level view which seemed less appropriate for my findings. It may prove useful to undertake an evidence synthesis similar that conducted by Dixon-Woods et al. (2006), but including up to date evidence, in order to generate a population level theory of access specific to populations of socio-economic disadvantage.

The idea that informal networking may form a mechanism underpinning change at the level of the social group and community culture is not new. Indeed, Scott (2000) outlines the history of the discipline of social network analysis, explaining its origins at Harvard in the 1960's. However, the potential importance of this mechanism in regard to changes in community attitudes towards breastfeeding as a result of BPS interventions requires exploration. A study to explore this could employ qualitative approaches in combination with mathematical network modelling. Possible outcomes may include the development of a cost-benefit analysis of adopting a networking approach, medium-term measurable outcomes that could be useful in practice, and knowledge that could inform desirable characteristics for PSs fulfilling a networking role. For example, having a certain number of family and social contacts in the local area.

My findings suggest that a quantitative study analysing the contact data of several different BPS services commissioned using the principles of proportional universalism could be useful. Such a study could test the hypothesis that in such services women living in areas of deprivation may be less likely to be in receipt of peer support at all possible access opportunities, and that more socially advantaged women may take more than their fair share of the resource despite targeting efforts. Jolly et al. (2018) have undertaken a feasibility trial of peer support for mothers living in areas of deprivation. Their trial included careful gathering of data regarding the extent of mothers' engagement with PSs throughout the planned intervention. Although the peer support offered as part of the trial was not delivered under proportional universalism, the trial outcomes could have implications for practice.

Given the important way data sharing policy affected service development, a study exploring the work of data governance experts would be valuable. It would be useful to understand more about how data sharing policy decisions are made, compare interpretation of data sharing law across trusts, and to learn more about the perspectives, backgrounds, training, and motivations of data governance experts themselves.

10.5.2 Implications for policy and practice

Given the possibility that despite efforts to target resources, more socially advantaged mothers may end up receiving more of the peer support resource than more socially disadvantaged mothers, the extent to which the resource of peer support is delivered at a gradient in response to need could be monitored more closely. It would be useful if data could be collected and scrutinised to establish who exactly is accessing how much peer support as a proportion of the whole population. In addition, the relative impact of new service developments on the service utilisation of target and non-target women should be monitored. Such monitoring could be undertaken by peer support managers and /or be included in commission reporting requirements.

Proactive contacts both initially and on an ongoing basis, being woman centred, being ready to refer women on to other services, and working to develop social contacts and community cultures that are supportive of breastfeeding alongside one-to-one support are useful practices in this context. These could be adopted more widely when services are designed for similar contexts.

Findings suggest that BPS interventions in areas of deprivation may generate some outcomes that are measurable only over the medium to long term. For example, change to community cultures and linking women to other services. Findings also suggest that changes of service provider may interrupt networking mechanisms underpinning such outcomes, negatively impacting them. This suggests the need for policies encouraging long term commissioning, and that commissioners look for additional service outcomes over and above breastfeeding rates.

When planning a BPS service in an area of deprivation, the location and timing of contact between women and PSs at each of the three different levels at which peer support might work (individual, social group, and community) could be clarified and mapped onto mother’s pathways of care. Peer support managers could consider the theorised underpinning mechanisms of change for each level. These could then be used to generate specific job descriptions, necessary competencies, and desirable characteristics of PSs performing each of the three parts. This mapping exercise may result in practice changes regarding the desired characteristics of prospective PSs for each part of the role. For example, a peer supporter who will work to effect community change may ideally have many community contacts and be able to undertake this work as part of everyday life. Meanwhile a peer supporter giving early intensive one-to-one support may need more specialised interpersonal skills and be able to work at specific times.

Findings suggest that third sector organisations do have special knowledge of contexts, but that their practices may limit its gain and use. Commissioning requirements could include the use of practices, theories, and processes that drive service developments in response to the local context by enabling PSs and their managers to better gain and use contextual knowledge. For example, explanation of how new service developments relate to the local context could become incorporated into commission reporting requirements. By doing this, commissioners could raise the profile of the local context throughout the length of a commission and help drive practices to support the gathering and use of this kind of knowledge.

For peer support managers, one practice that could help drive this knowledge gathering and use could be to start to use the social ecological model as a theory underpinning their service's work. In particular, this could be used to guide discussions about context during supervision sessions and as part of management practices (e.g. when managers are making decisions about introducing new service developments such as new contacting pathways). The importance of context could be discussed with PSs as part of initial training and on a regular basis.

Given that my findings suggest data sharing policy has an important impact on service development, commissioners could work collaboratively with data governance experts throughout the whole commissioning cycle; from the time commissions are conceived, through the design phase, during implementation, and during review and re-commissioning. This would ensure data governance experts understand the aims of commissions and the potential impact on service equity of poor data sharing. It would also ensure commissioners understand the implications and feasibility of different service designs regarding data sharing from the point of view of the data sharing experts. By working together new ways of working to better enable data sharing for BPS services might be found. Sharing of best workable practices and data sharing agreements across the country could also prove useful.

10.6 STUDY STRENGTHS AND LIMITATIONS

The qualitative approach that I utilised allowed participant’s voices to be heard. Incorporating the views of women who have and have not engaged with peer support as well as those of PSs, health professionals, managers and commissioners is one of the study’s strengths. It helped facilitate a holistic view of service development. Women were recruited via a range of methods, i.e. via PSs, via health visitor clinics, via snowball sampling, and via breastfeeding groups. Rigour was considered from the outset. Methods such as member checking, reflexive practice, and discussions of interpretations amongst the supervisory team were included to ensure themes reflected participant’s views. The inductive case study design and data analysis methods allowed me to generate theoretical ideas about how and why services have developed in this context. This study is an original interpretation. It has generated theoretical ideas about how third sector organisations have developed BPS services for areas of deprivation which are relevant to current theory, policy, and practice.

There are a number of limitations to the study. First, this study was only focused on BPS delivered by third sector organisations, although there are other interventions designed to impact breastfeeding practices in areas of deprivation (see chapter 2). Second, the insights gained through undertaking phase one interviews with key organisational strategists and informants were restricted to the interpretations of individual participants. As such, they form one interpretation that cannot be attributed to whole organisations. However, findings stemming from these interviews formed one of three phase one data sets (i.e. the findings of the meta-synthesis, phase one interviews, and grey literature identified as part of the meta-synthesis). These three data sets were brought together to compare constructs arising across them (see chapter 7, section 7.2). In this way, theoretical ideas originating from phase one interviews were compared to those arising from the other data sets. This procedure facilitated the establishment of key facts and information about the organisational context and helped to inform phase two study design (i.e. relevant questions to explore in phase two), as well as allowing the development of theoretical ideas. There are features of the methods I used which are important to consider when assessing rigor (see chapter 5, section 5.5). The study drew a small set of participants from two areas of England where peer support interventions run by two third sector organisations were taking place. The findings are interpretations of the experiences of those specific participants, in their particular time and space and therefore cannot be generalised to other situations. However, the theoretical generalisations this study has generated for example, the idea that access to BPS maybe a central issue, may help guide future studies of similar interventions.

Because I did not have access to additional funding to pay for interpreters, I was not able to recruit mothers who could not speak English. At site 2 I did not meet any potential participants who could not speak English, and census figures suggest 83% of the population in that area for whom English was not their first language could speak

English well. However, at site 1, I met several potential participants who could not speak English. Census population figures suggest that across the whole site 1 area less than 2% of households have nobody with English as their main language, but that in three specific wards the figure is over 10%. Although I asked the site 1 infant feeding co-ordinator and other health professional participants to estimate what percentage of mothers in the area could not speak English, they were unable to do this. It is important therefore to acknowledge that my site 1 data does not include the perspectives of these women, and that this is a limitation, especially given that none of the site 1 PSs could speak any other languages and they too had no interpreters.

At site 2, I encountered significant problems when trying to carry out my planned recruitment methods. Health visitors working within the centre of the main city (the centre of the main target area) told me that they were overwhelmed with child protection work and unable to accommodate my attendance at their drop-in weigh clinic. The peer supporter giving city centre mothers text support told me she was too busy to help me with recruitment or to participate in my study herself. This meant that I was only able to recruit target women who had engaged with the service by attending breastfeeding or baby feeding groups within the community myself. Although all the women who had used the service that I recruited lived within the target area, several were not very socially deprived (see table 23). Because Organisation C (site 2), did not analyse the postcode quintile level of women engaging with their intervention, it was impossible for me to know whether the relative social advantage of my participants was representative of all the target women engaging with the service, or whether I had recruited some unusually socially advantaged participants.

Gaining ethical approval took longer than I anticipated and at site 1 the organisation running the service lost their contract leaving me very little time to gather data. This

meant that I did not have time to recruit women as I had intended (i.e. recruiting antenatally / very early in their postnatal journey and follow up at 6-8 weeks).
It is possible that participants put forward views they felt I wanted to hear and held back ideas they felt might be less socially desirable. Future studies could use serial interviews to build up trust and reduce the likelihood of this happening. In hindsight conducting more site visits to better engender trust may have been a better approach. The way I designed the data collection may have limited what women felt comfortable to disclose, thereby preventing me from learning about the other things they were dealing with beyond infant feeding. It may also be that health professionals who felt positive about breastfeeding and the peer support services were more likely to participate. This could have resulted in my gaining a more positive view of service embedding.

10.7 UNIQUE CONTRIBUTION TO KNOWLEDGE

This is the first study to seek to understand how third sector breastfeeding support organisations have developed their services for delivery in areas of deprivation. It makes several unique contributions to knowledge in relation to this main aim. First, context led service development is not the central focus of the third sector organisations; findings suggest that organisational practices do not facilitate the discussion, collection, and use of contextual knowledge to inform ongoing development of BPS services.

Second, in the context of deprivation, access to BPS is central; findings suggest that enabling women’s access to peer support is the most important process for services to develop. In the study findings access was conceptualised as a complex contextual issue whereby many aspects of the context of deprivation combined to make women’s access to peer support more difficult. Simultaneously, aspects of third sector organisation’s contexts affected their ability to facilitate women’s access.

Third, and again in relation to access, study findings suggest that networking (i.e. when mothers who have used BPS services and PSs talk to mothers and other people in the community about breastfeeding) might be an important mechanism by which BPS might work at a community level. Through such networking women can gain access to more supportive social and community environments.

Finally, one of the phase one objectives was to understand the extent to which third sector organisations have engaged with the health inequalities agenda. While work at the individual level (i.e. helping individual mothers and babies to breastfeed) was recognised to be contributing towards reducing health inequalities, impacts at the social group and community levels (i.e. to link women to other services, provide social support, and engender more supportive social environments), were not. This suggests that the organisations were not fully engaged with the health inequalities agenda.

This work has generated a number of important implications to help inform and improve policy and practice.

10.8 CONCLUSION

My study's aim of seeking to learn about the context of women's lives was met as far as was possible within the confines of the research methods employed. Key learning was that there were many different factors working at different levels of the SEM within women's contexts that could interact to influence their interactions with PSs.

My study's aim of learning about how women's lives interfaced with services was realised, including how context related issues interacted with the organisation's work. A key outcome was the idea that access formed the issue central to service development; aspects of women's contexts such as being unaware of services, not recognising normal breastfeeding issues had the potential to be resolved, having family members or social contacts with no experience of breastfeeding, lacking social support, having other caring responsibilities, lacking transport, experiencing language barriers, and lacking confidence to ask for help could serve to prevent women from seeking help or asking for support. This meant that proactive contacting was an important practice necessary to ensure both that contact was made in the first place, and that contact could take place at pivotal points in women's feeding journeys. This finding also led me to the idea that women living in areas of deprivation may be systematically less likely to receive peer support throughout their feeding journey. This link between the context and peer support practices affected service development in a staged way; firstly, funding levels and data sharing policy combined to determine service intensity, universality, and the extent to which PSs could systematically contact women. Secondly, intensity, universality and the extent of proactive contacting affected the extent to which PSs were able to learn about women's contexts and use that knowledge to further develop their services. Women's social and community environments affected their feeding experiences and interaction with services, and PSs sought to improve women's access to conducive wider social environments by trying to enable social group contacts and more supportive communities. A key outcome was the idea that informal networking might be a mechanism by which this change could take place.

A key outcome of my study was evidence suggesting that context-led development was not necessarily expected, organisational processes, practices, and theories to support context led development, and PSs' motivation to learn about women's contexts and apply such knowledge to service development were not necessarily present. Such findings led me to the idea that individualism working via data sharing law can impact upon context led service development. Despite this, my findings suggest that third sector breastfeeding organisations do have some special knowledge of the contexts in which they work, but they also have the potential to gain more.

My study's aim of gaining understanding about the impact of BPS on women's experiences was met. Women participants found peer support acceptable. They liked the woman centred, non-judgemental, non-directive approach. They appreciated the affirmational, informational, emotional and practical support. At site 1 PSs developed their role to emphasise their non-professional status, use the women centred approach to provide social support, empower women, and enable them to discuss whatever they wanted resulting in referral to other services. The methods I used did not allow in-depth exploration of whether, to what extent and how this support interacted with other issues women faced to help them reach or extend their feeding goals. However, these findings lend support to the idea that power and status inequality might be important in affecting women's access to services.

My study's aim of seeking to understand the history, ethos and values of third sector breastfeeding organisations and their attitudes towards health inequalities has been met. A key outcome is understanding that PSs and organisations want to support all women and tend to think about helping at the individual level rather than at the population level. Key strategists within the organisations felt that they worked to address health inequalities by helping individual mothers and babies to breastfeed, although service development on the ground suggested that in addition to this, PSs may work at a higher level, improving women's situations by referring them to other services and making more supportive social and community environments.

As explained in chapter 7, when planning phase two data collection I decided to add an additional objective. I wanted to gain understanding of how different types of knowledge were shared. I was particularly interested in PSs' knowledge of mother's contexts. This objective was met to some degree; phase two data suggested that at both sites this kind of knowledge was not shared as part of formal processes during supervision or as part of commissioning reporting.

10.9 CONCLUDING REFLECTION

When I look back over the whole experience of undertaking this study, I feel I have learned that it is important to be able to zoom in and take an individual level view, but also that it is equally important to be able to zoom out and see the wide, population level view. It was only when I undertook phase two of my study which forced me to see BPS services operating for whole populations, that I came to see the importance of access to services. I have learned to think about context itself as existing on several levels. I feel doing the study has helped me become more aware of the viewpoint I am taking (i.e. am I thinking about individuals, or am I thinking about populations?) and consciously think about it. I will be taking this with me into the future. When I look back to the beginning of this study, now I feel more positive about third sector breastfeeding organisations than I did back then. This is because the study has enabled me to see them within their own wider societal and political context, and to realise that they have limited powers within those contexts.

I have only managed to glimpse a tiny window into the worlds of other women through undertaking this study, but for that glimpse I am grateful. The study has helped me see more clearly that society as a whole does not value women and babies sufficiently, and that has made me sad. Gaining the insight that data sharing law can impact on access to services was important. It illustrated the immense complexity of the interaction between different layers of context. It would be easy to feel overwhelmed by this, to feel that it is all too complicated and to give up caring. But, maybe an important response to this feeling would be to think about how health inequalities theories have been communicated, and possible ways they could be better communicated in the future.

For me as a person, undertaking a PhD has pushed me beyond what I felt I was capable of. It has provided many opportunities such as working with my supervisory team and meeting other research students which I have greatly appreciated. I found obtaining ethical approval for phase two of my study particularly challenging. I especially enjoyed visiting the study sites and meeting participants. Balancing the demands of the study and my family has proved difficult, and I have appreciated the support of my supervisors, family and friends. I have learned the importance of endurance and patience through this process and feel that the whole undertaking has been worthwhile. It has been challenging, yet enjoyable, and I am extremely grateful to have been granted this opportunity.

REFERENCES

Abbott, B., & Williams, S. (2014). Widening the ‘representation gap’? The implications of the ‘lobbying act’ for worker representation in the UK. *Industrial Relations Journal, 45*(6), 507–523.

Acheson, D. (1998). *Independent Inquiry into inequalities in health report.* The Stationary Office. Retrieved from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/265503/ih.pdf

Aherns, T., & Chapman, C. S. (2007). Management Accounting as Practice. *Accounting, Organizations and Society. 32*, 1–27.

Ahmed, S., Macfarlane, A., Naylor, J., & Hastings, J. (2006). Evaluating bilingual peer support for breastfeeding in a local sure start. *British Journal of Midwifery, 14*(8), 467-470.

Aiken, A., & Thomson, G. (2013). Professionalization of a breast-feeding peer support service: Issues and experiences of peer supporters. *Midwifery, 29*, 145-151.

Alcock, P. (2017). The History of Third Sector Service Delivery in the UK. In J. Rees, & D. Mullins (Eds.), *The Third Sector Delivering Public Services Developments, innovations and challenges.* (pp. 19-40). Bristol: Policy Press.

Alexander, J., Anderson, T., Grant, M., Sanghera, J., & Jackson, D. (2003). An evaluation of a support group for breast-feeding women in Salisbury, UK. *Midwifery*, *19*, 215 – 220.

Anderson, T., & Grant, M. (2001). The art of community-based breastfeeding support: The Blandford breastfeeding support group, incorporating the 'Blandford Bosom Buddies'. *MIDIRS Midwifery Digest, 11*(1), S20.

Aryeetey, R., & Dykes, F. (2018). Global implications of the new WHO and UNICEF Implementation Guidance on the revised Baby Friendly Hospital Initiative. *Maternal and Child Nutrition,* 14, 1-4.

Atkins, S., Lewin, S., Smith, H., Engel, M., Fretheim, A., & Volmink, J. (2008). Conducting a meta-ethnography of qualitative literature: Lessons learnt. *BMC Medical Research Methodology, 8*(21). Retrieved from http://www.biomedcentral.com/1471_2288/8/21

Babbel, B., Mackenzie, M., Hastings, A., & Watt, G. (2019). How do general practitioners understand health inequalities and do their professional roles offer scope for mitigation? Constructions derived from the deep end of primary care, *Critical Public Health, 29*(2), 168-180.

Baby Café Lewisham Report. (2014). A Tale of Two Baby Cafes. *Perspective – NCT's journal on preparing parents for birth and early parenthood, 25* (Dec),6-7.

Balogun, O, O., O'Sullivan, E. J., McFadden, A., Ota, E., Gavine, A., Garner, C, D., Renfrew, M, J., & MacGillivray, S. (2016). Interventions for promoting the initiation of breastfeeding. *Cochrane Database of Systematic Reviews*, (11). Retrieved from: https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD001688.pub3/full

Barker, K. (1999) Peer Counselor Programs: Who, What and Why? *Leaven*, *35*(4**)**, 92. Retrieved from http://forumsdev.llli.org/llleaderweb/lv/lvaugsep99p92.html

Bates, M., (1989). The design of browsing and berry picking techniques for the online search interface. Retrieved from http://pages.gseis.ucla.edu/faculty/bates/berrypicking.html

Battersby, S. (2005). Supporting Breastfeeding Mothers. In J. Weinberger, C. Pickstone, & P. Hannon (Eds.), *'Learning from Sure Start' working with young children and their families,* (pp.86-102). Milton Keynes: Open University Press.

Battersby S (2001c) Simply the breast: evaluation of a peer support programme. Retrieved from http://www.sheffield.ac.uk/surestart/brstfrnt.html

Battersby, S. (2007). *An Evaluation of La Leche League Great Britain's Breastfeeding Peer Counsellor Programme.* Nottingham: La Leche League Great Britain.

Battersby, S., & Parkes, A. (2011). *La Leche League Great Britain (LLLGB) Ten New Groups Project: Evaluation.* UK: La Leche League Great Britain.

Battersby, S., & Sabin, K. (2002). Breastfeeding peer support - 'The Worldly Wise Project'. *MIDIRS Midwifery Digest, 12,* S29-32.

Battersby, S., (2001). The Worldly Wise Project A different approach to breastfeeding Support. *The Practicing Midwife, 4*(6), 30-31.

Bazelon, E. (2008). Founding Mothers. *New York Times Magazine, (Dec).*Retrieved from: https://www.nytimes.com/2008/12/28/magazine/28froelich-t.html

Bedding, K. (2013). Baby Café in County Durham: a success story. *Perspective - NCT's journal on preparing parents for birth and early parenthood*. *21*, 6. Retrieved from https://www.nct.org.uk/sites/default/files/related_documents/Perspective%20Dec%202013_0.pdf

Beitin, B. (2012). Interview and Sampling. In J. F. Gubrium, J. A. Holstein, A. B. Marvasti, & K. D. McKinney (Eds.), *The Sage Handbook of Interview Research.* (pp. 243-255). Thousand Oaks: Sage.

Bellah, R. N., Madsen, R., Sullivan, W. M., Swindler, A., & Tipton, S. M. (1985). *Habits of the Heart. Individualism and Commitment in American Life*. London: University of California Press.

Beresford, P., & Croft, S. (1983). Welfare pluralism: the new face of Fabianism. *Critical Social Policy, 9*(3) 19-39.

Bettany-Saltikov, J. (2012). *How to do a systematic literature review in nursing: a step-by-step guide*. Retrieved from https://www.dawsonera.com/preview/9780335242283/startPage/65

Bhavnani, V., & Newburn, M. (2013). NCT Breastfeeding Peer Support in East Lancashire. *Perspective - NCT's journal on preparing parents for birth and early parenthood*, June, 12-13.

Billis, D., & Glennerster, H. (1998). 'Human Services and the voluntary sector: towards a theory of comparative advantage'. *Journal of Social Policy, 27*(1), 79-98.

Binns, C. W., & Scott, J. A. (2002). Breastfeeding: Reasons for starting, reasons for stopping, and problems along the way. *Breastfeeding Review, 10*(2), 3-9.

Birt, L., Scott, S., Caver, D., Campbell, C., & Walter, F. (2016). Member Checking: A Tool to Enhance Trustworthiness or Merely a Nod to Validation? *Qualitative Health Research, 26*(13), 1802– 1811.

Black, D. (1980). *Inequalities in Health, report of a research working group*. London, United Kingdom: Department of Health & Social Security.

Bogner, A., & Menz, W. (2009). 'The theory-generating expert interview'. In A. Bogner, B. Littig and W. Menz (Eds.), *Interviewing Experts* (pp.43-81). Basingstoke. Palgrave Macmillan.

Bolton, G. (2010). *Reflective Practice Writing and Professional Development. 3rd Ed.* London: Sage.

Bourdieu, P. (1977). *Outline of a Theory of Practice.* Cambridge: Cambridge University Press.

Bourdieu, P. (1986). "The Forms of Capital." In J. G. Richardson (Ed.), *Handbook of theory and research for the sociology of education,* (pp. 241-258). New York: Greenwood Press.

Bourdieu, P. (1989). Social space and symbolic power. *Sociological Theory 7*(1), 14–25.

Bourdieu, P. (1998). The essence of neoliberalism What is neoliberalism? A programme for destroying collective structures which may impede the pure market logic. *Le*

Monde Diplomatique. December. Retrieved from https://mondediplo.com/1998/12/08bourdieu

Bowatte, G., Tham, R., Allen, K.J., Tan, D.J., Lau, M., Dai, X., et al. (2015). Breastfeeding and childhood acute otitis media: a systematic review and meta-analysis. *Acta Paediatrica, 104* (467), 85–95.

Boyer, K., (2012). Affect, corporeality and the limits of belonging: Breastfeeding in public in the contemporary UK. *Health and Place, 18,* 552-560.

Bragg, R. (2017). The truth is… that UK maternity pay is amongst the lowest in Europe. Retrieved from https://www.maternityaction.org.uk/2017/03/the-truth-is-that-uk-maternity-pay-is-amongst-the-lowest-in-europe/

Braveman, P. A., Cubbin, C., & Egerter, S. (2005). Socioeconomic status in health research: one size does not fit all. *JAMA, 294*, 2879–8.

Breastfeeding Network. (2019). Breastfeeding Information for Children and Young People. Retrieved from: https://www.breastfeedingnetwork.org.uk/breastfeeding-information-for-children-and-young-people/

Breastfeeding Network Report. (2016). *Evaluation of Breastfeeding Network.* Edinburgh: Blake Stephenson.

Bridges, N., Howell, G., & Schmied, V. (2018). Breastfeeding peer support on social networking sites. *Breastfeeding Review***.** *26*(2),17-27.

Britton, C., McCormick, F. M., Renfrew, M. J., Wade, A., & King, S. E. (2007). Support for breastfeeding mothers. *The Cochrane Database of Systematic Reviews*, (1), CD001141.

Broadfoot, M., Britten, J., & Sachs, M. (1999). The Breastfeeding Network Supporterline. *British Journal of Midwifery,7*(5), 320-321.

Brown, A., Raynor, P., and Lee, M. (2011). Young mothers who choose to breast feed: the importance of being part of a supportive breast-feeding community. *Midwifery, 27*(1), 53-9. doi: 10.1016/j.midw.2009.09.004.

Buckingham, H. (2009). 'Competition and contracts in the voluntary sector; exploring the implications for homelessness service providers in Southampton'. *Policy & Politics*, *37*(2), 235-54.

Burns, E., Schmied, V., Sheehan, A., & Fenwick, J. (2010). A metaethnographic synthesis of women's experience of breastfeeding. *Maternal & Child Nutrition*, *6*, 201–219.

Burr, V. (2003). Social Constructionism. 2nd Edition. London: Routledge.

Burr, V. (1995). An introduction to social constructionism. Florence, Kentucky, United States: Taylor & Frances/Routledge.

Cabinet Office. (2011). Open Public Services White Paper. Retrieved from www.official-documents.gov.uk

Cairns, B., Hutchison, R., Aiken, M. (2010). Its not what we do, its how we do it; managing the tension between service delivery and advocacy. *Voluntary Sector Review*, *1*(2), 193-207.

Cambridge Dictionary. (2019a). Context. Retrieved from: https://dictionary.cambridge.org/dictionary/english/context

Cambridge Dictionary. (2019b). Policy. Retrieved from: https://dictionary.cambridge.org/dictionary/english/policy

Cambridge Dictionary. (2019c). Holistic. Retrieved from: https://dictionary.cambridge.org/dictionary/english/holistic

Carmel, E., & Harlock, J. (2008). 'Instituting the "third sector" as a governable terrain: partnership, procurement and performance in the UK'. *Policy & Politics*, *36*(1), 155-172.

Carter, P. (1995). *Feminism, Breasts and Breast-feeding.* London: MacMillan Press.

Critical Appraisal Skills Programme. (2018). CASP Qualitative Checklist. 10 questions to help you make sense of qualitative research. Retrieved from: https://casp-uk.net/wp-content/uploads/2018/01/CASP-Qualitative-Checklist-2018.pdf

Ceci, C., Limacher, L, H., & McLeod, D., L. (2002). Language and Power: Ascribing Legitimacy to Interpretive Research. *Qualitative Health Research*, *12*(5), 713-720.

Charity Commission (2008), *'Speaking Out: Guidance on Campaigning and Political Activity by Charities'*. Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/610137/CC9.pdf

Charmaz, K. (2006). *Constructing grounded theory: A practical guide through qualitative analysis.* London: Sage.

Chung, M., Raman, G., Trikalinos, T., Lau, J., & Ip, S. (2008). Interventions in primary care to promote breastfeeding: An evidence review for the U.S. preventive services task force. *Annals of Internal Medicine*, *149*(8), 565-582.

Chowdhury, R., Sinha, B. Sankar, M. J.,Taneja, S.,Bhandari, N., Rollins, N., Bahl. R. & Martines, J. (2015). Breastfeeding and maternal health outcomes: a systematic review and meta-analysis. *Acta Pædiatrica, 104*, 96–113.

Clark, J., Kane, D., Wilding, K. & Bass, P. (2012). *UK Civil Society Almanac 2012.* London: National Council for Voluntary Organisations.

Clifford, D., Gaine-Raheme, F., & Mohan, J. (2012). Variations between Organisations and Localities in Government Funding of Third sector Activity: Evidence from the National Survey of Third-sector Organisations in England. *Urban Studies, 50*(5) 959–976.

Cohen, L., Manion, L., & Morrison, K. (2007). *Research methods in education* (6th Edition). London: Routledge.

Collins, C., McCartney, G., & Garnham, L. (2016). Neoliberalism and Health Inequalities. In K. E. Smith, S. Hill, & C. Bambra (Eds.), *Health Inequalities Critical Perspectives*. (pp. 124-137). Oxford: Oxford University Press.

Commission on Social Determinants of Health. (2008). *Commission on social determinants of health final report: Closing the gap in a generation: Health* *equity through action on the social determinants of health.* Geneva: World Health Organization.

Copeland, L., Merrett, L., McQuire, C., Grant, A., Gobat, N., Tedstone, S., … Paranjothy, S. (2018). Feasibility and acceptability of a motivational interviewing breastfeeding peer support intervention. *Maternal and Child Nutrition, e12703.* Retrieved from https://doi.org/10.1111/mcn.12703

Cousin, G. (2013). Reflexivity: The new reflective practice. *International Journal of Practice-based Learning in Health and Social Care, 1*(2), 3-7.

Cowley, S,. & Billings, J, R. (1999). Resources revisited: salutogenesis from a lay perspective. *Journal of Advanced Nursing, 29*(4), 994-1004

Cresswell, J. (2009). *Research Design Qualitative, Quantitative and Mixed Methods Approaches* (3rd ed.). Thousand Oaks: Sage.

Crossland, N., & Thomson, G., (2013). Issues of expertise: health professionals' views of a breastfeeding peer support service. In V. Hall Moran, & F. Dykes (Eds.), *Maternal and Infant Nutrition and Nurture*: *Controversies and challenges* (2nd ed) (pp.181-209). London: Quay Books.

Crossland, R., & Dykes, F. (2011). Infant and young child feeding: The rhetoric-reality gap. *MIDIRS Essence.* Retrieved from http://www.midirs.org/development/MIDIRSEssence.nsf/articles/A953981A4261E5B08025784E005A6126.

Crotty, M. (1998). *The foundations of social research: Meaning and perspective in the research process.* London: Sage.

Crowson, N, J. (2011). Introduction: The Voluntary Sector in 1980s Britain. *Contemporary British History*, *25*(4), 491-498. DOI: 10.1080/13619462.2011.623861

Curtis, P., Woodhill, R., & Stapleton, S. (2007). The peer-professional interface in a community-based, breast feeding peer-support project. *Midwifery*, *23*,146–156.

Czerniak, S., & Michalski, R. (2015). *Philosophy as critique of the mind: the doctrinal evolution of critical theory.*Frankfurt am Main, Germand and Bern, Switzerland: Perter Lang GmnH, Internationaler Verlag der Wissenschaften.

Dahlgren, G., & Whitehead, M. (1991). *Policies and strategies to promote social equity in health.* Stockholm: Institute for future studies.

Darwent, K. L., & Kempenaar, L. E. (2014). A comparison of breastfeeding women's, peer supporters' and student midwives' breastfeeding knowledge and attitudes. *Nurse Education in Practice*, *14,* 319e325

Daunton, M. (1996). *Charity, self-interest and welfare in the English Past*. London: Routledge.

Davis Smith, J., Rochester, C. & Hedley, R. (1995). *An Introduction to the Voluntary Sector,* London: Routledge.

De Tocqueville, A. (2003). *Democracy in America and Two Essays on America.* London: Penguin Classics.

Dennis, C. (2002). Breastfeeding peer support: Maternal and volunteer perceptions from a randomized controlled trial. *Birth, 29*(3), 169-176.

Dennis, C. (2003). Peer support within a health care context: A concept analysis. *International Journal of Nursing Studies, 40*(3), 321-332.

Dennis, C., Hodnett, E., Gallop, R., & Chalmers, B. (2002). The effect of peer support on breast-feeding duration among primiparous women: A randomized controlled trial. *CMAJ - Canadian Medical Association Journal, 166*(1), 21-28.

Denzin, N., K. (1989). *The Research Act* (3rd Edition). Englewood Cliffs, New Jersey: Prentice Hall.

Department of Health. (2004). *National service framework for children, young people and maternity services*. London, United Kingdom: Department of Health.

Department of Health. (2005). *Choosing health: Making healthy choices easier.* London: Department of Health.

Department of Health. (2010a). *Healthy lives, healthy people: Our strategy for public health in England.* London: Department of Health.

Department of Health. (2010b). *Revision to the operating framework for the NHS in England 2010/11.*London: Department of Health.

Department of Health. (2012a). *The Public Health Outcomes Framework for England, 2013-2016.* London: Department of Health.

Department of Health. (2012b). The Family Nurse Partnership Programme Information leaflet. Retrieved from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/216864/The-Family-Nurse-Partnership-Programme-Information-leaflet.pdf

Department of Health. (2016). *Joint review of partnerships and investment in voluntary, community and social enterprise organisations in the health and care sector. Final report produced in partnership by representatives of the VCSE sector and the Department of Health, NHS England, and Public Health England*. Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/524243/VCSE_Investment_Review_A.pdf

DHSS. (1974). *Present day practice in infant feeding. Report on health and Social Subjects No 9*. London, United Kingdom: Her Majesty's Stationery Office.

DHSS. (1980). *Present Day Practice in Infant Feeding:1980.* London: HMSO.

DHSS. (1988). *Present Day Practice in Infant Feeding: Third Report.* Reports on Social Subjects *No 20*. London: HMSO.

Dickinson, H., Allen, K., Alcock, P., Macmillan, R., & Glasby, J. (2012). *The Role of the Third Sector in Delivering Social Care. NIHR School for Social Care Research Scoping Review*. Retrieved from http://www.lse.ac.uk/LSEHealthAndSocialCare/pdf/SSCR-Scoping-Review_2_web.pdf

Dixon-Woods, M., Agarwal, S., Jones, D., Young, B., & Sutton, A. (2005). Synthesising qualitative and quantitative evidence: a review of possible methods. *Journal of Health Services Research & Policy, 10*(1), 45–53.

Dixon-Woods, M., Cavers., D., Agarwal, A. E., Arthur, A., Harvey, J., Hsu, R., … Sutton, A. J. (2006). Conducting a critical interpretive synthesis of the literature on access to healthcare by vulnerable groups. *BMC Medical Research Methodology, 6*, 35. doi: 10.1186/1471-2288-6-35

Dixon-Woods, M., Fitzpatrick, R., & Roberts, K. (2001). Including qualitative research in Systematic Reviews: Opportunities and problems. *Journal of Evaluation in Clinical Practice, 7*(2), 125-133.

Dodds, R., Newburn, M., & Muller, C. (2010). *NCT Breastfeeding Support Services The Evidence.* London: NCT.

Douglas, M., (2015). Beyond ‘health’: Why don’t we tackle the cause of health inequalities? In K. E. Smith, S. Hill & C. Bambra (Eds.), *Health Inequalities critical perspectives* (pp. 109-124). Oxford: Oxford University Press.

Down, J., & Maddox, A. (2016). Coming to a Hospital of a Community Centre Near You. *Perspective - NCT’s journal on preparing parents for birth and early parenthood, 31.*

Downe, S. (2008). Meta-synthesis: a guide to knitting smoke. *Evidence Based Midwifery* 6(1): 4-8.

Downe, S., Finlayson, K., Walsh, D., Lavender, T. (2009). 'Weighing up and balancing out': a meta-synthesis of barriers to antenatal care for marginalised women in high-income countries'. *British Journal of Obstetrics and Gynaecology, 116(4), 518-29.*

Downe, S., Simpson. L., & Trafford, K. (2007). Expert intrapartum maternity care: a meta-synthesis. *Journal of Advanced Nursing*, 57(2), 127–140.

Downe, S., Walsh, D., Simpson, L., & Steen, M. (2009). Template for meta-synthesis, Available from sdowne@uclan.ac.uk

Doyle, S. (2007). Member checking with older women: A framework for negotiating meaning. *Health Care for Women International, 8*, 888–908.

Durlak, J. A. (1979). Comparative effectiveness of Paraprofessional and Professional Helpers. *Psychological Bulletin, 86*(1), 80-92.

Dykes, F. (2003). *Infant feeding initiative: A report evaluating the breastfeeding practice projects 1999-2002.* London: Department of Health.

Dykes, F. (2005). Government funded breastfeeding peer support projects: implications for practice. *Maternal & Child Nutrition, 1*, 21-31.

Dykes, F., & Hall Moran, V. (2006). Transmitted nutritional deprivation from mother to child: A socio-biological perspective. In: Hall Moran, V and Dykes, F. (eds) Maternal and Infant Nutrition & Nurture: Controversies and Challenges. pp. 6-39, London: Quay Books.

Dykes, F., & Williams, C. (1999). Falling by the wayside: A phenomenological exploration of perceived breast-milk inadequacy in lactating women. *Midwifery, 15*(4), 232-246.

Dykes, F., (2003). *Infant Feeding Initiative. A Report Evaluating the Breastfeeding Practice Projects 1999–2002.* London: Department of Health.

Dykes, F., & Flacking, R. (2016). *Ethnographic Research in Maternal and Child Health*. Routledge: Oxon.

Dyson, L., Renfrew, M., McFadden, A., McCormick, F., Herbert, G., & Thomas, J. (2006). *Promotion of breastfeeding initiation and duration. Evidence into practice briefing*. Retrieved from http://www.nice.org.uk/niceMedia/pdf/EAB_Breastfeeding_Final_Versionpdf

Eisenhardt, K. M., (1989). Building Theories from Case Study Research. *The Academy of Management Review*, *14*(4), 532-550.

Eisenhardt, K., M. (2002). Building Theories from Case Study Research. In M. Huberman, & M. B. Miles (Eds.), *The Qualitative Researcher's Companion* (pp.5-37). London: Sage.

Eng, E., & Smith, J., (1995). Natural helping functions of lay health advisors in breast cancer education. *Breast Cancer Research and Treatment, 35*, 23–29.

Entwistle, F., Kendall, S., & Mead, M. (2007). The promotion of breastfeeding among low-income women: midwives' knowledge and attitudes following a WHO/UNICEF breastfeeding management course. *Evidence Based Midwifery*, 5(1): 29-34. Retrieved from: http://search.ebscohost.com/login.aspx?direct=true&db=ccm&AN=106163809&site=ehost-live

Esty, D. C., Goldstone, J. A., Gurr, T. R., Harff, B., Levy, M., Dabelko, G. D., . . . Unger, A. N. (1998). *State Failure Task Force Report: Phase II Findings.* McLean, Virginia: Science Applications International Corporation.

Etheridge, S. (2016). *Mamas Community Breastfeeding Peer Support Programme.* Thesis: Leicester University.

Etzioni, A. (1999). Debate: The good society. *The Journal of Political Philosophy*, *7*(1), 88-103.

European Commission. (2018). *2018 Reform of Data Protection Rules.* Retrieved from https://ec.europa.eu/commission/priorities/justice-and-fundamental-rights/data-protection/2018-reform-eu-data-protection-rules_en

Fenech, G., & Thomson, G. (2014). Tormented by ghosts from their past': A meta-synthesis to explore the psychosocial implications of a traumatic birth on maternal well-being. *Midwifery, 30*, 185-193.

Fevre, R. (2016). *Individualism and Inequality The Future of Work and Politics.* Cheltenham: Edward Elgar.

Fish, S., (1990). How to recognize a poem when you see one. In D. Bartholomae & A. Petrosky (Eds.), *Ways of reading: An anthology for writers* (2nd ed.), (pp. 178-91). Boston: Bedford Books.

Flick, U. (2014). *An Introduction to Qualitative Research. Fifth Edition*. London: Sage.

Flides, V. (1986). *Breasts Bottles and Babies a history of infant feeding*. Edinburgh: Edinburgh University Press.

Foster, K. (1997). *Infant feeding 1995: A survey of infant feeding practices in the United Kingdom.* London: Stationary Office. Retrieved from http://webarchive.nationalarchives.gov.uk/+/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_4019365

Foucault, M. (1978). *The History of sexuality, Vol 1*. New York: Trans R Hurley.

Foucault, M. (1980). *Power/knowledge: Selected interviews and other writings 1972-1977*. (C. Gordon (Ed)). New York: Pantheon.

Fox, R. (2013). Baby Cafes: a social model of support for mothers. *Perspective - NCT's journal on preparing parents for birth and early parenthood*, Issue *21*(Dec), 5.

Fox, R., & McMullen, S. (2014). Baby Café Report of Baby Café Services During 2014. London: NCT.

Fox, R., & McMullen, S. (2015). Baby Café Report of Baby Café Services During 2015. London: NCT.

Fox, R., McMullen, S., & Newburn, M. (2015). UK women's experiences of breastfeeding and additional breastfeeding support: a qualitative study of Baby Café services. *BMC Pregnancy and Childbirth*, *15*,147. Doi: 10.1186/s12884-015-0581-5

Fyfes, N., R. (2005). Making Space for ‘‘Neo-communitarianism’’? The Third Sector, State and Civil Society in the UK. *Antipode*, *37*(3), 536-557.

Galobardes, B., Lynch, J., & Davey Smith, G. (2007). Measuring socioeconomic position in health research. *British Medical Bulletin*, *81-82*(21-37), 21-37. DOI:10.1093/bmb/ldm001

Garthwaite, K., Smith, K. E., Bambra, C., & Pearce, J. (2015). Desperately seeking reductions in health inequalities: perspectives of UK researchers on past, present and future directions in health inequalities research. *Sociology of Health & Illness*, 1-20. doi: 10.1111/1467-9566. 12374.

Giddens, A. (1971). *Capitalism and modern social theory: An analysis of the writings of Marx, Durkheim and Max Weber*. Cambridge: Cambridge University Press.

Giddens, A. (1998). *The Third Way: The Renewal of Social Democracy*. London: Polity Press.

Gill, S. (2001). The Peer Counsellor Programme in Great Britain. *LEAVEN, 37*(2), 46-7.

Glazer, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research.* Chicago: Aldine.

Glencross, J. (1998). *"Evaluation of the La Leche Peer Counsellor Support Programme in Nottinghamshire".* Dissertation presented to the Nottingham School of Public Health, University of Nottingham.

Godin, K., Stapleton, J., Kirkpatrick, S. L., Hanning, R. M., & Leatherdale, S. T. (2015). Applying Systematic Review search methods to grey literature: a case study examining guidelines for school breakfast programs in Canada. *Systematic Reviews, 4*(138). DOI: 1186/s13643-015-0125-0.

Graffy, J. P. (2002). *Evaluating breastfeeding support: a randomised controlled trial*. Medical Doctorate thesis. University of Birmingham.

Graffy, J., & Taylor, J. (2005). What information, advice, and support do women want with breastfeeding? *Birth, 32*(3), 179-186.

Graffy, J., Eldridge, S., Taylor, J., & Williams, A. (2004). Randomized controlled trial of support from volunteer counselors for mothers considering breast feeding. *BMJ: British Medical Journal (International Edition), 328*(7430), 26-29.

Grant, A, McEwan K., Tedstone, S.,Greene G., Copeland L., Hunter, B.,Sanders J., Phillips, R., Robling R., Paranjothy, S. (2018). Availability of breastfeeding peer support in the United Kingdom: A cross-sectional study. *Maternal and Child Nutrition*, *14*. Retrieved from e12476. https://doi.org/10.1111/mcn.12476

Greenhalgh, T., Robert, G., MacFarlane, F., Bate, P., Kyriakidou, O., & Peacock, R. (2005). Storylines of research in diffusion of innovation: a meta-narrative approach to systematic review. *Social Science and Medicine, 61*(2),417-30.

Groleau, D., Sigouin, C., & D'souza, N. (2013). Power to negotiate spatial barriers to breastfeeding in a western context: When motherhood meets poverty. *Health &Place. 24*, 250–259. Retrieved from http://dx.doi.org/10.1016/j.healthplace.2013.08.011

Grummer-Strawn, L., & Rollins, N. (2015). Summarizing the health effects of breastfeeding. Editorial. *Acta Paediatrica*, *104*,1-2. Doi: 10.1111.apa.13136

Guba, E. G., & Lincoln, Y. S. (1994). Competing paradigms in qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 105-117). Thousand Oaks, CA: Sage Publications.

Gulliford, M., Figueroa-Munoz, J., Morgan, M., Hughes, D., Gibson, B., Beech, R., & Hudson, M. (2002). What does 'access to health care' mean? *Journal of Health Service Research Policy*, *7*, 186–188.

Hall Moran, V., Dykes, F., Edwards, J., Burt, S., & Whitmore, M. (2005). An evaluation of the breastfeeding support skills of midwives and voluntary breastfeeding supporters using the Breastfeeding Support Skills Tool (BeSST). *Maternal and Child Nutrition*, *1*, 241–249.

Hall Moran, V., Dykes, F., Burt, S., & Shuck, C. (2006). Breastfeeding support for adolescent mothers: similarities and differences in the approach of midwives and qualified breastfeeding supporters. *International Breastfeeding Journal, 1*(23), doi:10.1186/1746-4358-1-23

Hansmann, H. B. (1980) The role of non-profit enterprise. *Yale Law Journal*, *89,* 835–901.

Harris, J., Springett, J., Croot, L., Booth, A., Campbell, F., Thompson, J., … Yang, Y. (2015). Can community-based peer support promote health literacy and reduce inequalities? A realist review. *Public Health Research, 3*(3). Doi: 10.3310/phr03030

Harris, M. (2010), 'Third sector organizations in a contradictory policy environment'. In D. Billis (ed.), *Hybrid Organizations and the Third Sector* (pp. 25-45). Basingstoke: Palgrave Macmillan.

Harper, M., & Cole, P. (2012). Member checking: Can benefits be gained similar to group therapy. *The Qualitative Report*, *17*, 510–517.

Hastrup, K. (1995). *A passage to anthropology between experience and theory.* London: Routledge.

Healey, A. (2013). *Breastfeeding Support Submission to the NICE shared learning database. Guidance products: QS37*. Retrieved from: https://www.nice.org.uk/contents/item/display/30854

Hegney, D., Fallon, T., & O'Brien, M. L. (2008). Against all odds: A retrospective case-controlled study of women who experienced extraordinary breastfeeding problems. *Journal of Clinical Nursing, 17,* 1182-1192.

Helman, C. G. (2001). *Culture, health and illness* (4th ed.). London: Butterworth Heineman.

Hermanns, H. (2004). Interviewing as an activity. In U. Flick, E. Kardoff, & I. Steinke (Eds.), *A Companion to Qualitative Research* (pp.209-214). London: Sage.

Heyvaert, M., Hannes, K., & Onghena, P. (2016). *Using mixed methods research synthesis for literature reviews: The mixed methods research synthesis approach*. Los Angeles: Sage Publications. ISBN: 9781483358291.

HM Government. (2011). *Open Public Services White Paper.* Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/255288/OpenPublicServices-WhitePaper.pdf

Hoddinott, P., & Pill, R. (1999). Nobody actually tells you: A study of infant feeding. *British Journal of Midwifery*, *7*(9), 558-565.

Hoddinott, P., & Pill, R. (2000). A qualitative study of women's views about how health professionals communicate about infant feeding. *Health Expectations, 3*(4), 224-233.

Hoddinott, P., Britten, J., & Pill, R. (2009a). Why do interventions work in some places and not others: A breastfeeding support group trial. *Social Science & Medicine, 70*(5), 769-778.

Hoddinott, P., Britten, J., Prescott, G. J., Tappin, D., Ludbrook, A., & Godden, D. J. (2009b). Effectiveness of policy to provide breastfeeding groups (BIG) for pregnant and breastfeeding mothers in primary care: cluster randomised controlled trial. *British Medical Journal*, *338*: a3026. doi:10.1136/bmj.a3026

Hoddinott, P., Chalmers, M., & Pill, R. (2006b). One-to-one or group based peer support for breastfeeding? Womens' perceptions of a breastfeeding peer coaching intervention. *Birth- Issues in Perinatal Care, 33*, 139-146.

Hoddinott, P., Craig, L. C. A., Britten, J., & McInnes, R. M. (2012). A serial qualitative interview study of infant feeding experiences: Idealism meets realism. *BMJ Open, 2*(2), e000504-e000504.

Hoddinott, P., Lee, A. J., & Pill, R., (2006a). Effectiveness of a Breastfeeding Peer Coaching Intervention in Rural Scotland. *Birth, 33*(1), 27-36.

Hoddinott, P., Seyara, R., & Marais, D. (2011). Global evidence synthesis and UK idiosyncrasy: Why have recent UK trials had no significant effects on breastfeeding rates? *Maternal & Child Nutrition, 7*(3), 221-227.

Horta, B. L., Bahl, R., Martines, J. C., & Victoria, C. G. (2007). *Evidence on the long-term effects of breastfeeding: Systematic review and meta-analysis.* Retrieved from http://apps.who.int/iris/bitstream/10665/43623/1/9789241595230_eng.pdf

Horta, B.L., de Mola, C.L., & Victora, C.G. (2015). Breastfeeding and intelligence: a systematic review and meta-analysis. Acta Paediatrica, *104* (467), 14–9.

House of Commons Library. (2014). *'Transparency of Lobbying, Non-Party Campaigning and Trade Union Administration Bill, Lords Amendments', 29 January, SN/PC/6796*. Retrieved from https://services.parliament.uk/bills/2013-14/transparencyoflobbyingnonpartycampaigningandtradeunionadministration.html

House, E.R. (1993). *Professional Evaluation: Social Impact and Political Consequences*. California: Sage.

Humphrey, N. (1993). *A history of the mind*. London: Vintage Books.

Hunt, L., & Thomson, G. (2016). Pressure and judgement within a dichotomous landscape of infant feeding: A grounded theory study to explore why breastfeeding women do not access peer support provision. *Maternal and Child Nutrition. 13*(2). doi: 10.1111/mcn.12279

Hunter, L., Magill-Cuerden, J., & McCourt, C. (2015). Disempowered, passive and isolated: how teenage mothers' postnatal inpatient experiences in the UK impact on the initiation and continuation of breastfeeding. *Maternal and Child Nutrition*, 11, 47–58.

Ignjatović, S., & Buturović, Z. (2018). Breastfeeding Divisions in Ethics and Politics of Feminism. *Sociologija, LX*(1), 84-95.

The Information Centre. (2010). *Infant Feeding Survey (2010): Early Results.* London: The Information Centre for Health and Social Care.

Information Commissioner's Office. (2018). *Guide to the General Data Protection Regulation (GDPR).* Retrieved from https://ico.org.uk/media/for-organisations/guide-to-the-general-data-protection-regulation-gdpr-1-0.pdf

Ingram, J., (2013). A mixed methods evaluation of peer support in Bristol, UK: Mothers', midwives' and peer supporters' views and the effects on breastfeeding. *BMC Pregnancy and Childbirth*, *13*:192. Retrieved from https://doi.org/10.1186/1471-2393-13-192

Ingram, J., & Johnson, D. (2004). A feasibility study of an intervention to enhance family support for breastfeeding in a deprived area of Bristol, UK. *Midwifery,* 20: 367-379.

Ingram, J., Rosser, J., & Jackson, D. (2005). Breastfeeding peer supporters and a community support group: Evaluating their effectiveness. *Maternal & Child Nutrition*, *1*, 111-118.

Institute of Health Equity. (2018). *Reducing Health Inequalities Through New Models of Care a resource for new care models*. Retrieved from http://www.instituteofhealthequity.org/resources-reports/reducing-health-inequalities-through-new-models-of-care-a-resource-for-new-care-models/reducing-health-inequalities-through-new-models-of-care-a-resource-for-new-care-models.pdf

Ip, S., Chung, M., Raman, G., Chew, P., Magula, N., DeVine, D., … Lau, J. (2007). *Breastfeeding and maternal and infant health outcomes in developed countries.* Retrieved from https://archive.ahrq.gov/downloads/pub/evidence/pdf/brfout/brfout.pdf.

Islam, M. P. (2015). Why are ‘hard-to-reach’ women not engaging in a breastfeeding peer support programme? *Community Practitioner. Feb*, 36-41.

Jackson, D. (2004). *West Howe breastfeeding support group: making a difference.* Thesis. Institute of health and community studies. University of Bournemouth.

James, L. M., & Vo, H. T. (2010). *The Encyclopedia of Research Design*. (Eds Salkind N, J). London: Sage.

Johnston-Robledo I., Wares S., Fricker J., Parek L. (2007). Indecent exposure: self-objectification and young women's attitudes toward breastfeeding. *Sex Roles, 56,*429–437.

Jolly, K., Ingram, L., Freeemantle, N., Khan, K., Chambers, J., Hamburger, R. …. Macarthur, C. (2011). Effect of a peer support service on breastfeeding continuation in the UK: A randomized controlled trial. *Midwifery, 28*, 740-745.

Jolly, K., Ingram, L., Khan, K. S., Deeks, J. J., Freemantle, N., & MacArthur, C. (2012). Systematic review of peer support for breastfeeding continuation: Metaregression analysis of the effect of setting, intensity, and timing. *British Medical Journal, 344*(1), d8287-d8287. doi: 10.1136/bmj.d8287

Jolly, K, Ingram, J, Clarke, J, Johnson, D., Trickey, H., Thomson, G., …. Hoddinott, P. (2018). Protocol for a feasibility trial for improving breast feeding initiation and continuation: assets-based infant feeding help before and after birth (ABA) *BMJ Open,8*, e019142. doi: 10.1136/bmjopen-2017-019142

Jones, D, A., & West, R, R. (1986). Effect of a lactation nurse on the success of breast-feeding: a randomised controlled trial. *Journal of Epidemiology and Community Health*, 40, 45-49.

Kaunonen, M., Hannula, L., & Tarkka, M. (2012). A systematic review of peer support interventions for breastfeeding. *Journal of Clinical Nursing, 21*(14), 1943-1954.

Kempennar, L. E., & Darwent, K. L. (2011). The impact of peer support training on mothers' attitudes towards and knowledge of breastfeeding. *Maternal and Child Nutrition, 9*(3),359-68.

Kim, H. S., & Holter, I. M. (1995). Critical Theory for science of nursing practice. In A. Omery, C.E. Kasper, & G. Page (Eds.), *In search of nursing science* (pp. 205-219). Thousand Oaks, California: Sage.

King, D., & Wood, S. (1999). The political economy of neoliberalism: Britain and the United States in the 1980s. In H. Keschet, P. Lange, G. Marks, & J. D. Stephens (Eds.), *Continuity and change in contemporary capitalism* (pp.371- 397). Cambridge: Cambridge University Press.

Kirkham, M. (2000). Breastfriends Doncaster 2000. *The Practicing Midwife, 3*(7), 20-21.

Kirkham, M., Sherridan, A., Thornton, D., & Smale, M., (2006). 'Breastfriends' Doncaster: The story of our peer support project. In V. Hall Moran & F. Dykes (Eds.), *Maternal and Infant Nutrition and Nurture Controversies and Challenges* (pp.250-275). London: Quay Books.

Kramnick, I. (2003). *Introduction to Democracy in America and Two Essays on America by Alexis de Tocqueville.* London: Penguin Classics.

Kriznik, N. M. (2015). *What's the problem of health inequality represented to be?: A post-structuralist analysis of English public health policy 1980-201.* Retrieved from http://etheses.dur.ac.uk/11328/Durham eThesis.

La Leche League. (2013). *LLL Leadership, is it for you?* Retrieved from https://www.laleche.org.uk/wp-content/uploads/2015/09/LIIFY-Examining-Your-Options.pdf

La Leche League. (2018b). *La Leche League, a year of celebration.* Retrieved from https://www.laleche.org.uk/la-leche-league-year-celebration/

La Leche League. (2018a). *A Brief History of La Leche League International.* Retrieved from https://www.llli.org/about/history/).

La Leche League Great Britain. (2005a). Breastfeeding Peer Counsellor Programme. Nottingham: LLLGB.

La Leche League Great Britain. (2005b). Breastfeeding Peer Counsellor Programme Information Sheet. Nottingham: LLLGB.

Lavender, T., Baker, L., Smyth, R., Collins, S., Spofforth, A., & Dey, P. (2005). Breastfeeding expectations versus reality: a cluster randomised controlled trial. *BJOG: an international journal of obstetrics and gynaecology.* 112(8):1047–53.

Leeming, D., Marshall, J., & Locke, A. (2017). Understanding process and context in breastfeeding support interventions: The potential of qualitative research. *Maternal and Child Nutrition*, *13*, e12407. Retrieved from https://doi.org/10.1111/mcn.12407

Levesque, J. F., Harris, M. F., & Russell, G. (2013). Patient-centred access to health care: conceptualising access at the interface of health systems and populations. *International Journal for Equity in Health*, *12*(18). Retrieved from http://www.equityhealthj.com/content/12/1/18

Lincoln, Y., & Guba, E.G., (1985). *Naturalistic inquiry*. Newbury Park, California: Sage.

Lockley, R., & Hart, A. (2003). Professional Issues. Addressing inequalities in health: The Breasts Benefits project. *British Journal of Midwifery,* 11(5): 281-287. Retrieved from: http://search.ebscohost.com/login.aspx?direct=true&db=ccm&AN=106706744&site=ehost-live

Lumbiganon, P., Martis, R., Laopaiboon, M., Festin, M, R., Ho, J, J., & Hakimi, M. (2012) Antenatal breastfeeding education for increasing breastfeeding Duration. *Cochrane Database of Systematic Reviews*, (11). Retrieved from: https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD006425.pub4/full

Lyon, A. R., Whitaker, K., Locke, J., Cook, C. R., King, K. M., Duong, M., Davis, Weist, M. D., Ehrhart, M. G., and Aarons, G. A. (2018). The impact of inter-organizational alignment (IOA) on implementation outcomes: evaluating unique and shared organizational influences in education sector mental health. *Implementation Science 13*(24). Retrieved from: https://doi.org/10.1186/s13012-018-0721-1

MacGregor, E., & Hughes, M. (2010). Breastfeeding experiences of mothers from disadvantaged groups: a review. *Community Practitioner;* 83, 7.

Macmillan, R. (2010). *The Third Sector Delivering Public Services: An evidence review*. Birmingham: Third Sector Research Centre.

Macmillan, R. (2013). ‘De-coupling the state and the third sector? The Big Society as a spontaneous order’. *Voluntary Sector review*, *4*(2), 185-203.

Marmot, M. (2004). Tackling health inequalities since the Acheson Inquiry. *Journal of Epidemiology and Community Health, 58*, 262–263. doi: 10.1136/jech.2003.010264

Marmot, M. (2010). *Fair Society, Healthy Lives: The Marmot Review*: *Strategic Review of Health Inequalities in England post-2010*. Retrieved from https://www.gov.uk/dfid-research-outputs/fair-society-healthy-lives-the-marmot-review-strategic-review-of-health-inequalities-in-england-post-2010#citation

Marmot, M. (2017). Closing the health gap. *Scandinavian Journal of Public Health, 45*, 723–731

Marsh, D., & Furlong, P. (2002). A Skin Not A Sweater: Ontology and Epistemology in Political Science. In D. Marsh, & G. Stoker (Eds.), *Theory and Methods in Political Science, 2nd Ed* (pp. 17-11). England: Palgrave Macmillan.

Martin, J., &White, A. (1988). *Infant Feeding 1985.* London: Office for Population Censuses and Surveys.

Martinez-Brockman, J.L., Harari, N., Segura-Pérez, S.,Goeschel, L., Bozzi, V.,Pérez-Escamilla, R. (2017). Impact of the *Lactation Advice Through Texting Can Help* (LATCH) Trial on Time to First Contact and Exclusive Breastfeeding among WIC Participants. *Journal of Nutrition Education and Behaviour, 50*(1), 33-42.

Maslow, A. H. (1943). A Theory of Human Motivation. *Psychological Review, 50*(4),370-96.

Mason, J. (1996). *Qualitative Researching 2nd Edition*. London: Sage.

Maternity Action. (2018). *Breastfeeding in Public Places.* Retrieved from https://www.maternityaction.org.uk/advice-2/mums-dads-scenarios/6-breastfeeding-rights/breastfeeding-in-public-places/

McAndrew, F., Thompson, J., Fellows, L., Large, A., Speed, M., & Renfrew, M. J., (2012). Infant feeding survey 2010. *The Information Centre for Health and Social Care.* Retrieved from http://www.hscic.gov.uk/catalogue/PUB08694/Infant-Feeding-Survey-2010-Consolidated-Report.pdf

McFadden, A. & Toole, G. (2006). Exploring women's views of breastfeeding: a focus group study within an area with high levels of socio-economic deprivation. *Maternal and Child Nutrition*, *2,*156–168.

McFadden, A., Gavine, A., Renfrew, M.J, Wade, A., Buchanan, P., Taylor, .JL., … MacGillivray, S. (2017). *Support for healthy breastfeeding mothers with healthy term babies (review).* The Cochrane database of systematic reviews, issue 2. Art no.: CD001141. DOI: 10.1002/14651858. CD001141. Pub 5.

McGrath, Y., Sumnall, H., Edmonds, K., McVeigh, J., & Bellis, M. (2006). *Review of grey literature on drug prevention among young people.* London: National Institute for Health and Clinical Excellence. ISBN: 1-84629-184-4.

McInnes, R. J., Hoddinott, P., Jane Britten, J., Darwent, K., and Craig, L. C. A. (2013). Significant others, situations and infant feeding behaviour change processes: a serial qualitative interview study. *BMC Pregnancy and Childbirth*, *13* (114). Retrieved from http://www.biomedcentral.com/1471-2393/13/114.

McInnes, R. J., Hoddinott, P., Britten, J., Darwent, K., & Craig, L. C. A. (2013). Significant others, situations and infant feeding behaviour change processes: a serial qualitative interview study. *BMC Pregnancy and Childbirth, 13*,114.

McLaren, L., & Hawe, P. (2005). Ecological perspectives in health research. *Journal of Epidemiology and Community Health, 59*, 6–14.

McLeroy, K. R., Bibbeau, D., Steckler, A., & Glanz, K. (1988). An ecological perspective on health promotion programmes. *Health Education Quarterly, 15*(4), 351-377.

McPhereson, M, Smith-Lovin, L., & Cook, J. M. (2001). Birds of a feather: Homophily in Social Networks. *Annual Review of Sociology, 27*, 415–44.

Meier, E. R., Olson, B. H., Benton, P., Eghtedary, K., & Song, W. O. (2007). A qualitative evaluation of a breastfeeding peer counselor programme. *Journal of Human Lactation, 23*, 262-268.

Merriam, S. B. (1988). *Qualitative Research and Case Study Applications in Education*. San Francisco: Jossey-Bass A Wiley Imprint.

Merriam Webster. (2019). Definition of decentralization. *Merriam Webster Online Dictionary*. Retrieved from: https://www.merriam-webster.com/dictionary/decentralization

Mickens, A. D., Modeste, N., Montgomery, S., & Taylor, M. (2009). Peer support and breastfeeding intentions among black WIC participants. *Journal of Human Lactation, 25*(2), 157-162.

Mifsud, D. (2016). *'Decentralised'* neoliberalism and/or *'masked'* recentralisation? The policy to practice trajectory of Maltese school reform through the lens of neoliberalism and Foucault. *Journal of Education Policy, 31*(4), 443-465. Doi:10.1080/02680939.2015.1121409

Milbourne, L. (2013). *Voluntary sector in transition: Hard times or opportunities?* Bristol: Policy Press.

Milbourne, L., & Cushman, M. (2015). Complying, Transforming or Resisting in the New Austerity? Realigning Social Welfare and Independent Action among English Voluntary Organisations. *Journal of Society and Politics***,** *44*(3), 463–485.

Miles, M.B., Huberman, A, M., & Saldana, J. (2014). *Qualitative Data Analysis: A Methods Sourcebook. Edition 3.* London: Sage.

Ministry of Health. (1943). *The Breastfeeding of Infants*. *Report of the Advisory Committee on Mothers and Young Children.* London: HMSO.

Mirowski, P., & Plehwe, D. (2009). *The Road from Mont Pèlerin The Making of the Neoliberal Thought Collective.* London: Harvard University Press.

Morse, J.M., & Doberneck, B. (1995). Delineating the concept of hope. *Journal of Nursing Scholarship, 27,* 277–285.

Muirhead, P. E., Butcher, G., Rankin, J., & Munley, A. (2006). The effect of a programme of organized and supervised peer support on the initiation and duration of breastfeeding: A randomized trial. *The British Journal of General Practice, 56*(524), 191-197.

Muller, C., Newburn, M., Wise, P, Dodds, R., & Bhavnani, V. (2009). *NCT Breastfeeding Peer Support Project.* London: NCT.

Murphy, E., & Dingwall, R. (2001). “The Ethics of Ethnography”. In P. Atkinson, A. Coffey, S. Delamont, J. Lofland, & L. Lofland (Eds.), *Handbook of Ethnography* (pp.339-351). London Sage.

Nankunda, J., Tumwine, J. K., Nankabirwa, V., & Tylleskar, T. (2010). 'She would sit with me': Mothers' experience of individual peer support for exclusive breastfeeding in Uganda. *International Breastfeeding Journal, 5*(16), 1-13.

National Audit Office. (2016). *What are civil society organisations?* Retrieved from htpps://www.nao.org.uk/successful-commissioning/introduction/what-are-civil-society-organisations-and-their-benefits-for-commissioners/#notes

National Childbirth Trust. (2018). *History – NCT*. Retrieved from https://www.nct.org.uk/about-nct/history

NCT. (2013). *NCT County Durham and Darlington Baby Café and peer support project report 2012-2013.* London: NCT.

NCT. (2016). *Providing Support and Guidance on Breastfeeding: How the NCT network of Baby Cafes is helping mothers across the UK.* Retrieved from https://www.gov.uk/governemnt//collections/health-matters-public-health-issues

Negin, J., Coffman, J., Vizintin, P., and Reynes-Greenow, C. (2016). The influence of grandmothers on breastfeeding rates: a systematic review. *BMC Pregnancy and Childbirth, (16),* 91 DOI 10.1186/s12884-016-0880-5

NHS. (2019). *NHS long term plan*. Retrieved from 13.4.19 at: https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/

NICE. (2005). *The effectiveness of public health interventions to promote the duration of breastfeeding: Systematic review*. London: National Institute for Health and Clinical Excellence.

NICE. (2008). *A peer support programme for women who breastfeed: Commissioning guide*. London: National Institute for Health and Clinical Excellence.

NICE. (2011). *Review of Public Health guidance (PH 11) – Improving the nutrition of pregnant and breastfeeding mothers and children in low income households. National Institute for Health and Clinical Excellence.* Retrieved from: http://www.nice.org.uk/guidance/ph11/evidence/review-decision-2011-545978845

Noblit, G.W., & Hare, D. (1988). *Meta-Ethnography: Synthesizing Qualitative Studies*. Newbury Park, California: Sage.

Norris, N. (1993). *Understanding Evaluation*. London: Kogan Page.

O'Brien, E., Myles, P., & Pritchard, C. (2016). The portrayal of infant feeding in British women's magazines: a qualitative and quantitative content analysis. *Journal of Public Health*, *39*(2), 221–226. Retrieved from https://doi.org/10.1093/pubmed/fdw024

Oakley, A. (1992). *Social support and motherhood.* Oxford: Blackwell.

Oliver, A. (2008). *Reflections on the Development of Health Inequalities Policy in the United Kingdom. LSE Working Paper Number 11/2008. LSE Health*. Retrieved from http://www.lse.ac.uk/lse-health/assets/documents/working-paper-series/LSEHWP11.pdf

Organization for Economic Cooperation and Development. (2009). *Breastfeeding Rates.* Retrieved from: http://www.oecd.org/els/family/43136964.pdf

Palmer, G. (2009). *The Politics of Breastfeeding.* London: Pinter and Martin.

Patton, M. Q. (1999). Enhancing the quality and credibility of qualitative analysis. *Health Services Research, 34*(5 part 2), 1189-1208.

Pawson, R., & Tilley, N. (1997). *Realistic Evaluation*. London: Sage.

Pearson, A. (2010). Evidenced-based healthcare and qualitative research. *Journal of Research in Nursing, 15*(6), 489-493.

Penchansky, R., & Thomas, W.J. (1981). The concept of access: definition and relationship to consumer satisfaction. *Journal of Medical Care*, *19*, 127–140.

Pérez-Escamilla, R., Hromi-Fiedler, A.J., Gubert, M.B., Doucet, K., Meyers, S., & dos Santos Buccini, G. (2018). Becoming Breastfeeding Friendly Index: Development and application for scaling-up breastfeeding programmes globally. *Maternal and Child Nutrition*. *14*, e12596. Retrieved from https://doi.org/10.1111/mcn.12596

Pérez-Escamilla, R., & Sellen, D. (2015). Equity in Breastfeeding: Where Do We Go from Here? *Journal of Human Lactation*, *31*(1), 12–14.

Peshkin, A. (1985). ‘Virtuous subjectivity: In the participant-observer’s ‘I’s’. In D. Berg, & K. Smith (Eds.), *Exploring Clinical Methods for Social Research* (pp.267-282). Beverly Hills California: Sage.

Peshkin, A. (1988). In search of subjectivity – one’s own. *Educational Researcher, 17*(7), 17–21.

Popay, J., & Williams, G. (1994). *Researching the People’s Health.* London: Routledge.

Popay, J., Whitehead, M., & Hunter, D. (2010). Injustice is killing people on a large scale—but what is to be done about it? *Journal of Public Health, 32*(2), 148 – 149.

Porter, S. (2015). Realist evaluation: an immanent critique. *Nursing Philosophy, 16,* 239–251.

Potts, H. W. W., Keen, J., Denby, T., Featherstone, I., Patterson, D., Anderson, J.,… Blandford, A. (2011). *Towards a better understanding of delivering e-health systems: A Systematic Review using meta-narrative method and two case studies. Final report.* London: NIHR Service Delivery and Organisation Programme.

Powell, K. (2012). *A sociological analysis of an area-based health initiative: a vehicle for social change? Thesis. University of Chester.* Retrieved from https://chesterrep.openrepository.com/bitstream/handle/10034/620351/Katie+Powell+Thesis+7+02+14.pdf;jsessionid=0CD2C87E9D5B38FBF7C3530BA7120BCE?sequence=1

Public Health England. (2017). *Finger tips Public health Profiles.* Retrieved from https://fingertips.phe.org.uk/profile-group/child-health/profile/child-health-pregnancy/data#page/0/gid/1938133035/pat/6/par/E12000008/ati/102/are/E06000036

Quintero Romero, S., Bernal, R., Barbiero, C., Passamonte, R., & Cattaneo, A. (2006). A rapid ethnographic study of breastfeeding in the north and south of Italy. *International Breastfeeding Journal*, *1*,14-8.

Raheim, M, A., Magnusse, L. H., Ragnhild, J. T. S., Lunde, A. S., Jacobsen, T., & Blystad, A. (2016). Researcher researched relationship in qualitative research: Shifts in positions and researcher vulnerability. *International Journal of Qualitative Studies on Health and Well-being, 11*, 30996. Retrieved from http://dx.doi.org/10.3402/qhw.v11.30996.

Raine, P. (2003). Promoting breast-feeding in a deprived area: The influence of a peer support initiative. *Health and Social Care in the Community, 11*(6), 463-469.

Raine, P., & Woodward, P. (2003). Promoting breastfeeding: A peer support initiative. *Community Practitioner*. *76*(6), 211.

Raphael, D. (2011). A discourse analysis of the social determinants of Health. *Critical Public Health*, *21*(2), 221-236. Doi: 10.1080/09581596.2010.485606

Rees, J., & Mullins, D. (2017). *The Third Sector Delivering Public Services Developments, innovations and challenges.* Bristol: Policy Press.

Relton, C., Strong, M., Thomas, K, J., Whelan, B., Walters, S, J., Burrows, J....Renfrew, M, J. (2018). Effect of Financial Incentives on Breastfeeding: A Cluster Randomized Clinical Trial. *JAMA Pediatrics*,172(2), e174523.

Renfrew, M. J., McCormick, F. M., Wade, A., Quinn, B., & Dowswell, T. (2012a). Support for healthy breastfeeding mothers with healthy term babies. *The Cochrane Database of Systematic Reviews,* 5, CD001141.

Renfrew, M. J., PoKhrel, S., Quigley, M., McCormick, F., Fox-Rushby, J., Dodds, R., … Williams, A. (2012b). *Preventing disease and saving resources: the potential contribution of increasing breastfeeding rates in the UK. UNICEF UK.* Retrieved from https://www.unicef.org.uk/babyfriendly/wp-content/uploads/sites/2/2012/11/Preventing_disease_saving_resources_policy_doc.pdf

Ritchie, J., & Lewis, J. (2003). *Qualitative Research Practice A Guide for Social Science Students and Researchers*. London: Sage.

Robling, M., Bekkers, M., Bell, K., Butler, C,C., Cannings-John, R., Channon, S., ... & Torgerson, D. (2016). Effectiveness of a nurse-led intensive home-visitation programme for first-time teenage mothers (Building Blocks): a pragmatic randomised controlled trial. *Lancet*; 387: 146–55.

Rochester, C. (2013). *Rediscovering Voluntary Action: The Beat of a Different Drum*, Basingstoke: Palgrave Macmillan.

Rogers, C. R. (1951). *Client Centred Therapy*. USA: Robinson Publishing.

Rogers, M. (2003). Baby Friendly: a way to accreditation. Part 1. *British Journal of Midwifery*, 11, 9, 556-563.

Rollins, N., Bhandari, N., Hajeebhoy, N., Horton, S., Lutter, C. K., Martines, J. C., Piwoz, E. G., Richter, L. M., & Victora, C. G. (2016). Why invest, and what it will take to improve breastfeeding practices? *Lancet, 387*, 491–504.

Rossman, B., Engstrom, J. L., Meier, P. P., Vonderheid, S. C., Norr, K. F., & Hill, P. D. (2011). 'They've walked in my shoes': Mothers experiences of breastfeeding in a bottle-feeding culture. *Journal of Human Lactation*, *27*, 14-24.

Roulston, K. (2014). Analysing interviews. In U. Flick (Ed.), *The Sage Handbook of qualitative data analysis* (pp. 297-312). London: Sage.

Royal College of Nursing. (2011). *Informed consent in health and social care research. RCN Guidance for Nurses 2nd Edition*. Retrieved from http://www.rcn.org.uk/__data/assets/pdf_file/0010/78607/002267.pdf

Rubin, H. J., & Rubin, I. S. (2005). *Qualitative Interviewing (Second Edition): The art of hearing data.* Thousand Oaks: Sage.

Russell, C., Taylor, C., & Ball, H. (2015). Risk and Realities – Mothers' and breastfeeding peer supporters' reflections on provision of infant safe sleep education. *MAINN Conference Abstracts. Maternal and Child Nutrition, Supl (2),*106.

Sankar, M.J., Sinha, B., Chowdhury, R., Bhandari, N., Taneja, S., Martines, J., et al. (2015). Optimal breastfeeding practices and infant and child mortality: a systematic review and meta-analysis. *Acta Paediatrica*, *104* (467), 3–13.

Sandelowski, M., Docherty, S., & Emden, C. (1997). Qualitative Metasynthesis: Issues and Techniques. *Research in Nursing & Health, 20,* 365-371.

Semenic, S., Childerhose, J. E., Lauziere, J., & Groleau, D. (2012). Barriers, Facilitators, and Recommendations Related to Implementing the Baby-Friendly Initiative (BFI): An Integrative Review. *Journal of Human Lactation*, *28*(3), 317-334.

Schatzki, T., R. (2002). *The Site of the Social: A Philosophical Account of the Constitution of Social Life and Change.* America: Penn State Press.

Sherridan, A. (2010). *Breastfeeding Peer Counsellors' Reflections on their Support Role in a Northern Town.* Thesis: Sheffield Hallam University.

Schmied, V., Beake, S., Sheehan, A., McCourt, C., & Dykes, F. (2010). Women's perceptions and experiences of breastfeeding support: A metasynthesis. *Birth, 38*(1), 49-60.

Scotland, J. (2012). Exploring the Philosophical Underpinnings of Research: Relating Ontology and Epistemology to the Methodology and Methods of the Scientific, Interpretive, and Critical Research Paradigms. *English Language Teaching*, *5*(9), 9-16.

Scott, J. (2000). *Social Network Analysis, a Handbook, second Edition.* London: Sage.

Scott, J. A., & Mostyn, T. (2003). Women's experiences of breastfeeding in a bottlefeeding culture. *Journal of Human Lactation, 19*, 270-277.

Scott, S., Pritchard, C., & Szatkowski, L. (2017). The impact of breastfeeding peer support for mothers aged under 25: a time series analysis. *Maternal and Child Nutrition,13*, e12241. Retrieved from **https://doi.org/10.1111/mcn.12241**

Seale, C. (1999). *The Quality of Qualitative Research*, Oxford: Blackwell.

Sharp, K., (1998). The case for case studies in nursing research: the problem of generalisation. *Journal of Advanced Nursing*, *27*, 785-789.

Shaw, K.E. (1978). Understanding the Curriculum; The Approach Through Case Studies. *Journal of Curriculum Studies*, *10*(1), 1-17. Retrieved from https://doi.org/10.1080/0022027780100102

Simons, H. (1987). *Getting to Know Schools in a Democracy: The Politics and Process of Evaluation*. Lewes: The Falmer Press.

Simons, H. (2009). *Case Study Research in Practice*. London: Sage.

Smale, M. (2004). *Training breastfeeding peer supporters: an enabling approach.* Sheffield: Women's Informed Childbearing and Health (WICH) Research Group.

Smale, M., Newburn, M., & Dodds, R. (2004). *Review of Evidence: Peer Support for Breastfeeding.* London: NCT.

Smith, K. E. (2013). *Beyond Evidence-Based Policy in Public health: The Interplay of ideas*. Basingstoke: Palgrave Macmillan.

Smith, K. E., Bambra, C., & Hill, S. (2015). UK experiences of health inequalities. In K. E. Smith, S. Hill & C. Bambra (Eds.), *Health Inequalities critical perspectives* (pp. 1-21). Oxford: Oxford University Press.

South, J., Meah, A., Bagnall, A., Kinsella, K., Branney, P., White, J., Gamsu, M. (2010). *People in Public Health – a study of approaches to* *develop and support people in public health roles Report for the National Institute for Health Research Service Delivery and Organisation programme. SDO project (08/1716/206).* Retrieved from https://www.leedsbeckett.ac.uk/health/piph/documents/PIPH%20Final%20Report.pdf

South, J., Kinsella, K., & Meah, A. (2012). Lay perspectives on lay health worker roles, boundaries and participation within three UK community-based health promotion projects. *Health Education Research*, *27*(4), 656–670.

Spencer, L., Ritchie, J., Lewis, J., & Dillon, L. (2003). Quality in qualitative evaluation: a framework for assessing research evidence. London: Cabinet Office. Retrieved from: www.gsr.gov.uk/evaluating_policy/era_papers/qual_eval.asp

Spradely, J. P. (1980). *Participant observation.* New York: Holt Rinehart and Winston.

Stahl, B. (2011). Critical Social Information Systems Research. In R. D., Galliers, & W. Curries (Eds.), *The Oxford Handbook of Management Information Systems: Critical Perspectives and new Direction* (pp.119-229). Oxford: Oxford University Press.

Stake, R. E. (2006). *Multiple Case Study Analysis*. New York: Guilford Press.

Stake, R. E., (1995). *The Art of Case Study Research.* London: Sage.

Stirk, P. M. R. (2000). *Critical Theory, Politics and Society: An introduction.* New York: Pinter.

Sweat, M. D., & Denison, J. A., (1995). Reducing HIV incidence in developing countries with structural and environmental interventions. *AIDS*, *9*(Sup A), S25 1-7.

Thomas, J., & Harden, A. (2008). Methods for the thematic synthesis of qualitative systematic reviews. *BMC Medical Research Methodology, 8*, 45. Retrieved from https://doi.org/10.1186/1471-2288-8-45

Thomson, G., & Trickey, H. (2013). What works for breastfeeding peer support: Time to get real? *European Medical Journal - Gynecology and Obstetrics, 1,* 15-22.

Thomson, G., Ballam, M-C., & Hymers, K., (2015). Building social capital through breastfeeding peer support: insights from an evaluation of a voluntary breastfeeding peer support service in North-West England. *International Breastfeeding Journal*, *10*:15.

Thomson, G., Bilson, A., & Dykes, F, C. (2012). Implementing the WHO/UNICEF Baby Friendly Initiative in the community: a 'hearts and minds' approach. *Midwifery*. 28: 258–264.

Thomson, G., Crossland, N., & Dykes, F. (2012a). Giving me hope: Women's reflections on a breastfeeding peer support service. *Maternal and Child Nutrition, 8*(3), 340-353.

Thomson, G., Dykes, F., Hurley, M., & Hoddinott, P. (2012b). Incentives as connectors: Insights into a breastfeeding incentive intervention in a disadvantaged area of North-West England. *BMC Pregnancy and Childbirth, 12*(1), 22-22.

Thomson,G.,EsbichBurton, K., & Flacking, R., (2015). Shame if you do, Shame if you don't: Women's experiences of infant feeding. *Maternal And Child Nutrition*, *11*(1), 33- 46.

Thorne, S., Jensen. L., Kearney, M.H., Noblit, G., & Sandelowski, M. (2004). Qualitative meta-synthesis: Reflections on methodological orientation and ideological agenda. *Qualitive Health Research*,*14*(10),1342–1365.

Trickey, H. (2014). *NCT Breastfeeding Peer Support: Evidence and Rationale.* London:NCT.

Trickey, H., Thomson, G., Grant, A., Sanders, J., Mann, M., Murphy, S., Paranjothy, S. (2018). A realist review of one-to-one breastfeeding peer support experiments conducted in developed country settings. *Maternal and Child Nutrition*., *14*(1). doi: 10.1111/mcn.12559.

Tudor Hart, J., (1971). The Inverse Care Law. *The Lancet*, *297*(7696), 405-412. Retrieved from https://doi.org/10.1016/S0140-6736(71)92410-X

UK Data Services Census Support. (2019). Deprivation Data. Retrieved from:

https://census.ukdataservice.ac.uk/get-data/related/deprivation

Undurraga, T. (2015). Neoliberalism in Argentina and Chile: common antecedents, divergent paths. *Revista de Sociologica y Politica*, *23*(55), 11-34.

UNICEF BFI. (2019). *Accreditation, Statistics and Awards Table.* Retrieved from https://www.unicef.org.uk/babyfriendly/about/accreditation-statistics-and-awards-table/

UNICEF. (2018). *Baby Friendly Initiative.* Retrieved from https://www.unicef.org.uk/babyfriendly/baby-friendly-resources/international-code-marketing-breastmilk-substitutes-resources/the-code/

Vari, P., Vogeltanz-Holm, N., Olsen, G., Anderson, C., Holm, J. H., Peterson, H., & Henly, S. (2013) Community Breastfeeding Attitudes and Beliefs, *Health Care for Women* International, (34),7, 592-606, DOI: 10.1080/07399332.2012.655391

Victora, C. G., Bahl, R., Barros, A. J. D., , Franca, G. V. A., Horton, S., Krasevec, J., Murch, S., Sankar, M. J., Walker, N., & Rollins, N. C. (2016). Breastfeeding in the 21st century: epidemiology, mechanisms, and lifelong effect. *Lancet, 387*, 475–90.

Voluntary, Community, and Social Enterprise (VCSE). (2016). *Joint review of partnerships and investment in voluntary, community and social enterprise organisations in the health and care sector.* Retrieved from https://vcsereview.org.uk/2016/05/26/final-report-published/

VCSE. (2018). *Sustainable and effective voluntary, community and social enterprise organisations in health and care: an action plan.* Retrieved from https://voluntarycommunitysocialenterprisereview.files.wordpress.com/2018/05/vcse-review-action-plan-may-2018.pdf

Walsh, D., & Downe, S. (2005a). Meta-synthesis method for qualitative research: a literature review. *Journal of Advanced Nursing*, *50*(2), 204-11.

Walsh, D., & Downe, S. (2005b). Appraising the quality of qualitative research. *Midwifery*, *22*,108-119.

Webber, T., & Hickling, S. (2014). Meeting Important Needs in Inner London. *Perspective – NCT's journal on preparing parents for birth and early parenthood*, *25*(Dec), 5-6.

Weedon, C. (1997). *Feminist practice and post structuralist theory*, 2nd edition. Cambridge: Blackwell.

Whitehead, M. (2007). A typology of actions to tackle social inequalities in health. *Journal of Epidemiology and Community Health*, *61*,473–478. doi: 10.1136/jech.2005.037242

Whitehead, M., & Dahlgren, G. (2006). *Concepts and principles for tackling social inequities in health: Levelling up Part 1*. Copenhagen, Denmark: World Health Organization Regional Office for Europe.

Whitmore, M. (2013). *Breastfeeding Support Submission to the NICE shared learning database. Guidance products: QS37*. Retrieved from https://www.nice.org.uk/contents/item/display/30854

Whittlemore, R., & Knapfl, K. (2005). The Integrative Review: Updated Methodology. *Journal of Advanced Nursing*, *52*(5), 546-553.

WHO & UNICEF. (2009). *Baby Friendly Hospital Initiative. Revised, updated and expanded for integrated care*. Retrieved from http://www.who.int/nutrition/publications/infantfeeding/bfhi_trainingcourse/en/

WHO. (2001). World Medical Association Declaration of Helsinki. *Bulletin of the World Health Organisation*, *79*(4), 373-375.

WHO. (2003). *Global strategy for infant and young child feeding.* Retrieved from https://apps.who.int/iris/bitstream/handle/10665/42590/9241562218.pdf;jsessionid=42F612689DB8C09411E08203B8DE3016?sequence=1

WHO. (2017). *Guideline: Protecting, promoting and supporting breastfeeding in facilities providing newborn services*. Retrieved from https://apps.who.int/iris/bitstream/handle/10665/259386/9789241550086-eng.pdf?sequence=1

Williams, G.H. (2003). The determinants of health: structure, context and agency. *Sociology of health and Illness, 25*(3), 131-154.

Williams, S. (1995). Theorising class, health and lifestyles: can Bourdieu help us? *Sociology of Health & Illness, 17*(5), 577-604.

Wilson, A.C., Forsyth, J.S., Greene, S.A., Irvine, L., Hau, C., & Howie, P.W. (1998). Relation of infant diet to childhood health: seven year follow up of cohort of children in Dundee infant feeding study, *British Medical Journal, 316*(7124), 21.

Wong, G. (2018). A brief introduction to realist research approaches. Evidence Synthesis Working Group, School for Primary Care Research, NIHR. Retrieved from: https://www.spcr.nihr.ac.uk/files/news/wong/@@download

World Bank. (1997). *Decentralization and Health Care.* Retrieved from http://www.worldbank.org/publicsector/decentralization/healthcare.htm.

World Breastfeeding Trends Initiative. (2016). *UK report card.* Retrieved from http://www.worldbreastfeedingtrends.org/GenerateReports/reportcard/UK-reportcard-2016.pdf

Wright, J. (1996). Breastfeeding and Deprivation: The Nottingham peer counsellor programme. *MIDIRS Midwifery Digest, 6*(2), 212-215.

Yin, R. (2014). *Case Study Research Design and Methods. Fifth Edition.* London: Sage.

Zimmermann, D. R., & Guttman, N., (2001). Breast is best: Knowledge among low income mothers is not enough. *Journal of Human Lactation, 17*, 14-19.

APPENDICES

Appendix 1. Table showing the different types of review considered

Name of method	Aspects of method	Appropriate for my study?	Source info.
Meta synthesis	Synthesises qualitative study findings to give more in-depth description of phenomenon. Analysis Noblit and Hare (1988).	Yes. What if I get diverse data sources?	Fenech & Thomson (2014). Walsh & Downe (2005b)
Meta-ethnographic synthesis	Can generate theory, uses Noblit and Hare (1988) for analysis. I can't see how different from meta synthesis – as above, will it be ok if get diverse data sources?	Yes. "Line of argument" bit at end of analysis links to some case study methods whereby you frequently summarise your findings/thoughts.	Schmied et al. (2011); Atkins et al. (2008).
Meta-narrative	Storyline development. Good for bridging paradigms when literature very diverse.	Don't think I will need to bridge paradigms.	Greenhalgh et al. (2005); Potts et al. (2011).
Integrative review	Good when have diff types of data, can bring together. Constant comparative analysis methods.	Depends on my aim. Good if want to include outcome data. Do I want to do this though? This method similar to methods	Whittlemore & Knapfl (2005); Semenic, Childerhose, Lauziere, & Groleau, (2012.)

		discussed in case study methods including the analysis methods.	
Joanna Briggs Method	Aggregative but with some interpretation. Looks like does use Noblit and Hare (1988) again.	I can’t really see difference to meta synthesis - is this just someone’s formalised instructions? Complicated.	Pearson (2010)
Formal Grounded Theory	Good for generating theory. Analysis similar to integrative review, but looks like less structure to help you.	Method links to some case study methods. Instructions not as clear as for an integrative review.	Heyvaert, Hannes, & Onghena (2016)
Meta study	Looks like a quantitative method.	Unless I have the wrong end of the stick, this one not for me.	

Appendix 2. Meta-synthesis search strategy

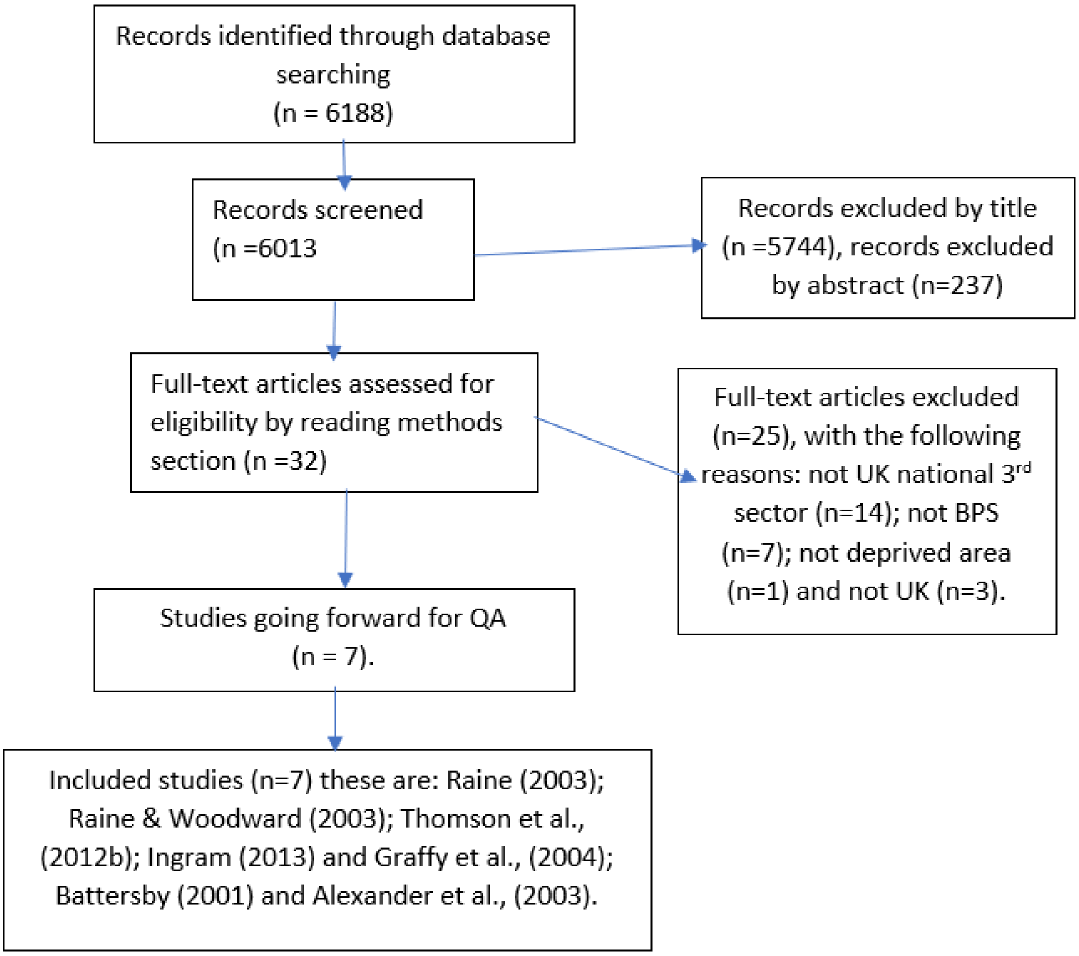
Meta-synthesis search strategy:

Search name	Term searched for	Search name	Term searched for
S1	Wom?n	S25	Mother-to-mother
S2	maternal	S26	Counsel*
S3	Mother*	S27	Non-professional
S4	patient	S28	Volunteer*
S5	consumer	S29	Peer group
S6	Service user	S30	Lay*
S7	Service-user	S31	Peer*
S8	S1 OR S2 OR S3 OR S4 OR S5 OR S6 OR S7	S32	Peer-counsel?*
S9	Socio*	S33	Voluntary worker*
S10	Socioeconomic*	S34	S21 OR S22 OR S23 OR S24 OR S25 OR S26 OR S27 OR S28 OR S29 OR S30 OR S31 OR S32 OR S33
S11	Deprive*	S35	breastfeeding
S12	Marginali?*	S36	Breast-feeding
S13	Disadvantage*	S37	Breast feeding
S14	Low income	S38	breastfed
S15	poverty	S39	Infant feeding
S16	Inequalit*	S40	Lactat*
S17	poorest	S41	Milk, human
S18	underprivileged	S42	Nursing mother*
S19	vulnerable	S43	Breastfe*

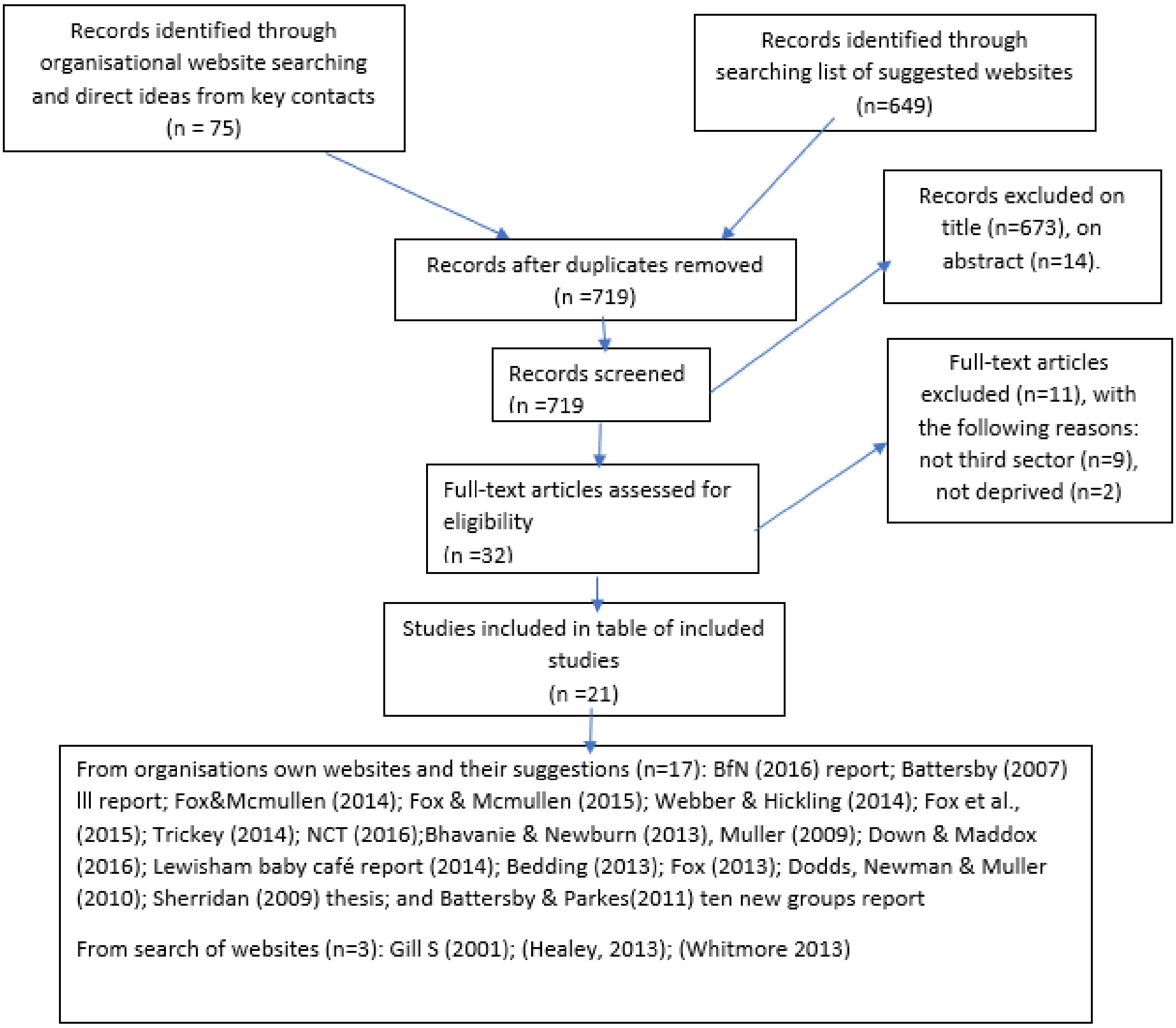
S20	S9 OR S10 OR S11 OR S12 OR S13 OR S14 OR S15 OR S16 OR S17 OR S18 OR S19	S44	Breast-fe*
S21	Peer support	S45	Breast fe*
S22	Lay support	S46	S35 OR S36 OR S37 OR S38 OR S39 OR S40 OR S41 OR S42 OR S43 OR S44 OR S45
S23	Volunteer support	S47	S8 AND S20 AND S34 AND S46
S24	Mother to mother		

Appendix 3 Flow diagrams (Prisma) showing published literature searches, grey literature search and berry picking search.

Flow diagram for published literature search.



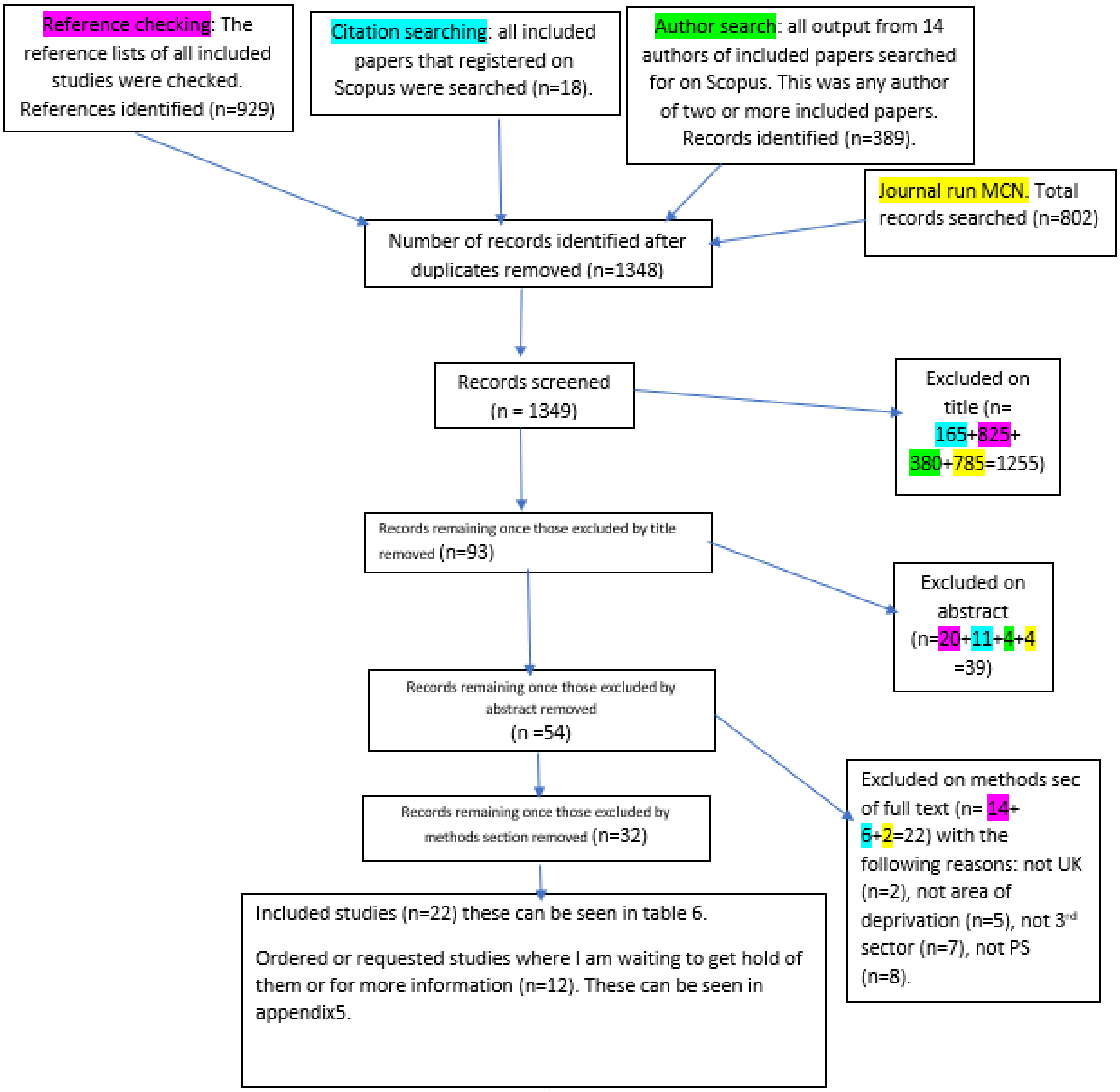
Prisma diagram for grey literature search.



From organisations own websites and their suggestions (n=17): BfN (2016) report; Battersby (2007) Ill report; Fox&Mcmullen (2014); Fox & Mcmullen (2015); Webber & Hickling (2014); Fox et al., (2015); Trickey (2014); NCT (2016);Bhavanie & Newburn (2013), Muller (2009); Down & Maddox (2016); Lewisham baby café report (2014); Bedding (2013); Fox (2013); Dodds, Newman & Muller (2010); Sherridan (2009) thesis; and Battersby & Parkes(2011) ten new groups report

From search of websites (n=3): Gill S (2001); (Healey, 2013); (Whitmore 2013)

Prisma diagram for berry picking procedures.



Appendix 4. List of target websites

List of target websites shown via email to key informants from each breastfeeding organisation: www.nct.org.uk ; www.breastfeedingnetwork.org.uk ; www.laleche.org.uk ; abm.me.uk ; realbabymilk.org ; www.familiesandbabies.org.uk ; www.unicef.org.uk/babyfriendly

Following feedback from key informants the following websites were added to the list above:

https://www.evidence.nhs.uk/Search?q=breastfeeding+Peer+support+programmes

http://www.bmj.com/content/344/bmj.d8287

http://www.llli.org/

https://www.laleche.org.uk/antenatal-courses/

http://onlinelibrary.wiley.com/doi/10.1111/apa.2015.104.issue-S467/issuetoc

http://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-015-0581-5

https://www.gov.uk/government/case-studies/providing-support-and-guidance-on-breastfeeding

http://www.nets.nihr.ac.uk/projects/hta/131805

Appendix 5. Table showing 50 studies meeting inclusion criteria that were quality assessed

The template used below is that suggested by Downe et al. (2009) to be used for undertaking meta-synthesis of qualitative research studies.

Table 1 - Initial screen (full text papers)

Reviewer: Louise Hunt

Date of review: Autumn 2016

Code	**Author/date**	**Concerns women living in areas of socio-economic deprivation**	**Concerns breastfeeding peer support interventions provided by UK third sector national breastfeeding organisations**	**(insert inclusion criteria 3)**	**IN?**	**Comments**
(1)	Raine (2003)	Yes	Yes		Yes	PS were trained by LLL.

(6)(first grey lit study on my list)	BfN report (2016)	Yes (not specifically explained – but inferred)	Yes		Yes	BfN
(3)	Thomson et al.(2012b)	Y	Y		Y	BfN
(2)	Raine & Woodward (2003)	Y	Y (PS trained using LLL training delivered by the HP's who were trained to do this by LLL)		Y	LLL
(4)	Ingram J (2013)	Y	Y (trained by LLL, supervised by LLL and ABM counsellors)		Y	LLL
(5)	Graffy et al (2004)	Y (phrase 'mixed and deprived' used – attempt to reach out to other areas)	Y		Y	NCT

(7)	Battersby (2007)	Y	Y		Y	LLL
(8)	Fox and McMullen (2014) (baby café report)	Y (baby café an effort to reach out)	Y		Y	Baby café.
(9)	Fox and McMullen (2015) (baby café report)	Y (babt café an effort to reach out)	Y		Y	Baby Café.
(10)	Webber & Hickling (2014)	Y	Y		Y	Baby Cafe
(11)	Fox et al. (2015)	Y(un clear, but baby café as above so we are including)	Y		Y	Baby café.

(12)	Trickey (2014) NCT breastfeeding peer support: evidence and rationale	Y (about the way NCT does PS, implies for every area)	Y		Y	NCT
(13)	NCT (2016) (case study, providing support and guidance on breastfeeding)	Y (decided to include as baby café – they say it is accessible for all)	Y		Y	NCT baby café report.
(14)	Bhavanie & Newburn (2013)	Y	Y		Y	NCT
(15)	Muller (2009)	Y (ish – their aim was to engage with diverse SE areas, but not necessarily managed to do that, but intention was there)	Y		Y	NCT

(16)	Down & Maddox (2016)	Y	Y		Y	NCT sales pitch for their services.
(17)	Lewisham Baby café report (2014) (A tale of two baby cafés)	Y (not clear whether to what extent women living in the area of deprivation where venue is use the service as it mentions women travelling from affluent nearby area and other boroughs)	Y (nct bfing counsellor provides the service)		Y	Baby café situated in an area of deprivation.
(18)	Bedding (2013)	UC (decision was to include as is baby café and this is an attempt to reach out)	Y (PS training provided by NCT)		Y	Baby Café.
(19)	Fox (2013) Baby café report.	Y (61% of baby café's are in areas of multiple deprivation)	Y		Y	Baby café.

(20)	Sherridan (2009) (thesis)	Y	Y		Y	LLL
(21)	Gill (2001) (LLLI short report)	Y	Y		Y	LLL
(22)	Healey (2013) (BfN Wigan report)	Y	Y		Y	BfN.
(23)	Whitmore (2013) (BfN Blackpool report)	Y	Y		Y	BfN
(24)	Thomson et al. (2015)	Y	Y		Y	BfN

(25)	Curtis et al. (2007)	Y	Y (Doncaster breastfriends)		Y	NCT (via Mary Smale)
(26)	Thomson et al. (2012a)	Y	Y		Y	BfN
(27)	Dykes (2003)	Y	Y (mixture of organisations included)		Y	LLL.
(28)	Kirkham et al. (2006)	Y	Y		Y	NCT (training designed by NCT Specialist).
(29)	Wright (1996)	Y	Y		Y	LLL trained PS.

(30)	Fox, Muller & Newburn (2015)	Y (baby café=trying to reach out)	Y		Y	Baby café.
(31)	Battersby (2001)	Y	Y		Y	LLL
(32)	Aiken & Thomson (2013)	Y	Y		Y	BfN
(33)	Crossland & Thomson (2013)	Y	Y		Y	BfN.
(34)	Hall Moran et al. (2006)	Y(young mothers, decided to include)	Y		Y	BfN

(35)	Hall Moran et al. (2005)	Y (as above)	Y		Y	BfN.
(36)	South et al. (2012)	Y	Y		Y	LLL (paid PS were trained by LLL)
(37)	South et al. (2010)	Y	Y		Y	LLL (the paid PS were trained by LLL)
(38)	Kempenar & Darwent (2011)	Y (personal communication from authors confirmed this)	Y		Y	BfN.
(39)	Darwent & Kempenar (2014)	Y(personal communication from author confirmed this)	Y		Y	BfN

(40)	Dykes (2005)	Y	Y (some third sector projects others not)		Y	Mix.
(41)	Graffy & Taylor (2005)	Y (mixed or deprived area)	Y		Y	NCT.
(42)	Smale (2004)	Y	Y		Y	NCT
(43)	Ingram et al. (2005)	Y	Y (training designed by LLL leader and trainee ABM counsellor)		Y	LLL/ABM
(44)	Alexander et al. (2003)	Y	Y (some of the people involved in planning training were from NCT and LLL)		Y	NCT / LLL.

(45)	Battersby & Parkes (2011)	Y	Y		Y	LLL
(46)	Kirkham (2000)	Y	Y		Y	NCT inspired training.
(47)	Etheridge (2016) MSc thesis.	Y	Y		Y	LLL wrote training.
(48)	Broadfoot et al. (1999)	Y	Y		Y	BfN
(49)	Dodds, Newburn & Muller (2010)(NCT	Y	Y		Y	NCT

	breastfeeding support services – the evidence)					
(50)	Battersby (2005)	Y	Y		Y	LLL

Table 2 - QUALITY ASSESSMENT TOOL (Similar to CASP)

Reviewer: Louise Hunt

Date: 7.11.16

Complete the first row using Y=yes, N=no, UC= unclear

Code	**Author (year)**	**Participants appropriate for question?**	**Design appropriate for aims and**	**Methods described?**	**Sample size & sampling**	**Does the data analysis fit with**	**Reflexivity present?**	**Study ethical?**	**Do the data presented**	**Is the context**	**Include?**

	and country		theoretical perspective?		justified?	the chosen methodology?			justify the findings?	described sufficiently?	
(1)	Raine P (2003) UK	Y (6 health professionals, 6 peer supporters, 6 mothers. Aim: evaluate experiences, developing a culture of breastfeeding and whether project had potential for community capital building)	UC (no theoretical perspective given)	Y (used Grounded Theory analysis methods, used semi-structured interviews and observation to generate interview schedules – not justified or explained. Methods used explained but not an overall methodology)	N (no mention of why sample sizes the size they were, no mention of theoretical saturation if was using Grounded Theory)	UC (says used Grounded Theory analysis methods but no mention of whether this was their overall methodology also no theoretical sampling mentioned)	N	UC (says information given re confidentiality etc but no mention of ethical review)	UC (there is actually only on quote from a mother. Not loads of material presented)	Y	Score C. Include.
(6)	BfN (2016)	Y (mothers, health professionals, BfN staff, interviews, focus groups and surveys)	UC (design appropriate for aims but no theoretical position given)	Y (methods used described, but not placed within a methodology as a whole)	UC (sampling reflected BfN activity, but no justification for the size of the samples was given)	UV (no info given about how data was analysed, despite focus groups and interviews being used, does not look like a method of thematic analysis or other qualitative method employed. Tables used a bit. Descriptive	N	UC (no mention of ethics at all)	Y (but because no idea about how analysed, hard to feel confident in them)	UC (does describe UK breastfeeding context as a whole. Does not describe context of specific areas where focus groups	Score C. Exclude as not published in peer review journal.

						account of all data. No methodology was given)				took place for example)	
(3)	Thomson et al. (2012b)	Y	Y	Y	Y	Y	UC (does not talk about reflexivity exactly, but does explain how themes were discussed with team and with partnership others)	Y	Y	Y	Score A. Include.
(2)	Raine & Woodward (2003)	Y	UC (no theoretical position given, but aim to evaluate using qualitative methods so in that sense yes)	Y	N (not explained or justified)	UC (not clear whether Grounded Theory used as overall methodology – used Grounded Theory methods of analysis)	N (no mention)	Y (ethics permission gained)	Y	Y	Score C. Include.
(4)	Ingram (2013)	Y	UC (no theoretical position given, but aims of evaluation were clear).	Y	Y	Y (used thematic analysis for the qualitative bits of the evaluation and statistical tests for the qualitative data)	UC (not specifically mentioned but does say themes discussed with whole	Y (explains ethics permission gained and how study was ethical)	Y	Y (I would say yes, but not much detail on how the wards involved differed	Score A. Include.

							project team)			from the rest of the city)	
(5)	Graffy et al. (2004)	Y	UC (Theoretical position not made clear, but design was appropriate for aims of the study)	Y	Y	Y (quantitative)	N	Y (no overt mention of ethical approval, but does discuss steps taken in the design to make sure ethical principles upheld)	Y	N (very limited information given about context and this is important in terms of transferability – very hard to know)	Score B. (due to lack of info about context) Exclude as quantatative.
(7)	Battersby (2007)	Y (audit LLL peer support and a survey. Asking did e rates increase? Was knowledge increased? Were	UC (no theoretical position given, mix of quantitative and qualitative via questionnaire, think this is an overall drawing together of what they have. Note: no mothers views obtained)	Y (content analysis of peer counsellor and administrator curriculum; summaries of individual area reports. Reporting of changes in breastfeeding rates in some areas)	Y (did explain why samples were the size they were and impact)	Y	N	Y (got letter to say formal ethics not needed. Employed ethical principles throughout)	Y (highlights that all areas imp, i.e. need to change community awareness important)	UC (not much detail about each area is given, none re the training section)	Score D (the part based on area reports is not reliable. Overall this is not research evidence). Exclude not really research. Not published in peer

		communities More Pro reastfeeding?									reviewed journal.
(8)	Fox and McMullen (2014)	Y (uses urvey returns From cafes To describe Baby café Service)	UC (no theoretical position given, aims to describe baby café services, and designed to do this – descriptive data)	Y (clear description of how got data)	Y (clearly says number of cafes and response rate, and impact of this)	Y (overall methodology not overtly explained, but data analysis descriptive – fine)	N (but does note possible impact of not getting all the returns, i.e. picture might not be as good as it seems)	UC (no mention)	Y (yes but other data is missing i.e. whether women are travelling to get to baby café, so claim meets needs of local women may depend on how this defined).	N (this is an overall report on baby café, no real local background info given)	Score C. Exclude, not really research, not published in peer review.
(9)	Fox and McMullen (2015)	Y (as above)	UC (as above)	Y (as above)	Y (as above)	Y (as above)	N (as above)	UC (as above)	Y (as above)	N (as above, same report, different numbers)	Score C. Exclude, not really research as above, no peer review.

(10)	Webber & Hickling (2014)	(there were no participants – this is just a report on services) N	UC (no theoretical position given, aim was to report on services, which it does)	N (no explanation of how writers came to know about what they have written)	N (no sample taken)	N (no data analysis discussed except for reporting of attendance)	N	N (but this is not really a study, so wouldn't expect ethics to be involved)	UC (report seems reasonable, not really making any drastic claims)	Y (details given about socio-economic and diversity of area, seems appropriate for this report)	Score D (not really research evidence) Exclude, not research, not peer reviewed.
(11)	Fox et al (2015)	Y	Y (no theoretical position explicit but design appropriate for getting at experiences)	Y	Y (kept sampling till theoretical saturation reached)	Y (themes drawn out of transcribed data, doesn't give overall analytic methodology, but yes)	Y (discussion of impact of researcher being employed by NCT)	Y (ethical clearances and practices described)	Y	UC (does not give detail about each individual site, but general info overall. Not much on social and economic situation)	Score A. Include.
(12)	Trickey (2014)	UC (no Participants This was relating NCt PS services To research	UC (I think the aim was to show how NCT peer support practices align with research evidence, showing how they are evidence based. No theoretical position given)	N	N (no sampling, this question does not really apply)	UC (again, this question does not really apply)	N	UC (not really relevant as not data taken)	UC (this is just saying this is what we do and this is why we do it, doesn't offer evidence that these things actually take place)	N (not really mentioned how context impacts)(Note: table 2 looks like example of inverse care law Tudor-Hart (1971)	Score D? (A justification of their approach, but there are inconsistencies i.e. say they know being proactive important, but offer services that are not proactive) Not research evidence, more

		Evidence)									evidence review. Exclude, not research, not peer reviewed.
(13)	NCT (2016) (baby café case study – providing support & guidance on breastfeeding)	UC (this Case study I suspect draws On data from Baby café Reports, but does Not explain Participants At all)	UC (no theoretical position given, think aim is to report on services – source of info not made clear, uses quant and qual data which seems appropriate for a case study report of this kind)	N	N	N (no discussion of how got data, but I suspect it is from baby café reports. No discussion of analysis or methodology)	N	N	UC (uses quantitative data to suggest impact of baby café, i.e. 61% of users exclusively breastfed for 6 months, no discussion of likely reason for this figure)	N (claims suitable for all areas, but how they know this not explained)	Score D (not a research study, more a 'selling the service' pitch) Exclude, not research, not peer reviewed.
(14)	Bhavanie & Newburn (2013)	Y (explains aim Of article And source of data, does not Give number of Participants However)	Y (uses peer support log book and telephone interviews with trainers/co-ordinators. No theoretical postion given)	Y (but not detail, i.e. no idea number of interviews or whether any logs were missing etc)	N (no explanation of sampling or sample size)	UC (analysis not explained. No methodology given)	N	UC (no info given)	Y (not sure whether 50% retention rate of peer supporters at one year is good or not, not compared to others)	UC (not clear how they have responded to perspectives & needs of mothers for example)	Score D (not research, but clearer than other similar articles) Exclude, not research, not peer reviewed.

(15)	Muller et al (2009)	Y (small number Of mothers Receiving PS However, more Trainers, Co-ordinators And PS included)	Y (broad evaluation of policy to set up PS in local areas, mainly written questionnaires, small number qualitative focus groups and interview)	Y (sometimes methods don't fit findings i.e. 'reasonable diversity' of PS, but did not collect their educational level)	Y (explained why sample sizes smaller than hoped)	UC (no overall method given, analysis of data not explained)	N	UC (no info given re this although ethical practices were described)	UC (generally, yes but re reaching diverse socio-economic backgrounds really didn't get data that could demonstrate this)	N (no info given about the diff areas included in the evaluation)	Score C Exclude, not research, not peer reviewed.
(16)	Down & Maddox (2016)	UC (this is a Sales pitch for NCT services Does report Quant data And qual comment)	UC (no theoretical position, no design as such, no idea how balanced the comments given or data given are)	N	N (no info given about total number of projects etc)	N (no info about data analysis or methodology)	N	N	UC (suggests services suitable for families in deprived areas, can't tell really if this is so)	N (again claims services suitable for areas of dep. Real sales pitch strongly suggests interest on these areas only)	Score D (not research, but imp clearly outlines NCT's aim to work in these areas. There are some phrases in this one that make me feel v uncomfortable) Exclude, not research. Not peer reviewed.
(17)	Lewisham baby café report(2014)(a	(participants not explained) UC	UC (Theoretical position not explained, design was really just a report, but with some qualitative data as well).	UC (says did qualitative interviews with women for project but then also seems to have included comments of	N (no mention)	N (no mention of data analysis)	N	N (no mention, but this is more a report not a study really)	N (data presented don't really justify the statements made in this report)	UC (says venue is on multiply deprived housing estate, but also that people come	Score D (not really research evidence). Exclude, not research.

	tale of two baby café's)			Breastfeeding counsellor so not sure where that fits in)						to the group from affluent areas and from all boroughs of area)	Not peer reviewed.
(18)	Bedding (2013)	UC (basic report Not clear Participants who took part)	UC (no theoretical position given, aim was to report on services so I guess ok for that aim)	N (not explained how decided who to ask for comments or how knew this stuff)	N (not explained, not really any sampling I don't think)	UC (no analysis, no methodology)	N	N (but just a report, not a study)	UC (maybe term 'huge success' quite strong, but have trained peer supporters)	N (no info given about specific areas, but perhaps ok given this is a short report)	Score D (this is not a research report) Exclude, not research. Not peer reviewed.
(19)	Fox (2013) (baby café overview- short report)	Y (uses mainly Quant data From returns From baby cafes Some qual ata from Fox Study)	UC (no theoretical position given, aims to give overview of what baby café is, so in this way, yes)	UC (explains about data gathering from UK baby cafes, but it is not clear where the quotes from mothers come from)	UC (gives some info about origin of quantitative data, not so with qualitative)	UC (data analysis not explained or the methodology)	N	UC (does not mention)	Y (but hard to tell to what extent as not sure about data sources)	N (very limited but I guess trying to give overview of service, wonder what they think the impact of context is on this service?)	Score D (not a research study) Exclude not research. Not peer reviewed.

(20)	Sherridan (2009)	Y (explores PS experiences Of helping Women in deprived area to bf)	Y (clear theoretical position, appropriate qualitative methodology)	Y	Y (peer support already a group so chose focus groups)	Y (Grounded Theory analysis used)	Y	Y	Y	Y (extensive)	Score A Exclude – not published.
(21)	Gill (2001)	UC (no participants – just a report)	UC (no theoretical position, no design, more a report on what has happened)	N	N(not appropriate as more a report from founder)	N (no analysis, no methodology really)	N	N	UC (opinion really, but for a short report by founder, this is ok)	Y (says only provide peer support in areas of deprivation – ok for short report)	Score D (not research). Exclude, not research. Not peer reviewed.
(22)	Healey (2013)	UC (a case study Mentions focus groups At start and Qual feedback From mothers)	UC (no theoretical position given, aims to be a case study. Gives qualitative and quantitative data, not really a research study)	N (mentions focus groups, qualitative feedback from mothers and gives infant feeding data, but not overall plan)	UC (sampling not mentioned)	UC (analysis not explained, methodology not explained)	N	N	Y (Infant feeding data supports impact of service)	UC (not a lot of info – background breastfeeding rates low)	Score D (not a research report) Exclude, not research. Not peer reviewed.
(23)	Whitmore (2013)	UC (a case study Discusses qual Research and Infant	Y (case study which explains how have used qualitative insights to design their service)	N (mentions qualitative research and feedback, and gives infant feeding data)	UC (not explained)	UC (not explained, but does highlight idea of listening to women, this does come across as their approach)	N	N	Y	UC (does say entrenched bottle feeding culture)	Score D (this is a case study not a research report, as such it is good) Exclude,

		Feeding data)									not research, not peer reviewed.
(24)	Thomson et al (2015)	Y (HP, PS & thers. Log books)	Y (clearly explained)	Y	Y	Y	UC (but does explain how two authors discussed analysis together)	Y (explained)	Y	Y	Score A. Include.
(25)	Curtis et al (2007)	Y (wanted to know about how intervention Was working sed focus groups HP + PS)	Y (descriptive qualitative evaluation. Suited aim)	Y	Y	Y (clearly explained with implications)	Y (thematic analysis)	UC (does explain that founder of breastfriends works for same organisation but that researchers separate)	Y (clearly explained)	UC (not much info given)	Score A Include.
(26)	Thomson et al (2012a)	Y	Y(qualitative exploratory evaluation of service)	Y	Y (invited women from antenatal and post-natal bit of service)	Y	UC (does not specifically mention)	Y	Y	Y (good info about area and service)	Score A. Include.

(27)	Dykes (2003)	Y (aim to evalu ate large number Of projects)	Y (standardised summaries of each project drawn up. This enabled aims to be fulfilled)	Y (methods of evaluation in each project described, they were all different. The method of drawing all these together in one big evaluation also described)	Y (explained number of projects and also sample sizes within projects also explained)	Y (Used themes to group projects into groups)	Y (on p12 it says project contributors were reflexive, also lots of consideration of the type of evidence and the interpretation of this p10-12)	UC	Y (findings are cautious as related to the type of data available)	Y (explained the requirement for each year of the whole).	Score B (because how each project was evaluated was variable and had to draw all this together) Include. (discussed with supervisors)
(28)	Kirkham et al (2006)	UC (book Chapter drawing On experience of Authors and Curtis evaluation Not a Research study exactly)	Y (chapter aims to tell story of Doncaster breastfriends, and methods used do this well)	UC (explains how project developed)	UC (not exactly sampling)	UC (does not explain data analysis methods used for the Curtis evaluation data)	UC	UC	Y (qualitative data do justify findings)	Y	Score C. Include.
(29)	Wright (1996)	UC (no articipants, more A piece Explaining Local practice re	UC (no real design, no theoretical position, aims to communicate local practice. Does use some local quantatative data.)	UC (not really any methods to describe, but does describe local practice clearly)	UC (no sample really)	UC (no real data analysis)	N	UC (not really a study, more a local practice report)	Y (small amount of quant data relates to the narrative)	Y (good picture given of the context)	Score D (not really research, more local practice report).

		Peer support)									Exclude, not research.
(30)	Fox, Muller & Newburn (2015)	Y (qual interview appropriate for exploring experiences of service users)	Y (does not actually give theoretical, but qual interviews seem appropriate for aims of study)	Y	N (no mention)	Y	N	UC (no mention)	Y	N (context of where did interviews not given at all)	Score B (this is an abstract from MAINN conference so space limited, full paper is also included in this table) Exclude – full paper already included.
(31)	Battersby (2001)	Y(aimed to establish whether service was acceptable to mothers)	Y (no overt theoretical position given, but yes design and aims congruent)	Y	Y (explains why sample size not as had wanted and what they did about this but not possible impact of this on results)	UC (does not explain how data was analysed)	N	Y (gained ethical clearance for interviews)	UC (some statements made at the end not backed up with any data)	Y (details about area given)	Score C. Include.

(33)	Crossland & Thomson (2013)	Y (large evaluation. Qualitative, aimed To see experiences And impact of service)	Y	Y(interviews and focus groups)	Y	Y (thematic analysis)	UC	Y (clearly explained)	Y	UC	Score A. Include.
(32)	Aiken & Thomson (2013)	Y (experience of transition to more professional type service)	Y	Y	Y	Y	UC (but does discuss discussion of themes amongst authors)	Y	Y	Y	Score A. Include.
(34)	Hall Moran et al (2006)	Y (exploration of attitudes and knowledge of midwives and peer supporters in response to vignettes Teenage mothers)	Y	Y	Y (explained peer supporters had to be convenience sample as not enough to be random)	Y	Y (mentions reflection as part of method, and explains which researchers did what)	UC (on p3 it says had permission from head of midwifery to involve midwives)	Y	UC (not much detail re this)	Score A. Exclude as quantitative.

(35)	Hall Moran et al (2005)	Y (Midwives And Peer supporters)	Y (quantitative application of BEssT tool)	Y	Y (explained power calculation to work out sample size and limitations of the sample size)	Y (quantitative)	UC (did explain that tested inter-rater reliability which was high)	Y (clearly explained)	Y	N (not much detail on area, but this was about MW and PS skills)	Score A. Exclude as quantitative
(36)	South et al (2012)	Y (qualitative exploration of lay interpretation of lay health worker roles)	Y (46 participants over 3 case studies qualitative design. No overt theoretical position given)	Y	Y (sampling deliberately for rich samples – deliberately chose people who had experience of services)	Y (thematic analysis)	UC (mentions taking of reflexive field notes)	Y (clearly explained)	Y	UC (not much info at all about area)	Score A. Include (after discussion with supervisors, as themes cross cutting this is fine to include as can see where each bit has come from)
(37)	South et al (2010)	Y (exploring lay peoples experience of lay health workers)	Y (case studies plus expert hearings)	Y (focus groups and individual interviews)	Y (explained clearly)	Y (thematic)	UC (researchers took reflexive notes see p146-147).	Y (clearly explained)	Y (on p152 and p182 some data about breastfeeding case, but generally all cases muddled up in reporting so hard to see what is what	N (virtually none)	Score A Exclude Unable to tell which case study quotes and idea came from , so after discussion with supervisors exclude.

(38)	Kempenar & Darwent (2011)	Y(mothers undertaking BfN training)	Y (Positive approach. Questionnaire to measure objectively knowledge and attitude before and after the training)	Y	Y(discusses limitations of sample size and not calculating power needed)	Y(statistical analysis)	N	Y (ethical clearances explained)	Y	N (no detail about context given)	Score A. Exclude as quantitative.
(39)	Darwent & Kempenar (2014)	Y(questionnaire)	Y (no theoretical position given, but aim was to compare knowledge and attitude across peer supporters, mothers and student midwives so yes)	Y	UC (recruitment explained but size of samples not justified or proportion of whole that participated)	Y	N (but does discuss ways the recruitment may have affected results)	Y (ethics clearance and practices explained well)	Y	N (no real explanation of context)	Score A. Exclude as quantitative.
(40)	Dykes (2005)	Y (Question was to identify best practice, summarize projects)	Y (summarise and condense each project draw out themes and similarities best practice)	Y	Y(included all peer support projects)	UC (each report summarised and condensed)	UC	UC (not specifically mentioned)	Y (examples given throughout)	UC (some info given in the table about each scheme)	Score B Exclude after discussion with supervisors as cannot see which bit came from projects meeting my criteria.
(41)	Graffy & Taylor (2005)	Y (questionnaire sent to all who initiated breastfeeding	UC (reports on open questions on a questionnaire, not sure this design best for aim which was to find out what women want from	Y	Y (questionnaires sent to all women. Total 685)	Y (describes analysis clearly-Grounded Theory approach)	N	Y	Y	N (minimal info about area)	Score A. Include. (interesting that questions were about best and worst

		whether had the counsellor or not. Wanted to know what women want from support.)	breastfeeding support) No theoretical position given.								advice received when perhaps counsellors training may mean advice not their approach?)
(42)	Smale (2004)	UC (not really an applicable question as this is a training handbook)	UC (again, not really applicable, but the design on the handbook fits its aim)	UC (detailed exploration of methods used in training peer supporters)	UC (not an applicable question)	UC (as before)	UC	UC (not a relevant question)	UC (as before)	UC. (as before)	Score D. Exclude, not research.
(43)	Ingram et al (2005)	Y (wanted to know impact of setting up peer support	Y (mix of quantitative and qualitative data and analysis)	Y	Y (questionnaires given to all peer supporters before and after training plus focus groups. All mothers who had attended a group sent postal	Y (each appropriate. Used descriptive statistics and statistical tests on quantitative data and thematic analysis of qualitative)	N	Y (clearly explained)	Y	UC (a socially and economically deprived part of Bristol)	Score A. Include.

					questionnaire)						
(44)	Alexander et al (2003)	Y (service evaluation seeking Women's views. Not qualitative)	Y (questionnaire developed through a focus group, so quantitative data from people attending. No contact with non-attenders)	Y	Y (not much consideration of impact of sampling or sampling size)	Y (descriptive analysis of questionnaire data)	N	Y (university committee)	Y (overall able to relate questionnaire findings to research already published)	UC (not much detail says a housing estate in area of deprivation)	Score B. Exclude as quantitative (only uses content analysis on questionnaire. Exclude as no qualitive analysis of the open questions. No themes).
(45)	Battersby & Parkes(2011)	Y (evaluation of process of setting up 10 new groups aims to give overview)	Y (questionnaires for new leaders, written accounts of experiences or telephone interviews with mothers) no theoretical position.	Y (no clear methodology)	Y (on p11 it explains why sampling not as planned. Small numbers, asked all new leaders and all mums attending to take part)	UC (descriptive account of questionnaire responses. No analysis methods of analysis explained)	UC.	Y (explained on p12)	Y (but lack of clarity re analysis techniques used means hard to know for sure)	N (no real info about each area given. Areas where no LL and deprivation, but not really clear was definitely deprived)	Score C. Exclude, not peer reviewed. (this is LLL evaluating the process of setting up new LLL groups in areas where none)

(46)	Kirkham (2000)	UC (this is A report on the project rather than a research study)	UC (as previously – this is a report on practice)	UC	UC	UC	UC	UC	UC	Y – explains setting.	Score D Exclude. Not a research study.
(47)	Etheridge (2016)	Y	Y design was action research – suitable for aims	Y- focus group (three participants) and semi-structured interviews (7 participants) with peer supporters. Also used whatsapp questions – five more peer supporters took part.	Y invited all peer supporters to take part. The participants came from 6 cohorts of peer supporters.	UC Does not explain clearly how themes that arose were came upon. Hence difficult to say.	Y reflects on own role and power relationship.	UC - explains that informed participants beforehand but did not do this in writing also no consent forms used. No ethics committee mentioned.	UC Due to lack of clarity regarding how they were arrived at.	Y Explains v complex multi cultural community.	Score C/D. Exclude as not published.
(48)	Broadfoot et al (1999)	Y (wanted to compare who were reaching with other known breastfeeding data and provide	Y survey data.	Y	Y Explained that sample not complete and why.	Y Quantitative data.	N no mention	UC no mention.	Y appears so.	UC	Score B/C. Exclude as quantitative.

		feedback to supporters and trainers)									
(49)	Dodds, Newburn & Muller (2010)	UC This is not a research study so this question not really relevant.	UC again this question not really relevant as not a research study.	UC This article discusses literature in light of NCT services.	UC no methods per se.	UC Not applicable.	UC not applicable	UC not applicable	UC not applicable	UC not applicable.	Score D Exclude as not research, not peer reviewed. Because this is not a research study, more a kind of lit review.
(50)	Battersby (2005)	Y this is a book chapter, but part of the chapter talks about an evaluation of the service, so in that way yes participants	Y there was an evaluation questionnaire for mothers. Breastfeeding rates in the area also gathered. Mentions some evaluation of whether paid peer support workers would be cost effective also.	Y Really this chapter gives an account of the project which is illustrated with some data. It aims to give the reader an overview and feel for what the project entailed.	Y no details however.	UC some mention of sampling sizes and problems associated with this.	UC no mention.	UC	Y	Y good info re area.	Score C. Exclude (not reporting on qualitative research really here).

		applicable									

Grading System (Downe et al 1997)

A: *No, or few flaws. The study credibility, transferability, dependability and confirmability is high.*

B: *Some flaws, unlikely to affect the credibility, transferability, dependability and/or confirmability of the study.*

C: *Some flaws that may affect the credibility, transferability, dependability and/or confirmability of the study.*

D: *Significant flaws that are very likely to affect the credibility, transferability, dependability and/or confirmability of the study.*

Consider: are all studies to be included, or only those that meet or exceed one of the grades above?

Table 3 - CHARACTERISTICS OF INCLUDED STUDIES & FINDINGS

Reviewer: Louise Hunt   Date: 29.11.16.

Code	Author (year)	Aim(s)	Theoretical perspective	Methodology	Setting	Sample selection method	Sample size and characteristics	Method of data collection	Method of data analysis	COMMENT
(3)	Thomson et al. (2012b)	To investigate the uptake, impact and meanings of a breastfeeding incentive intervention which was part of an existing peer support service.	Doesn't actually say. – interpretive I think.	Descriptive statistics about the peer support service and the incentive intervention. Breastfeeding rates gathered before and after the intervention. Qualitative interviews with mothers and a focus group with peer supporters.	Disadvantaged area of North West England.	Mothers invited by the peer supporters. Focus group for peer supporters – all took part. Not sure what proportion of the total births in the target area the 141 mothers who signed up for peer supportin the first place was)	141 mothers signed up for usual peer support programme were invited onto the incentives intervention. 94 completed or partially completed incentive programme. 26 individual interviews with mothers (all mothers invited). One focus grp with all the 4 peer supporters who delivered the intervention.	In-depth interviews and a focus group. Also, descriptive statistics from log books etc.	Thematic network analysis. Descriptive statistics.	Clearly explained.
KEY FINDINGS (author(s)):										

The incentives acted as connectors – global theme. Within this 'Facilitating connections' was an organising theme consisting of the following basic themes: 'encouraging access', 'connecting to self and others' and 'relating to the outside world'. The other organising theme was 'Facilitating relationships and wellbeing' which consisted of the following basic themes: 'being rewarded', 'encouraging sensitive dialogues and opportunities for support' and 'being on the journey together'. Overall links being central to their work came across. Like a spider's web, these can be multi directional, but seem highly relevant in the context where knowledge and confidence about breastfeeding low.
OTHER FINDINGS (not identified by the author(s))
I just noticed that the broader context was brought in here when the theme 'encouraging sensitive dialogues and opportunities for support' was discussed, i.e. the mother experiencing racism. Before the incentive scheme there was less than one home visit per woman (0.9 on average), whereas after there was 3.3. Getting to know about the broad context of the women's lives and what they are facing may be difficult. Who does not accept service? Lots about 'getting foot in the door' here. Access being key, because otherwise can't do any of the rest of it.

Reviewer: Louise Hunt Date: 30.11.16.

Code	**Author (year)**	**Aim(s)**	**Theoretical perspective**	**Methodology**	**Setting**	**Sample selection method**	**Sample size and characteristics**	**Method of data collection**	**Method of data analysis**	**COMMENT**

(4)	Ingram (2013)	To evaluate the provision of a targeted peer support service in specific deprived areas of the city. Service was one ante natal visit, contact at 48hrs post birth and ongoing support for two weeks, then access to breastfeeding groups.	Not given.	Qualitative interviews, a focus group, an online questionnaire with open ended questions and gathering breastfeeding statistics.	Socially deprived area of South Bristol, UK.	All mothers receiving service asked to complete questionnaire. At the end of questionnaire women invited for a telephone interview 48 agreed. Purposive sample (14) of those putting name forward for interview were interviewed to get broad range of postcodes and baby's ages. Midwifery teams invited to take part in telephone interview. 7 out of 8 peer supporters took part in focus group. Doesn't say what proportion of total number of health professionals took part. Definitely potential for those most keen to have their views reported.	163 mothers completed online the survey. This was 38.5% of those who agreed to take part in the evaluation. No information given as to what percentage of those accepting the service this formed. Also don't know what proportion of all births in the area accepted the service. 14 mothers were interviewed, 7 out of 8 peer supporters were interviewed in focus group, 8 health professionals were interviewed via telephone. Total and exclusive breastfeeding rates at initiation and 8 weeks were compared for the year before the intervention began and the first year of the intervention.	Qualitative interviews, a focus group and an online questionnaire.	The transcripts from the interviews and the open- ended answers on the survey were analysed using thematic analysis with an inductive approach (Braun & Clarke, 2006).	Clear account of study.
KEY FINDINGS (author(s)):										

Antenatal visit facilitated women to ask questions and get realistic information they wanted with no time pressure, thus reducing anxiety and increasing confidence. Postnatal contact, being there, communicating via several different methods, timely practical support enabled breastfeeding continuation through ‘tough times’. Peer supporters facilitated others to also support the mother, i.e. the partner and other mothers at breastfeeding groups. Partnership working with health professionals and role demarcation important.
OTHER FINDINGS (not identified by the author(s))
The words that keep coming to mind reading this are ‘enabling’, ‘facilitating’, ‘being’. The peer supporters feel to me from reading this account like their presence is kind of bolstering and enabling access to knowledge in a timely and ‘in tune’ kind of a way.

Reviewer: Louise Hunt Date: 29.11.16.

Code	**Author (year)**	**Aim(s)**	**Theoretical perspective**	**Methodology**	**Setting**	**Sample selection method**	**Sample size and characteristics**	**Method of data collection**	**Method of data analysis**	**COMMENT**

<table>
<tr><td>(5)</td><td>Graffy & Taylor (2005)</td><td>To examine women’s perspectives on the information, advice and support they receive with breastfeeding.</td><td>Not discussed.</td><td>Qualitative analysis of open questions on a questionnaire about women’s experiences of breastfeeding support. Completed this when babies were six weeks old.</td><td>Deprived or mixed area in London England.</td><td>654 women completed the questionnaire. It was given to all women in a randomised controlled trial, half had had a breastfeeding counsellor, half had not. Results of both groups are combined here, but one section just about breastfeeding counsellors.</td><td>654 women, 75% were first time mums, 31% were of minority ethnic origin.</td><td>Questionnaires left in baby notes for completion at six-week check- up. all women in both arms of trial. If not filled in, 2 reminders sent via post and phone call.</td><td>Thematic analysis using Grounded Theory type methods. Used various forms of triangulation in their analysis, between researchers, member checking etc.</td><td>Think study well done. Only small bit that I can use (about breastfeeding counsellor support)</td></tr>
<tr><td colspan="11">KEY FINDINGS (author(s)):</td></tr>
<tr><td colspan="11">Key findings were that women wanted information about breastfeeding and what to expect, practical help with positioning, effective advice and suggestions, and reassurance and encouragement. Can’t use this stuff as at least half of the participants had no contact at all with the breastfeeding counsellor, however one small section is about the women’s reports on breastfeeding counsellor support. This finds that those women who had engaged with the counsellor valued her highly. Women particularly valued that she had breastfed herself, she was knowledgeable, non-judgmental, reassuring and prepared to listen. This was the same whether the woman had continued to breastfeed or not.</td></tr>
<tr><td colspan="11">OTHER FINDINGS (not identified by the author(s))</td></tr>
<tr><td colspan="11">Main finding I noticed is the use of the word ‘advice’ and ‘advisor’ although they say they checked the face validity of their questionnaire with health professionals and ‘lay advisors’ (were these the NCT counsellors?) before they used it, the word ‘advice’ is central to it (they asked what advice was most helpful? And what advice was least helpful?) This seems so strange to me having read all the grey literature from the NCT about their philosophy of not giving advice, woman centred non-directional support. This seems contrary to what the breastfeeding counsellors would have been doing. Could have been interpreted by the women that they did not give advice! Which leads me to question firstly whether the researchers understood the underpinning philosophy of the support they were testing, and secondly to what extent that alleged underpinning philosophy is really being used.</td></tr>
</table>

Reviewer: Louise Hunt Date: 29.11.16.

Code	Author (year)	Aim(s)	Theoretical perspective	Methodology	Setting	Sample selection method	Sample size and characteristics	Method of data collection	Method of data analysis	COMMENT
(43)	Ingram et al. (2005)	To evaluate the setting up of a peer support initiative (training peer supporters and setting up breastfeeding peer support group) in an area of deprivation.	Not discussed. Mixed methods broad evaluation, but with a qualitative component.	Focus groups and questionnaire with the 6 peer supporters, questionnaire given to all mothers who attended group in first 5 months. Breastfeeding rates extracted from routine data.	Socio-economically deprived area of South Bristol UK.	All 6 peer supporters completed questionnaire and focus groups. All 35 mums who attended group in first 5 months given questionnaire.	6 peer supporters, 35 women who attended the group.	3 focus groups with the peer supporters, peer supporters completed two questionnaires. Questionnaires sent by post to all women who attended group in first 5 months.	Thematic analysis was used to analyse transcribed focus grp data.	Overall a broad evaluation with qualitative element.

KEY FINDINGS (author(s)):
Training increased the peer supporters' confidence and knowledge, it also made them want to share this with others. Women attending the group appreciated the feeling of belonging it gave, and that it made breastfeeding visible in their community. It linked them up in a social way. Breastfeeding rates increased.

OTHER FINDINGS (not identified by the author(s))
Feels like there was good health professionals 'buy in' for this scheme. It was referrals from health professionals that put the peer supporters in touch with the women in the first place. The peer supporters also allowed to visit homes. Access to women totally via health professionals. This seemed to work well here, the health professionals had got hold of the money for the initiative in the first place so were motivated. I noticed how breastfeeding in public was a problem for one peer supporter before the peer support training, what made a difference for her?

Reviewer: Louise Hunt Date: 29.11.16.

Code	**Author (year)**	**Aim(s)**	**Theoretical perspective**	**Methodology**	**Setting**	**Sample selection method**	**Sample size and characteristics**	**Method of data collection**	**Method of data analysis**	**COMMENT**
(11)	Fox et al. (2015)	To focus on the breastfeeding experiences and experiences of receiving breastfeeding support of women attending baby café's .	Not given.	Qualitative. In-depth interviews and focus groups.	8 baby cafes in the UK	Women at baby cafes approached and ask if they would like to take part – convenience sampling. If distressed not approached, but some of those women then approached researcher.	51 mothers took part in 36 interviews and five focus groups. All mothers were attending a baby café. Most participants older and highly educated. Quite a high number born outside the UK.	In-depth interviews and focus groups.	Used NVIVO software to code data. Themes were drawn out- cross referencing used. Ideas checked between researchers.	The eight baby cafes were chosen to give range of qualifications of the facilitator (i.e. health professionals/breastfeeding counsellor), length of time running etc but NOT to vary by socio-economic deprivation per-se. Actual analytic technique not very well described.

<table>
<tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="11">KEY FINDINGS (author(s)):</td></tr>
<tr><td colspan="11">Women not well prepared for the realities of breastfeeding. Women felt guilt and blame when it was harder than they expected. Women valued the baby café and support they got there – both expert and social. They valued other breastfeeding mothers and peer supporters as role models. Overall reports on the feeding experiences of the women attending, and also their experiences of actually attending.</td></tr>
<tr><td colspan="11">OTHER FINDINGS (not identified by the author(s))</td></tr>
<tr><td colspan="11">I noticed how in describing the semi-structured interview schedule dichotomies were in there from the start (i.e. expectations versus realities, positives and negatives of breastfeeding). Authors distinguish between expert and social support (another dichotomy), but I am thinking exactly what knowledge is being used in each? Also, the women attending for expert support really it seems to me had had a lack of adequate support in the system generally – they had problems that could and should have been picked up earlier. Most people would have thrown in the towel well before getting to the baby café, so making me think about the word ‘expert’, because is this really ‘expert’ knowledge? Is adequate knowledge about breastfeeding actually available to women in the system? Given that the women in this sample were older and well educated, where does this leave everybody else? Inverse care law? Inverse evidence law?</td></tr>
</table>

Reviewer: Louise Hunt Date: 29.11.16.

Code	Author (year)	Aim(s)	Theoretical perspective	Methodology	Setting	Sample selection method	Sample size and characteristics	Method of data collection	Method of data analysis	COMMENT
(25)	Curtis et al. (2007)	To explore the peer supporter – professional interface within a BPS intervention.	Not discussed.	Descriptive qualitative study design. Focus groups.	Area of deprivation in Northern England. Community peer support project.	All 7 peer supporters involved in project invited to take part, all agreed. A convenience sample of health professionals was taken. All health professionals working in the project area invited to take part, 9 agreed. Not told total number this came from however.	Peer supporters (n=7) Health professionals (n=9) these were community midwives and health visitors.	Focus groups with peer supporters and health professionals (each group separately, one focus group each)	Thematic analysis.	I enjoyed reading this paper.

KEY FINDINGS (author(s)):
Highlights the benefits to the peer supporters themselves of getting involved and how they changed through it. Explains how being involved 'lightened the load' for the health professionals, and how they learned from the peer supporters to a certain extent. Boundaries between what the peer supporters should or shouldn't do were problematic and gatekeeping behaviour noted. Power and ownership over this kind of work important to understand and keep working on communication between peer supporters and health professionals.
OTHER FINDINGS (not identified by the author(s))

The growth of the peer supporters was most interesting to me, the change in their attitude to professional knowledge was stark. Reminded me of the 'women's ways of knowing' book, seemed that the training had enabled a link between their embodied knowledge and other forms of knowledge and this was empowering. I was also struck by the social isolation of the peer supporters before the training.

Reviewer: Louise Hunt Date: 29.11.16.

Code	Author (year)	Aim(s)	Theoretical perspective	Methodology	Setting	Sample selection method	Sample size and characteristics	Method of data collection	Method of data analysis	COMMENT
(26)	Thomson et al. (2012a).	Qualitative exploratory evaluation. Aims to evaluate BPS service, to gain insight into how women experience BPS and how the support is given – what form it actually takes.	Not explained	Qualitative study.	North West England, 1600 births per year. Approximately 60% initiation rate. Area of deprivation.	Not sure what proportion of those who initiated accessed the service. Peer supporters invited women to take part.	47 women, aged between 19-39.	In-depth interviews with 47 women receiving the BPS service. Focus groups	Used 'hope' framework as basis of analysis. Comparisons of segments of data made within each of seven 'hope' headings.	Conceptually dense.
KEY FINDINGS (author(s)):										

Peer supporters worked in many ways to support women to reach their goal. Realistic assessment of the situation, gathering resources, providing information about possible unwanted outcomes, providing feedback, praise and encouragement. This resonates strongly with my own experience of this role.
OTHER FINDINGS (not identified by the author(s))
Can't think of any.

Reviewer: Louise Hunt Date: 29.11.16.

Code	**Author date**	**Aim(s)**	**Theoretical perspective**	**Methodology**	**Setting**	**Sample selection method**	**Sample size and characteristics**	**Method of data collection**	**Method of data analysis**	**COMMENT**
(24)	Thomson et al. (2015).	To explain how this BPS service is embedded into the community.	Not explained	Qualitative evaluation study.	North West England. Areas of deprivation.	All health professionals invited to take part via email. Co-ordinators recruited peer supporters and mothers who had used the service. All potential participants given information sheet	24 breastfeeding women, 13 peer supporters, 50 Health professionals.	Interview (group or individual). Also looked at monthly monitoring reports compiled by peer supporters.	Thematic analysis, Braun & Clarke, using social capital concepts as lens.	Love this paper, linking, networks, webs, bonds, building knitting

						and asked to contact researchers if wanted to participate.				together on every side.
KEY FINDINGS (author(s)):										
Details the many different relationships involved in a BPS service, bonds between peer supporters and people inside the service, bonds outward to women, so they form part of a community, links to health professionals enabling access to women, throwing lines out to the wider community to raise awareness and 'normalise' breastfeeding, seeking to gain more access to more women through building trust with health professionals and other workers.										
OTHER FINDINGS (not identified by the author(s))										
Webs, nets, spinning a web, a safety net for women, a secure community, links, connections, bonds, lines, 'life lines', building… I like the idea of spinning webs, and then they enable, access and all that entails. The 'all that that entails' then strengthens the web further as the women are enabled to make links, via the web with other women, etc..										

Reviewer: Louise Hunt Date: 29.11.16.

Code	**Author (year)**	**Aim(s)**	**Theoretical perspective**	**Methodology**	**Setting**	**Sample selection method**	**Sample size and characteristics**	**Method of data collection**	**Method of data analysis**	**COMMENT**
(32)	Aiken & Thomson (2013)	To describe issues arising as a voluntary service changes to a more professional one	Not described.	Descriptive qualitative study.	North West England, area of deprivation.	All peer supporters asked if like to take part by co-ordinators via info sheet.	19 peer supporters. Most paid, some volunteer. All had been purely volunteers in past.	Group and individual semi-structured interviews. Some peer supporters took part in several interviews.	Thematic network analysis. Attride-Sterling model.	The relationships and connections exposed as voluntary becomes more professional.
KEY FINDINGS (author(s)):										
Changes in the way the peer supporters viewed time – less available as the relationship changed. The Peer -Professional interface, roles, responsibilities, tensions. The tension between professionalisation enabling more access to women, but with a bit of a cost. The issue around knowledge, who's got what knowledge and how it's used important.										
OTHER FINDINGS (not identified by the author(s))										
I am just thinking about these relationships as they fit within the larger web. How does different types of knowledge and their deployment map onto 'the web'?										

Code	Author (year)	Aim(s)	Theoretical perspective	Methodology	Setting	Sample selection method	Sample size and characteristics	Method of data collection	Method of data analysis	COMMENT
(33)	Crossland & Thomson (2013)	In-depth evaluation of a BPS service over two years.	UC	Action based study over two years.	North West England. Area of deprivation. Service covered antenatal, perinatal period and post- natal hospital and community support untill 8 weeks. Then ongoing access to groups.		Service users (47), Health professionals (n=40), Peer supporters (n=19).	Focus groups and interviews.	Thematic network analysis (Attride-Sterling).	This complements Thomson et al. (2012a) paper -'giving me hope', the women's experiences of receiving the service.

KEY FINDINGS (author(s)):

Key findings relate to what expertise consists of (related to theoretical ideas). The peer supporter as an expert bringing experiential knowledge alongside theoretical knowledge. Theme relating to the potential for peer supporters work to result in de-skilling of health professionals. Themes about gate keeping and how health professionals sometimes don't trust peer supporters. Ownership of knowledge and who is allowed to share it with mothers. Access to mothers themselves.

OTHER FINDINGS (not identified by the author(s))

Can't think of any. So fascinating this paper. I just feel the contrast between the attitudes of some of the health professionals and the idea of peer support in the Raine (2003) paper – ten years earlier, all about building community capacity, and peer supporters making health professionals more culturally relevant. But still the idea that breastfeeding and indeed any infant feeding (n.b. quote about baby led weaning) is a medical matter. Ownership by health professionals of these issues.

Code	Author (year)	Aim(s)	Theoretical perspective	Methodology	Setting	Sample selection method	Sample size and characteristics	Method of data collection	Method of data analysis	COMMENT
(1)	Raine (2003)	To describe stakeholders experiences of this BPS project, explore the development of a culture of breastfeeding and consider whether the intervention might build community capacity.	Not given	Qualitative evaluation -	Area of deprivation in North of England.	All peer supporters invited to take part in an interview either at project meetings or via co-ordinator. Mothers were invited directly at groups or via peer supporters and health professionals. Health professionals invited by letter	Health professionals (n=6), Peer supporters (n=6), mothers (n=6). Peer supporters (n=7) kept diaries which were analysed as well. Project meetings attended for 2 months and observations made. It also sounds like the researcher went to the group as well, but not clear whether observations made there were included in study.	In-depth interviews, diaries and direct observation	Used some categorical indexing and Grounded Theory methods, but don't think it was a Grounded Theory study (no evidence of this really). Doesn't actually say if used constant comparisons or quite what. But did make themes.	A pioneer type BPS project. Emphasises building community capacity and culture change over changes in breastfeeding rates.

KEY FINDINGS (author(s)):

A BPS project can empower local mothers, can value their experiential knowledge of breastfeeding. It can help start developing a culture of breastfeeding where there is none. Health professionals may not all have the same attitude to it however. May not want to let go or work with peer supporters.

OTHER FINDINGS (not identified by the author(s))

I wonder whether the concept of what 'breastfeeding is' is at stake here. This paper strongly takes the view of breastfeeding as social and also places BPS interventions within broader sure start aims of building community capacity. This has been lost somewhat as things have developed over time.										
Code	**Author (year)**	**Aim(s)**	**Theoretical perspective**	**Methodology**	**Setting**	**Sample selection method**	**Sample size and characteristics**	**Method of data collection**	**Method of data analysis**	**COMMENT**
(27)	Dykes (2003)	To draw out findings from a very large and diverse set of projects funded by Department of Health.	NC	Each project asked to send back report. Standardised information drawn from each report. The outcomes of all the projects then drawn together forming findings.	Areas of deprivation all over country.	All the Department of Health funded projects were included, but some gave better/ more detailed information than others.		Reports from project co-ordinators	Used qualitative type methods to draw out the key findings – meta-synthesis type methods.	
KEY FINDINGS (author(s)):										
OTHER FINDINGS (not identified by the author(s))										

Code	Author (year)	Aim(s)	Theoretical perspective	Methodology	Setting	Sample selection method	Sample size and characteristics	Method of data collection	Method of data analysis	COMMENT
(2)	Raine & Woodward (2003)	Aims to report on an evaluation of the introduction of a BPS initiative. This is a sister publication to Raine (2003)	Doesn't mention.	In-depth qualitative methods.	Area of deprivation North of England.	Peer supporters invited for interview at group or via co-ordinator, mothers invited at group. Health professionals via letter	Peer supporters (n=6), Health professionals (n=6), mothers (n=6).	Interviews, diaries, direct observation	Grounded Theory methods used, not clear exactly what however.	This is a sister publication to Raine (2003), slightly more professional focussed.

KEY FINDINGS (author(s)):

The breastfeeding group did start to develop a culture of breastfeeding in the area. There were issues around health professionals – peer supporter communication and integration.

OTHER FINDINGS (not identified by the author(s))

I am wondering about the knowledge aspect here -health professionals were reassured that peer supporters had the same training as them and therefore gave the same 'advice', but the other types of knowledge the peer supporters used less obvious from this one.

Code	**Author (year)**	**Aim(s)**	**Theoretical perspective**	**Methodology**	**Setting**	**Sample selection method**	**Sample size and characteristics**	**Method of data collection**	**Method of data analysis**	**COMMENT**
(36)	South et al. (2012)	To examine lay perspectives of lay health worker roles via three case studies, one of which is BPS.	Not clear	Qualitative case studies.	Three cases. One is BPS intervention in deprived area. Little Angels.	Samples people who had received the project. Everyone who agreed to take part was interviewed at the normal group setting (at a later date after initial recruitment).	11 of the 46 project interviews took place as part of the BPS case.	Paired interviews and focus groups. Also, direct observation by researchers.	Thematic analysis. Through this drew up case reports for each case according to the themes. Then did cross case analysis.	It is interesting to see BPS in conjunction with other non- related projects.

KEY FINDINGS (author(s)):
Findings relate to how lay people saw the lay health workers and their boundaries. It highlighted the importance of a caring quality relationship. Access to social networks also came through. The idea of how people receiving the service might start to think about volunteering themselves was also explored. It is interesting to see how the ideas within BPS interventions are mirrored in other interventions.
OTHER FINDINGS (not identified by the author(s))
Can’t think of any.

Code	**Author (year)**	**Aim(s)**	**Theoretical perspective**	**Methodology**	**Setting**	**Sample selection method**	**Sample size and characteristics**	**Method of data collection**	**Method of data analysis**	**COMMENT**

<table>
<tr><td>(31)</td><td>Battersby (2001)</td><td>To report on the setting up of a BPS project.</td><td>UC</td><td>Qualitative descriptive.</td><td>Urban area of deprivation.</td><td>Not mentioned</td><td>16 mothers who has used service</td><td>Interviews with mothers (n=5), questionnaires for mothers (n=11)</td><td>Not mentioned.</td><td>Like this study, but quality not great. I quite like it being on paper.</td></tr>
<tr><td colspan="11">KEY FINDINGS (author(s)):</td></tr>
<tr><td colspan="11">Key findings are that the women who engaged liked it. The things about the peer supporters that were important were shared experience, language and having time. Making sure many different forms of communication can be used is important. Getting realistic information to mothers antenatally also impportant.</td></tr>
<tr><td colspan="11">OTHER FINDINGS (not identified by the author(s))</td></tr>
<tr><td colspan="11">Bit of a problem with the old A word ‘advice’ here. Once again, the idea that it is important peer supporters do the ante natal stuff to avoid conflicting ‘advice’. This is yet more evidence of that confliction between what knowledge we are talking about here and how the information is passed on. To what extent do all involved (including researchers) understand and actually enact the non- directive thing? Very interesting.</td></tr>
</table>

Code	**Author (year)**	**Aim(s)**	**Theoretical perspective**	**Methodology**	**Setting**	**Sample selection method**	**Sample size and characteristics**	**Method of data collection**	**Method of data analysis**	**COMMENT**

<table>
<tr><td>(28)</td><td>Kirkham (2006)</td><td>To tell the story of Doncaster breastfriends development.</td><td>UC</td><td>Draws on the Curtis evaluation material</td><td>North of England area of deprivation.</td><td>As per Curtis paper.</td><td>As per Curtis paper</td><td>As per Curtis paper</td><td>As per Curtis paper. But this chapter also goes on to a broader discussion of the whole project.</td><td>Got to be my favourite chapter in whole world.</td></tr>
<tr><td colspan="11">KEY FINDINGS (author(s)):</td></tr>
<tr><td colspan="11">Overall the aim of the whole project is to change the culture of Doncaster so that breastfeeding is seen as normal. This was done via setting up BPS in several areas. Health professional relationships crucial and problematic. Links to issues around what knowledge is, power relations and how knowledge and power are used. Brings in issues around midwifery education, medicalisation of childcare generally. This is a great chapter as it gives an historical perspective on the progress of the scheme. Interesting that they say the knowledge about breastfeeding women might actually want may not correspond with the ‘right’ knowledge health professionals feel they must impart.

Other findings not mentioned by author: They do pick up on this but I just wonder about the whole inequality in status and power thing. How interesting that some health professionals did not see the peer supporters as worthy of delivering breastfeeding messages. While health professionals still see knowledge about breastfeeding as theirs, and theoretical, biological knowledge, can this culture change really happen?</td></tr>
</table>

Please reference this document as follows:

Downe S, Walsh D, Simpson L, Steen M 2009 Template for metasynthesis, Available from sdowne@uclan.ac.uk

Appendix 6. Twelve meta-synthesis documents I was unable to find

Name of author	Type of document	Where found it	Why ordered/requested it, date and where ordered/requested from.	
Glencross J (1988)	Dissertation found via berry picking.	Referenced in Sarah Gills LLLi report. i.e. (Gill, 2001).	Dissertation re LLL peer supporters in Nottinghamshire. Requested from Nottingham University on 26.10.16. Not in British Library Ethos holdings. Email sent to librarian 2.11.16.	Not available at Nottingham University library or at their school of epidemiology archive. Reply from librarian 4.11.16.
Battersby (2001c) "Simply the breast" An evaluation of a peer breastfeeding support programme – submitted to Department of Health.	Grey doc. Found via berry picking.	Battersby (2007) and Dykes (2003) report. Reference lists.	Requested from Sheffield University on 28.10.16 also requested from Sue Battersby 28.10,16.	Waiting. No reply. Give up.
Battersby (2002a) The breast is best supporters project (BIBS) Submitted to Department of Health 2002.	Grey doc. Found via berry picking.	As above	As above	Waiting – no reply from Battersby or LLL GB. Give up
Battersby (2002b) Breast is best supporters project: an evaluation of the merged…a report to sure start	Grey doc. Found via berry picking.	As above.	As above	Waiting, no reply. Give up.

La Leche League GB (2005a) Breastfeeding Peer Counsellor Programme. Nottingham. LLLGB.	Grey report, found via berry picking.	Battersby (2007) reference list.	Requested from LLLGB press liaison via email 28.10.16.	Waiting – no reply, give up
La Leche League GB (2005b) Breastfeeding Peer Counsellor Programme Information Sheet. Nottingham LLLGB.	Grey doc, found via berry picking.	Battersby (2007) reference list	Requested from LLLGB press liaison via email 28.10.16.	Waiting – no reply. Give up.
Graffy J P (2002) Evaluating breastfeeding support : a randomised controlled trial.. [MD thesis] Uni of Birmingham	Medical doctorate dissertation, found via berry picking.	Graffy et al (2004) ref list.	Requested from University of Birmingham on 29.10.16 not on their Ethos depository.	Waiting for a response from Birmingham, waited, contacted several times, not able to get it. Give up.
NCT (2013) NCT County Durham and Darlington Baby Café and peer support project report 2012-2013. London NCT.	Grey report. Found via berry picking.	Bedding (2013) ref list	Request via email to NCT contact 29.10.16.	Waiting – NCT contact thinks she can get it. No reply. Give up. Waited, contacted, no reply – give up.
Smale, Newburn & Dodds (2004) NCT evidence based briefing : PS for breastfeeding. New Digest 2004; (27): 14-18.	Grey report found via berry picking	Muller (2009) ref list.	Request via email to NCT contact. Not available on NCT website. Request sent 29.10.16.	Waiting –NCT contact thinks she can get it, waited, contacted – no reply give up.
Jackson D (2004) West Howe	Dissertation found via berry picking	BfN (2016) report reference list.	I can-not find on Bournemouth University	Waiting not available have

breastfeeding support group: making a difference. Insitute of healh and community studied Uni of Bournemouth			depository. Emailed library support team 2.11.16.	tried everything.
Dodds, Newburn & Muller (2010)	Grey	Found via the grey lit search	I am waiting to get an email address (email sent to contact on 29.10.16). No reply yet).	Waiting – no reply
Russell, Taylor & Ball (2015)	Conference proceedings abstract Risk and Realities – Mothers' and breastfeeding peer supporters' reflections on provision of infant safe sleep education (page 106)	Berry picking.	Waiting for confirmation re whether peer support was 3rd sector or not. Email sent to CK Russell 14.11.16.	Waiting, no reply from authors. Nothing has been published based on this work that I have been able to find.

Appendix 7. Table linking the 18 projects forming part of Dykes (2003)'s review.

The projects were coded in the current meta-synthesis and their appropriate number given in brackets next to the Dykes (2003) reference in the meta-synthesis text.

Number given in meta-synthesis text	Project name	Page number of project summary in Dykes (2003)
1	Anderson et al (2002)	72
2	Battersby (2001a)	82
3	Battersby (2001b)	84
4	Battersby (2002)	86
5	Brown et al (2001)	94
6	Charlton, Meredith and Jennings (2001)	97
7	Clarke et al (2002a)	100
8	Curtis et al (2001)	107
9	Dassut and Ridgers (2002)	109
10	de Wyman (2002)	110
11	Dye (2001)	116
12	Hastings et al (2001)	137
13	Kirkham (2002)	150
14	Lincoln and Jones (2002)	152
15	Locke (2001)	154
16	Rosser (2002)	166
17	Woodward P (2001)	198
18	Woodward V (2002)	200

Appendix 8. Participant Information sheets for all interviews and observations

This appendix includes the participant information sheets used in all interviews and the observation.

Index to appendix 8:

Information sheet for key strategists taking part in phase one interviews.

uclan
University of Central Lancashire

Engagement with the health inequalities agenda: How have third sector breastfeeding organisations developed their services for delivery in areas of socio-economic deprivation?

Information Sheet for Key strategists – Phase 1.

I would like to invite you to take part in a study that aims to understand and explore whether and how UK national third sector breastfeeding organisations have adapted their breastfeeding peer support services for delivery in areas of socio-economic deprivation.

As part of this study we would like to talk to one or two key strategists within each UK national third sector breastfeeding organisation. Before you decide if you would like to take part, it is important for you to understand why the study is being done, and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. If there is anything that is not clear, or you would like more information, please contact a member of the team using the details provided at the end of the information sheet.

Why is the study being done?

This study will form two phases. Phase one will explore the perspectives of the organisations using literature review and interviews with key strategists. Phase two will concern at least two in-depth case studies of breastfeeding peer support interventions in areas of deprivation run by these organisations. We anticipate this will involve interviews with a range of stakeholders including women, peer supporters, peer support coordinators, and commissioners. Outcomes of the study may enable better design and targeting of future interventions in order that women's infant feeding experiences might be improved. Phase one of the study will be undertaken from October 2016 to February 2017, we are only recruiting for phase one at the moment.

Who is doing the study?

My name is Louise Hunt and I am undertaking this study as part of a PhD qualification. I have a nursing background, and have experience of working as a breastfeeding peer supporter.

Why have I been asked to participate?

We want to talk to one or two key strategists from each organisation.

What will I be asked to do?

If you agree to participate, you will take part in an audio-recorded interview (by skype or telephone). All interviews will be organised at a convenient time to suit you, and will take up to 45 minutes to complete.

At the start of the interview I will answer any questions you may have. The statements on the consent form (attached) will be read to you, and verbal consent will be recorded as appropriate. I would also like to record basic information about you such as your role, professional background, how long you have been in post, and your previous work roles within your organisation.

Interview questions will explore your perceptions of the history, development, values and ethos of your organisation, the health inequalities agenda, and whether and how your organisation has developed peer support services for delivery in areas of socio-economic deprivation.

The interview will be audio recorded with your consent. After data analysis has been undertaken, we would like to organise a second audio-recorded interview (via skype or telephone), to share the key findings, and see whether they match your experiences. It will also be possible for the main study themes and a summary of study outcomes to be sent to you.

Who has approved the study?

In order to make sure the study is conducted in a professional and ethical manner, it has been approved by the STEMH (Science, Engineering, Medicine and Health) University Ethics committee (project no: STEMH 558).

What will happen to the data, and how will confidentiality and anonymity be maintained?

We will use quotes in reports, presentations and papers generated from this study, however they will be anonymised, and you will not be identified. We ask that you do not disclose your name or that of other people during the interview, and that you do not disclose any identifying information regarding service users, other organisations, or voice any professional concerns about colleagues.

All data will be kept in a secure lockable filing cabinet, and /or on encrypted computer files. All personal data will be kept only until you have finished participating in the study, and will then be destroyed. Your data will be used for this phase of this research project alone.

In light of the relatively small number of relevant UK national organisations, there remains a possibility that 'insiders' may make educated guesses about individual and organisational identity. Please be assured that the research team will anonymise all data, maintain confidentiality, and will not enter into any communications regarding such speculation. If you would like to discuss this aspect further, please contact a member of the team using the contact details provided below.

Do I have to take part?

No – it is up to you to decide whether or not to take part. Even if you do agree to participate you are still free to not to answer all of the questions, and can stop the interview at any time without giving a reason. If you decide that you do not wish your data to be used within the study, all quotes/information can be removed within one month following the interview (by contacting myself on details provided below).

Are there any benefits to taking part?

Whilst there are no direct benefits to taking part in this study, it is hoped that it will give you an opportunity to reflect on your views, and to uncover insights into your organisation and its breastfeeding peer support provision. The results may also help inform future service delivery in this area.

Are there any risks to taking part?

Whilst no particular risks have been identified, if discussions lead to sensitive issues being raised, you will be encouraged to speak to your manager and / or to contact your GP. Information about finding counselling support would also be provided. If you were to want to make a complaint about your organisation, appropriate information would be provided either through providing details of your organisation's complaints policy, or through contacting a senior staff member on your behalf.

What do I do if I want to take part in the study?

If you would like to take part in the study, please contact me by phone or email within two weeks, and I will contact you to organise a convenient time for an interview.

What do I do if I have any concerns or issues about this study?

If you have any concerns or complaints about this study, please contact the University Officer for Ethics on 01772 892735 or via email at OfficerForEthics@uclan.ac.uk

Thank you for reading this information sheet and considering taking part in this study.

For further information on the study please contact:

Louise Hunt, Research Student: 07866 741 879 lhunt5@uclan.ac.uk
Professor Fiona Dykes, Professor of Maternal and Infant Health: 01772 893828 fcdykes@uclan.ac.uk
Dr Gill Thomson, Senior Research Fellow: 01772 894578 gthomson@uclan.ac.uk
Dr Karen Whittaker, Reader in Child and Family Health: 01772 893786 kwhittaker1@uclan.ac.uk

Maternal and Infant Nutrition and Nurture Unit (MAINN), School of Community Health and Midwifery, University of Central Lancashire, Preston, Lancashire, PR1 2HE

Information sheet for mothers (phase 2 interview).

uclan
University of Central Lancashire

Information Sheet for Mothers

An exploration of targeted breastfeeding peer support

Before you decide if you would like to take part, it is important for you to understand why the study is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. If you would like more information please contact us on the details provided at the end of the information sheet.

What is the study about?
My name is Louise Hunt. I have a nursing background and in the past, I have worked in breastfeeding peer support projects in a different part of the Country. I am undertaking this study as part of my PhD qualification. This study aims to explore how targeted breastfeeding support has developed. The study involves two case studies of targeted breastfeeding peer support projects run by two different voluntary breastfeeding organisations in two different parts of the Country. In each area this will involve interviews with several different groups of people connected to the service. The service run by XXX (org name) in XXX (County) forms one of my case study areas. It is a small case study restricted in size to selected areas.

As part of the study I would like to talk to mothers aged 18 or over who have a wide range of infant feeding experiences; some who have bottle-fed and some who have breastfed. I would like to talk to some mothers who have had support from the breastfeeding peer support service, and some who have not. I would like to talk to mothers with a range of ages. The study will take place from January to November 2018.

Why have I been asked to participate?
I want to talk to 5 mothers aged 18 years or over who have not had support from the XXX (org name) breastfeeding peer support service, and 5 mothers who have. Please note that you must be able to speak English.

Do I have to take part?
No – it is up to you to decide whether or not to take part. Even if you do agree you are still free to not answer all of the questions and can stop/end the interview at any time, and without giving a reason. You can leave the study at any time, but once your data has been analysed it will not be possible to withdraw it from the study. However, all data will be anonymised and it will not be possible to identify you from this data. Please contact the study team for more information.

What will I be asked to do?
To take part in an interview over the phone, via video conferencing, or face to face (e.g. at a community venue such as a Children's Centre, Neighbourhood Centre, or Library). The interview will be organised at a time/day to suit you, and will take around 30 – 45 minutes to complete. The

interview will usually take place when your baby is aged between four to six weeks old, but may happen when your baby is aged up to six months old.

At the start of the interview I will answer any questions you may have and ask you to sign a consent form. If the interview is completed over the telephone or by video conferencing, I will read the consent form to you, and your verbal consent will be audio recorded. I will also ask you to give me some information about you via a form, such as your age, ethnicity, marital status, postcode, highest level of qualification, how many children you have, current and previous infant feeding experiences, work life, marital status, and an optional question about weekly household income. During the interview I will ask you about your thoughts, feelings and experiences of infant feeding, and about your experiences of using or not using the peer support service. With your consent, I would like to digitally audio record the interview.

Once I have collected all the data, I would like to organise a second interview to share the findings and see whether they match your experiences. I can also send you the main findings of the study. If you are happy to take part in a second interview, or would like to have the findings sent to you, please leave your details on the consent form.

Are there any benefits to taking part?
While there are no direct benefits to taking part, it may give you an opportunity to reflect on your experiences of infant feeding and parenting. To thank you for your time, I will send you a £10 gift voucher at the end of each interview. Please note that I will not be able to provide travel expenses.

Are there any risks to taking part?
While there are no particular risks, if you are upset by any of the issues discussed, I can help you contact professionals/services to support you, and give you contact details of other support options. If you have any complaints about the care you received, I can give you details of appropriate complaints procedures, as well as support from health professionals should this be needed.

Will the data be kept confidential?
All the information you provide will be kept confidential unless I believe that you or someone else is at risk of serious harm. If this happens I will discuss this with you, and will pass the information to the appropriate services. No staff from the XXX (org name) will know whether you have decided to take part or not. Taking part will not affect the support you will be offered by the XXX (org name) breastfeeding peer support service.

What will happen to the data?
All data will be kept on University password protected encrypted computer files. All information will be linked using a participant code, and any documents or audio files containing personal identifying information will be stored separately from any data collected. When interviews are transcribed any information that could identify you will be removed. All personal data (e.g. contact details) will be kept only until you have finished taking part in the study and will then be destroyed. While the information you provide will be used in papers and presentations, you will not be able to be identified. I will share the findings with local healthcare providers and the Council.

What do I do if I want to take part in the study?
My project is a small study restricted in size to selected areas. In order to tell whether you live in one of the selected areas, I need to know your post code. I aim to interview mothers with a range of ages. If you are interested in taking part, please fill in the contact form (attached) indicating your age and postcode, and post or give it to me. I will call you to arrange an interview. Please note that if more

women agree to be interviewed than intended, it may not be possible to organise an interview with you. If this happens, or you live outside the selected study areas, I will let you know, and you will still be able to receive the main findings from the study.

Who has approved the study?

This study has had ethical clearance from; the Health Research Authority (ref XXX); XXX Research Ethics Committee (NHS) (ref XXX); XXX (County) NHS Trust R&D Department (ref XXX); XXX (County) County Council research governance committee (ref: xxx), and the University of Central Lancashire STEMH (Science, Engineering, Medicine and Health) ethics committee (project no: STEMH xxx). The study is funded by the University of Central Lancashire (as part of my PhD qualification).

What do I do if I have any concerns or issues about this study?

If you have any complaint's or concerns about this study please contact the University Office for Ethics at the University of Central Lancashire at OfficerForEthics@uclan.ac.uk.

Thank you for reading this information sheet and considering taking part in this study.

Primary investigator: Louise Hunt PhD Student, Maternal and Infant Nutrition and Nurture Unit (MAINN), School of Community Health and Midwifery, College of Health and Wellbeing, University of Central Lancashire, Preston, Lancashire, PR1 2HE. Tel: 07866 741 879. Email lhunt5@uclan.ac.uk

Supervisors at the University of Central Lancashire:

Professor Fiona Dykes fcdykes@uclan.ac.uk Tel: 01772 893828
Dr Gill Thomson gthomson@uclan.ac.uk Tel: 01772 894578
Dr Karen Whittaker kwhittaker1@uclan.ac.uk Tel: 01772 893786

Information sheet for peer supporters undertaking an interview (phase 2).

Interview Information Sheet - Peer Supporters

An exploration of targeted breastfeeding peer support

Before you decide if you would like to take part, it is important for you to understand why the study is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. If you would like more information please contact us on the details provided at the end of the information sheet.

What is the study about?

My name is Louise Hunt. I have a nursing background, and in the past, I have worked as a breastfeeding peer supporter and counsellor for a small local third sector breastfeeding organisation in a different part of the Country. I am undertaking this study as part of my PhD qualification. This study aims to explore how third sector breastfeeding support organisations have developed their breastfeeding peer support services for areas of deprivation. The study involves two case studies of targeted breastfeeding peer support projects run by two different third sector organisations in two different parts of the Country. In each area this will involve interviews with mothers who have/have not used the service who have a range of infant feeding experiences, peer supporters, health professionals, key stakeholders from within the third sector organisations, and commissioners. The service run by XXX (org name) in XXX (County) forms one of my case study areas. The study will take place from January to November 2018.

Why have I been asked to participate?

I want to talk to 5 peer supporters who have experience of providing peer support to women living in the areas /forming part of groups targeted by the breastfeeding peer support service run by the XXX (org name) in XXX (County), about their experience of the service and how it has developed.

Do I have to take part?

No – it is up to you to decide whether or not to take part. Even if you do agree you are still free to not answer all of the questions and can stop/end the interview at any time, and without giving a reason. You can leave the study at any time, but once your data has been analysed it will not be possible to withdraw it from the study. However, all data will be anonymised and it will not be possible to identify you from this data. Please contact the study team for more information.

What will I be asked to do?

To take part in an interview over the phone, via video conferencing, or face to face (e.g. at a community venue such as a Neighbourhood Centre, Children's Centre or Library). You can choose to undertake an interview individually, in pairs or in small groups with other peer supporters (a small group interview is a focus group interview). The interview/focus group can be organised at a time/day to suit you, and will take around 45 minutes to complete.

At the start of the interview I will answer any questions you may have and ask you to sign a consent form (please see attached). If the interview is completed over the telephone, or by video conferencing, I will read the consent form to you, and your verbal consent will be audio recorded. I will also ask you to give me some information about you via a form such as your age, ethnicity, marital status, postcode, highest level of qualification, how many children you have, current and previous infant feeding experiences, work life, marital status, and an optional question about weekly household income. If a focus group takes place, at the start I will ask everybody present not to discuss the content of the interview/focus group afterwards. During the interview I will ask you questions about your thoughts and feelings about feeding babies in your area, your experiences of becoming involved with and working/volunteering for the XXX's (org name) peer support service, and of how these services have developed for areas of deprivation. We ask that you do not disclose any identifying information regarding service users, or voice any professional concerns about colleagues. With your consent, I would like to digitally record the interview.

Once I have collected all the data, I would like to organise a second interview to share the findings and see whether they match your experiences. I can also send you the main findings of the study. If you would like to take part in a second interview, or have the main findings sent to you, please leave your details on the consent form.

Are there any risks or benefits to taking part?
While there are no direct benefits it will give you an opportunity to reflect on your views and experiences about how the peer support service has developed. The results may also help inform future service delivery in this area. Whilst no particular risks have been identified, if the discussions lead to sensitive or upsetting issues being raised, I can give you information about professionals/services to contact. If you have any complaints about an organisation, I can give you details of appropriate complaints procedures and union representatives. Please also note that should any issues of mal-practice be identified, then appropriate procedures will need to be followed.

What will happen to the data?
All data will be kept on University password protected encrypted computer files. All information will be linked using a participant code, and any documents or audio files containing personal identifying information will be stored separately from any data collected. When interviews are transcribed any information that could identify you will be removed. All personal data (e.g. contact details) will be kept only until you have finished taking part in the study and will then be destroyed. While the information you provide will be used in papers and presentations, you will not be able to be identified. I will share the findings with local healthcare providers and the Council.

What do I do if I want to take part in the study?
If you would like to take part in the study, please phone or email me using the contact details below within two weeks. I will then contact you to organise a convenient time/place for an interview/focus group. Please note that if more peer supporters agree to be interviewed than intended for this study, I may not be able to organise an interview with you. However, should this be the case, I will contact you to inform you, and provide the option of receiving the key findings.

Who has approved the study?
This study has had ethical clearance from; the Health Research Authority (ref XXX); XXX Research Ethics Committee (NHS) (ref XXX); XXX (County) NHS trust R&D Department (ref XXX); XXX (County) County Council research governance committee (ref: xxx); and the University of Central Lancashire

STEMH (Science, Engineering, Medicine and Health) ethics committee (project no: STEMH xxx). The study is funded by the University of Central Lancashire (as part of my PhD qualification).

What do I do if I have any concerns or issues about this study?
If you have any complaint's or concerns about this study please contact the University Office for Ethics at the University of Central Lancashire at OfficerForEthics@uclan.ac.uk.

Thank you for reading this information sheet and considering taking part in this study.

Primary investigator: Louise Hunt PhD Student, Maternal and Infant Nutrition and Nurture Unit (MAINN), School of Community Health and Midwifery, College of Health and Wellbeing, University of Central Lancashire, Preston, Lancashire, PR1 2HE. Tel: 07866 741 879. Email lhunt5@uclan.ac.uk

Supervisors at the University of Central Lancashire:
Professor Fiona Dykes fcdykes@uclan.ac.uk Tel: 01772 893828
Dr Gill Thomson gthomson@uclan.ac.uk Tel: 01772 894578
Dr Karen Whittaker kwhittaker1@uclan.ac.uk Tel: 01772 893786

Information sheet for health professionals, IFC, peer support manager/co-ordinator, and commissioner (phase two interviews).

Information Sheet – Stakeholders

An exploration of targeted breastfeeding peer support

Before you decide if you would like to take part, it is important for you to understand why the study is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. If there is anything that is not clear or you would like more information please contact a member of the team using the details provided at the end of the information sheet.

What is the study about?

My name is Louise Hunt. I have a nursing background, and in the past, I have worked as a breastfeeding peer supporter and counsellor for a small local third sector breastfeeding organisation in a different part of the Country. I am undertaking this study as part of my PhD qualification. This study aims to explore how third sector breastfeeding support organisations have developed their breastfeeding peer support services for areas of deprivation. The study involves two case studies of targeted breastfeeding peer support projects run by two different third sector organisations in two different parts of the Country. In each area this will involve interviews with mothers who have/have not used the service who have a range of infant feeding experiences, peer supporters, health professionals, key stakeholders from within the third sector organisations, and commissioners. The service run by XXX (org name) in XXX (County) forms one of my case study areas. The study will take place from January to November 2018.

Why have I been asked to participate?

You have been approached because of your knowledge and experience of the targeted breastfeeding peer support project run by the XXX (Org name) in XXX (County).

Do I have to take part?

No – it is up to you to decide whether or not to take part. Even if you do agree you are still free to not answer all of the questions and can stop/end the interview at any time, and without giving a reason. You can leave the study at any time, but once your data has been analysed it will not be possible to withdraw it from the study. However, all data will be anonymised and it will not be possible to identify you from this data. Please contact the study team for more information.

What will I be asked to do?

To take part in an individual interview (via telephone, video conferencing, or face to face) at a time and place to suit you. The interview will take around 45 minutes to complete.

At the start of the interview I will answer any questions you may have and ask you to sign a consent form (please see attached). If the interview is completed over the telephone or by video conferencing, I will read the consent form to you, and your verbal consent will be audio recorded. I would like to collect some information about your job role and how long you have been in post. The interview questions will explore your role and experiences in relation to this service and its development. We ask that you do not disclose any identifying information regarding service users, or voice any professional concerns about colleagues. With your consent, I would like to digitally audio record the interview.

Once I have collected all the data, I would like to organise a second interview to share the findings and see whether they match your experiences. I can also send you the main findings of the study. If you would like to take part in a second interview, or would like to have the findings sent to you, please leave your details on the consent form.

Are there any risks or benefits to taking part?
Whilst no particular risks have been identified, if discussions lead to sensitive or upsetting issues being raised, I can give you information about professionals/services to contact. If you have any complaints about an organisation, I can give you details of appropriate complaints procedures and union representatives. Please also note that should any issues of mal-practice be identified, then appropriate procedures will need to be followed. While there are no direct benefits it will give you an opportunity to reflect on your views and experiences about how the peer support service has developed in XXX (County). The results may also help inform future service delivery in this area.

What will happen to the data?
All data will be kept on University password protected encrypted computer files. All information will be linked using a participant code, and any documents or audio files containing personal identifying information will be stored separately from any data collected. When interviews are transcribed any information that could identify you will be removed. All personal data (e.g. contact details) will be kept only until you have finished taking part in the study and will then be destroyed. While the information you provide will be used in papers and presentations, you will not be able to be identified. I will share the findings with local healthcare providers and the Council.

What do I do if I want to take part in the study?
If you would like to take part in the study, please phone or email me using the contact details below within two weeks. I will then contact you to organise a convenient time/place for an interview. Please note that if more people agree to be interviewed than intended for this study, I may not be able to organise an interview with you. However, should this be the case, I will contact you to inform you, and provide the option of receiving the key findings.

Who has approved the study?
This study has had ethical clearance from; the Health Research Authority (ref XXX); XXX Research Ethics Committee (NHS) (ref XXX); XXX (County) NHS trust R&D Department (ref XXX); XXX (County) County Council research governance committee (ref: xxx); and the University of Central Lancashire STEMH (Science, Engineering, Medicine and Health) ethics committee (project no: STEMH xxx). The study is funded by the University of Central Lancashire (as part of my PhD qualification).

What do I do if I have any concerns or issues about this study?

If you have any complaint's or concerns about this study please contact the University Office for Ethics at the University of Central Lancashire at OfficerForEthics@uclan.ac.uk.

Thank you for reading this information sheet and considering taking part in this study.

Primary investigator: Louise Hunt PhD Student, Maternal and Infant Nutrition and Nurture Unit (MAINN), School of Community Health and Midwifery, College of Health and Wellbeing, University of Central Lancashire, Preston, Lancashire, PR1 2HE. Tel: 07866 741 879. Email lhunt5@uclan.ac.uk

Supervisors at the University of Central Lancashire:
Professor Fiona Dykes fcdykes@uclan.ac.uk Tel: 01772 893828
Dr Gill Thomson gthomson@uclan.ac.uk Tel: 01772 894578
Dr Karen Whittaker kwhittaker1@uclan.ac.uk Tel: 01772 893786

Information sheet for PSs taking part in observation (phase two observation).

Information Sheet - Observation of peer support supervision session

An exploration of targeted breastfeeding peer support

As part of this study I would like to observe a peer supporter supervision session. Before you decide if you would like to take part it is important for you to understand why the study is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. If you would like more information please contact us on the details provided at the end of the information sheet.

What is the study about?
My name is Louise Hunt. I have a nursing background, and in the past, I have worked as a breastfeeding peer supporter and counsellor for a small local third sector breastfeeding organisation in a different part of the Country. I am undertaking this study as part of my PhD qualification. This study aims to explore how third sector breastfeeding support organisations have developed their breastfeeding peer support services for areas of deprivation. The study involves two case studies of targeted breastfeeding peer support projects run by two different third sector organisations in two different parts of the Country. This will involve interviews with various different groups of people connected to the service. I would also like to observe a peer support supervision session in order to help me understand how service development takes place. The service run by XXX (org name) in XXX (County) forms one of my case study areas. The study will take place from January to November 2018.

Why have I been asked to take part?
You have been invited to take part as you are a peer supporter who provides breastfeeding support in a targeted area/to target groups, and who attends regular supervision sessions as part of the breastfeeding peer support service run by the XXX (org name) in XXX (County).

Do I have to take part?
No – it is entirely up to you whether you take part or not. The observation will only take place if all agree. During (and immediately after) the observation you are free to ask me not to note down (or to remove) details of specific comments raised/discussed.

What will I be asked to do?
At the start of the supervision session I will answer any questions you may have and ask you to sign a consent form. As I am purely there to observe, I will sit quietly, listening, watching and taking notes while your usual supervision session takes place. The main aim of the observation is to find out what and how information is shared, and how this information is used to change or adapt service provision.

After data analysis has been undertaken, it will be possible to have the main findings of the study sent to you. If you would like to receive them, please leave your details on the consent form.

Are there any risks or benefits to taking part?

There are no particular risks to taking part. Whilst there are no direct benefits to taking part in the observation, it is hoped that overall study outcomes may help inform future service delivery in this area.

What will happen to the data and will it be kept confidential?

During the observation I will not record/detail any names or information that could identify any individual. All data (field notes and consent forms) will be kept on University password protected encrypted computer files. All information will be linked using a participant code, and any documents containing personal identifying information will be stored separately from any data collected. When field notes are transcribed any information that could identify you will be removed. All personal data (e.g. contact details) will be kept only until you have finished taking part in the study (after the main findings have been sent to you), and will then be destroyed.

While the findings from this study will be used in papers and presentations, and will be shared with local healthcare providers and the council, you will not be able to be identified.

What do I do next?

Please note that it has been agreed with your supervisor that I will attend the planned supervision session on XXX (date and time). I hope this will be acceptable to all who attend, however, if there are any issues please contact me.

Who has approved the study?

This study has had ethical clearance from; the Health Research Authority (ref XXX); XXX Research Ethics Committee (NHS) (ref XXX); XXX (County) NHS trust R&D Department (ref XXX); XXX (County) County Council research governance committee (ref: xxx); and the University of Central Lancashire STEMH (Science, Engineering, Medicine and Health) ethics committee (project no: STEMH xxx). The study is funded by the University of Central Lancashire (as part of my PhD qualification).

What do I do if I have any concerns or issues about this study?

If you have any complaint's or concerns about this study please contact the University Office for Ethics at the University of Central Lancashire at OfficerForEthics@uclan.ac.uk.

Thank you for reading this information sheet and considering agreeing to the observation.

Primary investigator: Louise Hunt PhD Student, Maternal and Infant Nutrition and Nurture Unit (MAINN), School of Community Health and Midwifery, College of Health and Wellbeing, University of Central Lancashire, Preston, Lancashire, PR1 2HE. Tel: 07866 741 879. Email lhunt5@uclan.ac.uk

Supervisors at the University of Central Lancashire:
Professor Fiona Dykes fcdykes@uclan.ac.uk Tel: 01772 893828
Dr Gill Thomson gthomson@uclan.ac.uk Tel: 01772 894578
Dr Karen Whittaker kwhittaker1@uclan.ac.uk Tel: 01772 893786

Information sheet for supervisor of peer support supervision session where observation will take place (observation, phase two).

University of Central Lancashire

Information Sheet for Supervisor - Observation of peer support supervision session

An exploration of targeted breastfeeding peer support

As part of this study I would like to observe a peer supporter supervision session. Before you decide if you would like to take part it is important for you to understand why the study is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. If you would like more information please contact us on the details provided at the end of the information sheet.

What is the study about?
My name is Louise Hunt. I have a nursing background, and in the past, I have worked as a breastfeeding peer supporter and counsellor for a small local third sector breastfeeding organisation in a different part of the Country. I am undertaking this study as part of my PhD qualification. This study aims to explore how third sector breastfeeding support organisations have developed their breastfeeding peer support services for areas of deprivation. The study involves two case studies of targeted breastfeeding peer support projects run by two different third sector organisations in two different parts of the Country. This will involve interviews with various different groups of people connected to the service. I would also like to observe a peer support supervision session in order to help me understand how service development takes place. The service run by XXX (org name) in XXX (County) forms one of my case study areas. The study will take place from January to November 2018.

Why have I been asked to take part?
You have been invited to take part as you are a supervisor of peer supporters as part of the breastfeeding peer support service run by the XXX (org name) in XXX (County).

Do I have to take part?
No – it is entirely up to you whether you take part or not. The observation will only take place if you, and all those due to attend agree. During (and immediately after) the observation you are free to ask me not to note down (or to remove) details of specific comments raised/discussed.

What will I be asked to do?
If you decide you want to take part, you will contact me to let me know. I will then send study information to all peer supporters due to attend the supervision session. At the start of the supervision session I will answer any questions you and the peer supporters may have, and ask everyone to sign a

consent form. As I am purely there to observe, I will sit quietly, listening, watching and taking notes while your usual supervision session takes place. No names or identifying information will be recorded. The main aim of the observation is to find out what and how information is shared, and how this information is used to change or adapt service provision.

After data analysis has been undertaken, it will be possible to have the main findings of the study sent to you. If you would like to receive them, please leave your details on the consent form.

Are there any risks or benefits to taking part?
There are no particular risks to taking part. Whilst there are no direct benefits to taking part in the observation, it is hoped that overall study outcomes may help inform future service delivery in this area.

What will happen to the data and will it be kept confidential?
During the observation I will not record/detail any names or information that could identify any individual. All data (field notes and consent forms) will be kept on University password protected encrypted computer files. All information will be linked using a participant code, and any documents containing personal identifying information will be stored separately from any data collected. When field notes are transcribed any information that could identify you will be removed. All personal data (e.g. contact details) will be kept only until you have finished taking part in the study (after the main findings have been sent to you), and will then be destroyed.

While the findings from this study will be used in papers and presentations, and will be shared with local healthcare providers and the council, you will not be able to be identified.

What do I do next?
If you are happy for me to observe your upcoming supervision session (date), please phone or email me on the contact details given below within one week. I will then arrange to ensure that peer supporters are sent information about the observation in plenty of time.

Who has approved the study?
This study has had ethical clearance from; the Health Research Authority (ref XXX); XXX Research Ethics Committee (NHS) (ref XXX); XXX (County) NHS trust R&D Department (ref XXX); XXX (County) County Council research governance committee (ref: xxx); and the University of Central Lancashire STEMH (Science, Engineering, Medicine and Health) ethics committee (project no: STEMH xxx). The study is funded by the University of Central Lancashire (as part of my PhD qualification).

What do I do if I have any concerns or issues about this study?
If you have any complaint's or concerns about this study please contact the University Office for Ethics at the University of Central Lancashire at OfficerForEthics@uclan.ac.uk.

Thank you for reading this information sheet and considering agreeing to the observation.

Primary investigator: Louise Hunt PhD Student, Maternal and Infant Nutrition and Nurture Unit (MAINN), School of Community Health and Midwifery, College of Health and Wellbeing, University of Central Lancashire, Preston, Lancashire, PR1 2HE. Tel: 07866 741 879. Email lhunt5@uclan.ac.uk

Supervisors at the University of Central Lancashire:
Professor Fiona Dykes fcdykes@uclan.ac.uk Tel: 01772 893828
Dr Gill Thomson gthomson@uclan.ac.uk Tel: 01772 894578
Dr Karen Whittaker kwhittaker1@uclan.ac.uk Tel: 01772 893786

Appendix 9 Consent forms

This appendix contains all consent forms used in the study.
Index to appendix 9:

Phase	Participant group and research activity consent form was used for	Page number
One	Key strategists (interview)	479
Two	All phase two participants undertaking an individual interview (interview)	482
Two	PSs taking part in an observation (observation)	484
Two	Supervisor supervising peer support supervision session (observation)	486

Consent form for key strategists taking part in phase one interviews.

University of Central Lancashire

Engagement with the health inequalities agenda: How have third sector breastfeeding organisations developed their services for delivery in areas of socio-economic deprivation?

Consent Form (phase one): Interview

Please initial the boxes to indicate 'YES' to the following statements:

(1) I have read and understood the information sheet (version 3), have had the opportunity to ask questions, and have had them answered to my satisfaction.	☐

(2) I understand that I am free to not answer all of the questions during the interview, and may stop the interview at any point without giving a reason.	☐
(3) I understand I am able to withdraw my data from the study within a one month period (post interview).	☐
(4) I understand that my participation will be anonymous and any details that might identify me will not be included in reports, presentations or other publications produced from the study.	☐
(5) I agree to anonymised quotes being used within reports, presentations or other publications produced from the study.	☐
(6) I agree to the interview being digitally recorded.	☐
(7) I agree to the digital storage of anonymised data, and that it will be used for this phase of this research project alone.	☐
(8) I agree to take part in the interview.	☐

Name (PRINT):	Date:
Position/Job Role:	
Signature:	

Name of researcher taking consent:
Signature: Date:

I would like to be contacted again by the researcher to arrange a second interview to find out whether the outcomes of this study match my experience Yes/No I would like to receive a copy of the main themes of this study Yes/No I would like to receive a summary of the study findings Yes/No	Contact details:

Consent form for all phase two interview participants.

uclan
University of Central Lancashire

An exploration of targeted breastfeeding peer support

Consent Form (phase two): Individual interview

Please initial the boxes to indicate 'YES' to the following statements:

(1) I have read and understood the information sheet (version 1, date 14.12.17), have had the opportunity to ask questions, and have had them answered to my satisfaction.	☐
(2) I understand that I am free to not answer all of the questions during the interview, and may stop the interview at any point without giving a reason.	☐
(3) I understand that I can leave the study at any time, but once my data has been analysed it will not be possible to remove it from the study. I understand that all data will be anonymised and it will not be possible to identify me from it.	☐
(4) I understand that data related to my participation will be anonymised, and any details that might identify me will not be included in reports, presentations or other publications produced from the study.	☐
(5) I agree to anonymised quotes being used within reports, presentations or other publications produced from the study.	☐
(6) I agree to the interview being digitally recorded.	☐
(7) I understand that once my interview has been transcribed and checked the audio recording will be destroyed.	☐

(8) I agree to take part in the interview.	☐

Name (PRINT):	Date:
Position/Job Role:	
Signature:	
Name of researcher taking consent:	
Signature:	Date:

Consent form for PSs taking part in observations (phase two).

uclan
University of Central Lancashire

An exploration of targeted breastfeeding peer support

Consent Form for Peer Supporters: Observation of Peer Support Supervision.

Please initial the boxes to indicate 'YES' to the following statements:

(1) I have read and understood the information sheet (version 1, date 14.12.17), have had the opportunity to ask questions, and have had them answered to my satisfaction.	☐
(2) I understand that I am free to stop/leave the observation at any point and that I am able to request to withdraw/remove any comments I made immediately after the observation has finished.	☐
(3) I understand that I can leave the study at any time, but once my data has been analysed it will not be possible to remove it from the study.	☐
(4) I understand that anonymised data (field notes) will be collected, but any details that might identify me will not be included in reports, presentations or other publications produced from the study.	☐
(5) I agree to anonymised quotes being used within reports, presentations or other publications produced from the study.	☐
(6) I agree to the researcher observing the supervision session.	☐

Name (PRINT):	Date:
Position/Job Role:	
Signature:	
Name of researcher taking consent:	
Signature:	Date:

I would like to receive a summary of the study findings Yes/No	Contact details:

Consent from for the supervisor of the peer support supervision (phase two).

An exploration of targeted breastfeeding peer support

Consent Form for Supervisor: Observation of Peer Support Supervision.

Please initial the boxes to indicate 'YES' to the following statements:

(1) I have read and understood the information sheet for supervisors (version 1, date 12.2.18), have had the opportunity to ask questions, and have had them answered to my satisfaction.	☐
(2) I understand that I am free to stop/leave the observation at any point and that I am able to request to withdraw/remove any comments I made immediately after the observation has finished.	☐
(3) I understand that I can leave the study at any time, but once my data has been analysed it will not be possible to remove it from the study.	☐
(4) I understand that anonymised data (field notes) will be collected, but any details that might identify me will not be included in reports, presentations or other publications produced from the study.	☐
(5) I agree to anonymised quotes being used within reports, presentations or other publications produced from the study.	☐
(6) I agree to the researcher observing the supervision session that I am leading today.	☐

Name (PRINT):	Date:
Position/Job Role:	
Signature:	
Name of researcher taking consent:	
Signature:	Date:

I would like to receive a summary of the study findings Yes/No	Contact details:

Appendix 10 Covering letters

This appendix contains the covering letters provided to study participants.

Index to appendix 10:

Phase	Participant group and research activity covering letter pertains to	Page number
Two	Mothers (interviews)	488
Two	PSs and Infant feeding co-ordinator, commissioners, health professionals, peer support service manager and co-ordinator (interviews)	489
Two	PSs (observation)	490

Covering letter for mothers (phase two interviews)

University of Central Lancashire

Maternal and Infant Nutrition and Nurture Unit (MAINN),
School of Community Health and Midwifery,
College of Health and Wellbeing,
University of Central Lancashire,
Preston,
PR1 2HE

Date to be added.

Dear potential participant,

My name is Louise Hunt, I am a research student doing a PhD qualification. My study is looking at how targeted breastfeeding peer support has been developed by XXXX (name of third sector organisation) in your area. The study has been approved by the Health Research Authority (ref XXX), XXX Research Ethics Committee (NHS) (ref XXX), XXX (County) NHS trust R&D Department (ref XXX), XXX (County) County Council research governance committee (ref: xxx), and the University of Central Lancashire STEMH (Science, Engineering, Medicine and Health) ethics committee (project no: STEMH xxx).

As part of the study I would like to interview mothers who have a range of infant feeding experiences. I would like to talk to some mothers who have used the service and some who have not. Your involvement would mean taking part in an individual face to face, telephone or video conferencing interview.

Please find enclosed an information sheet. I would be very grateful if you would read this. My project is a small study restricted in size to selected areas. If you are interested in participating please fill in the contact form and post it to me, or call me to tell me your postcode to see if you live in one of the areas I am studying.

Please note that if more mothers agree to be interviewed than intended for this study, I may not be able to organise an interview with you. But if this happens, or you live outside the selected study area, I will contact you to let you know, and give you the option of receiving the key findings from the study.

If you need more information please contact me or my supervisors. I hope to hear from you soon.

Many thanks,

Louise Hunt, MSc, BSc. PhD Student, Tel: 07866 741879. Email: lhunt5@uclan.ac.uk

Covering letter for PSs, Infant feeding co-ordinator, commissioners, health professionals and peer support service manager and co-ordinator (phase 2 interviews).

uclan
University of Central Lancashire

Maternal and Infant Nutrition and Nurture Unit (MAINN),
School of Community Health and Midwifery,
College of Health and Wellbeing,
University of Central Lancashire,
Preston,
PR1 2HE

Date to be added.

Stakeholder/PS,

Address,

Dear XXX,

My name is Louise Hunt, I am a research student undertaking a PhD qualification. My study is looking at how third sector breastfeeding support organisations have developed their breastfeeding peer support services for areas of deprivation. As part of the study I am undertaking a case study of the project being run by XXXX (name of organisation) in XXX (area).

The study has been approved by the Health Research Authority (ref 238698), North West Greater Manchester West Research Ethics Committee (NHS) (ref 18/NW/0089); Lancashire Care NHS Foundation Trust, and East Lancashire Hospitals NHS Trust R&D Departments (ref 238698), and the University of Central Lancashire STEMH (Science, Engineering, Medicine and Health) ethics committee (project no: STEMH 558 Phase 2).

As part of this study, I would like to interview you to find out about your views on this topic. Your involvement would mean taking part in a telephone or face to face interview, which should last no longer than 45 minutes.
Please find enclosed a copy of the information sheet and consent form. I would be very grateful if you would read this, and if you would be willing to take part, please contact me within two weeks using the contact details below in order to make convenient arrangements for the interview to take place.

If you require any further information please do not hesitate to contact me or my supervisory team. I hope to hear from you soon.

Many thanks,

Louise Hunt, MSc, BSc. PhD Student, Tel: 07866 741879. Email: lhunt5@uclan.ac.uk

Covering letter for PSs taking part in observation (phase 2).

---

uclan
University of Central Lancashire

Maternal and Infant Nutrition and Nurture Unit (MAINN),
School of Community Health and Midwifery,
College of Health and Wellbeing,
University of Central Lancashire,
Preston,
PR1 2HE

Date to be added.

Peer Supporters,

Address,

Dear peer supporter,

My name is Louise Hunt, I am a research student undertaking a PhD qualification. My study is looking at how third sector breastfeeding support organisations have developed their breastfeeding peer support services for areas of deprivation. As part of the study I am undertaking a case study of the project being run by XXX (org name) in your area. The study has been approved by the Health Research Authority (ref XXX), XXX Research Ethics Committee (NHS) (ref XXX), XXX (County) NHS trust R&D Department (ref XXX), XXX (County) County Council research governance committee (ref: xxx), and the University of Central Lancashire STEMH (Science, Engineering, Medicine and Health) ethics committee (project no: STEMH xxx).

I would like to invite you to take part in the study. As part of the study I would like to observe the peer support supervision taking place on XXX (date) at XXX (venue) in order to understand how knowledge and information is shared. I would be most grateful if you could read the attached information and consider whether you would be interested in taking part. Observation will only go ahead if all agree.

If you require any further information please do not hesitate to contact me or my supervisory team.

Many thanks,

Louise Hunt, MSc, BSc. PhD Student, Tel: 07866 741879. Email: lhunt5@uclan.ac.uk

Appendix 11 Contact form

This appendix shows the contact form provided to mothers during phase two.
Contact form for mothers (phase 2).

An exploration of targeted breastfeeding peer support
Contact Form Mothers

Bodeglos,
Lewannick,
Launceston,
Cornwall.
PL15 7QD.
Email: lhunt5@uclan.ac.uk
Phone: 07866 741 879
4.7.18.

Dear potential participant,

If you would like to take part in the study, please fill in and return this contact form to me at the address above (also on the enclosed stamped addressed envelope). Please can you reply within one week and I will contact you to organise a convenient time for an interview. My project is a small study restricted in size to selected areas, in order to see whether you live in one of the selected areas, please fill in your postcode below. I aim to interview mothers with a range of ages, please indicate your age below. Please note that if more women agree to be interviewed than intended for this study, or if you do not live in one of the selected areas, I may not be able to organise an interview with you. But, if this happens, I will write to let you know and give you the option of receiving the key findings from the study. Many thanks,

Louise Hunt, research student.

I have read the information sheet about this study and would like to be contacted to arrange a time for an individual interview. I confirm that I am aged 18 or older, and am able to speak English.

Name:

Telephone:

Postcode:

Age: 18-19 years ☐ 20-29years☐ 30-39years☐ 40years or above☐

Appendix 12. Interview and observation schedules

This appendix provides all the interview schedules and the observation schedule used in this study.

Index to appendix 12:

Phase of study when schedule used	Participant role (s) for whom schedule was used	Page number
one	Key strategists	493
two	Mothers who had engaged with the peer support service	496
two	Mothers who had not engaged with the peer support service	499
two	PSs	501
two	The manager of the PSs/peer support co-ordinator.	5044
two	Community health professionals (community midwives and health visitors)	506
two	Infant feeding co-ordinator	508
two	Commissioners	510
two	Observation schedule for peer support supervision session	512

Interview schedule for key strategists (phase one interview).

University of Central Lancashire

Engagement with the health inequalities agenda: How have third sector breastfeeding organisations developed their services for delivery in areas of socio-economic deprivation?

Interview Schedule: Key Strategists – Phase 1.

Welcome.

Introductions.

Key topic areas:

Understanding the organisation

How would you explain the history of your organisation?

How would you outline its values and ethos?

Prompts: Have these changed over time? How? Why?

What are the main issues that concern your organisation?

Prompts: What are the aims of the organisation? Who is it for?

What is your organisation’s vision for the future?

Prompts: How will it get there? How will you know that it’s got there?

Breastfeeding peer support and the organisation

For the purposes of this study breastfeeding peer support is defined as: ‘The provision of emotional, appraisal, and informational assistance by a created social network member who possesses experiential knowledge of a specific behaviour or stressor and similar characteristics as the target population’ (Dennis, 2003, p329).

How would you define breastfeeding peer support within your organisation?

Prompts: How does breastfeeding peer support fit into what your organisation does?

How does breastfeeding peer support ‘work’?

How have the breastfeeding peer support practices of your organisation changed over time? Why?

Prompts: What role might you expect breastfeeding peer support to have in the future of your organisation? Why? What are the outcomes of having breastfeeding peer support?

Organisational experience of working in differing socio-economic areas

Please tell me about the experience your organisation has of providing breastfeeding peer support in areas with differing levels of socio-economic deprivation (explore in depth).

Prompts: What are the important differences between areas of socio-economic deprivation and other areas? How do these differences impact?

Thinking back to your ethos, how does this fit in?

What ‘model of action’ works best in areas of socio-economic deprivation? Why?

Prompts: How has your organisation reacted/adapted/responded? How have these experiences/this learning fed back into your organisation?

What factors constrain your organisation when working in areas of socio-economic deprivation? (Explore in depth).

The infant feeding health inequality

Please tell me about the evidence that shows that babies from more socially advantaged backgrounds are more likely to be breastfed.

Why do you think this is?

Could you explain how your organisation responds to this situation? Has the response changed over time? How? Why?

Prompts: What kinds of things does your organisation do in relation to the infant feeding health inequality? What would your organisation like to do? Future plans?

Closing questions.

Are there any other ways in which your organisation has developed that we have not discussed and you feel are important?

Are there any other ways in which your organisation has developed it’s breastfeeding peer support services that we have not discussed, and that you feel are important?

Is there anything that you might not have thought of before that has occurred to you during this interview?

Is there anything you would like to ask me?

Thank you for taking part in this study.

Clarify what participant wants re being contacted again for member check interview, themes of study and whether participant would like to have the anonymised interview transcript sent to them to check for potentially identifying information. Confirm that I will make sure this happens.

Reference

Dennis,C. (2003) Peer support within a health care context: A concept analysis. *International Journal of Nursing Studies,* **40**(3), 321-332.

Interview schedule for mothers who had engaged with and received support from the BPS service (phase two interviews)

uclan
University of Central Lancashire

An exploration of targeted breastfeeding peer support

Interview schedule for mothers who have had peer support from the service

Welcome, introductions, check participant is comfortable

Key topic areas:

Perceptions of infant feeding in this area

What is it like to have a baby around here?

What is feeding a baby like around here?

Prompts: What is it like to breastfeed around here? How much do you see breastfeeding happening around here?

Own infant feeding experiences

Please tell me about your experiences of feeding your baby.

Prompts: Where did you have your baby? What were the first few days like when you first came home? What were your main concerns at that time? Why was/ is breastfeeding important or not important? What difficulties did you face? How did things change over time?

Engaging with the XXX BPS intervention

How did you first hear about the service?

Prompts: When was this? Who told you? What did you think about it? What did you think the aims of the service were? Who did you think it was for?

First contact

How did the first contact with the service take place?

Prompts: When did the first contact happen? How did you feel about it at that point? (i.e. getting a phone call/getting a text through - How did that feel?).

What sorts of things did you talk about during the first contact?

Prompts: How was the first contact helpful/not helpful to you?

Ongoing contacts

How did you arrange the next contact?

Prompts: Who decided what would happen next? How did you feel about arrangements?

Please explain how the contacts happened from then on.

Prompts: How did the next contact take place? What sorts of things did you talk about? How was it helpful/unhelpful to you?

The peer supporters

Who are the peer supporters?

Prompts: What was the peer supporter like? What things about her were/are important/not important to you?

Please can you tell me about how the peer supporter talked to you?

Prompts: How did talking with her make you feel? How was her approach helpful/unhelpful? Was her approach similar or different to other people involved in your support? How was her approach the same/different?

What did the peer supporter tell you about other ways of finding support?

Prompts: What did you think about these? Did you make use of any of these things?

Community side of support (if not already covered above)
What do you know about any community groups/breastfeeding groups/baby groups run by the XXX in your area?

Prompts: Have you ever been to one? Do you know anybody who has been to one? What are these community groups for? How important/unimportant do you think they are?

Recommendations

How could the service develop in the future so that it meets the needs of local mothers better?

Closing

Is there anything that you might not have thought of before that has occurred to you during this interview?

Is there anything you would like to ask me?

Thank you for taking part.

Arrange to send £10 thank-you gift card.

Clarify what participant wants re being contacted again and main findings of study. Confirm that I will make sure this happens.

Interview schedule for mothers who had not engaged with and received support from the BPS service (phase two interviews).

uclan
University of Central Lancashire

An exploration of targeted breastfeeding peer support

Interview schedule for mothers who have not had peer support from the service

Welcome, introductions, check participant is comfortable.

Key topic areas:

Perceptions of infant feeding in this area

What is it like to have a baby around here?

What is feeding a baby like around here?

Own infant feeding experiences

Please tell me about your experiences of feeding your baby.

Prompts: Where did you have your baby? What were the first few days like when you first came home? What were your main concerns at that time? Why was/ is breastfeeding important or not important? What difficulties did you face? How did things change over time?

Awareness of the service

What have you heard about the XXX breastfeeding peer support service that operates in this area?

If have heard about it: When did you hear about it? From whom? What did they say? Have any of your friends / people you know ever talked about it?

What did you think about it?

Prompts: What did you think it was? What did you think the aims of the service might be? Who did you think it was for? Who did you think a peer supporter might be?

If not heard about it: What sorts of things did your midwife/health visitor say about the support available for breastfeeding around here? What sorts of things did they say in hospital? What did your friends / people you know say?

Give brief outline of what service is (i.e. it is other mums who have been trained to support mums with breastfeeding. They contact mums by phone or text and can come to your home to support you. They also run baby groups in the community), then ask - What do you think about it?

Reasons for not engaging

Why was this something you did not want to take part in?

Prompts: Did you consider taking part? What kinds of things put you off?

Closing

If had heard of service and did not feel it was appropriate, ask - What do you think would be better?

Is there anything that you might not have thought of before that has occurred to you during this interview?

Is there anything you would like to ask me?

Thank you for taking part.

Arrange to send the £10 thank-you gift card.

Clarify what participant wants re being contacted again and findings of study. Confirm that I will make sure this happens.

Interview schedule for PSs (phase two interviews).

An exploration of targeted breastfeeding peer support

Interview schedule for peer supporters

Welcome, introductions, check participant is comfortable

Key topic areas:

Perceptions of infant feeding in the target areas

What is it like to have a baby in the areas targeted by this service?

What is feeding a baby like in those areas?

What sorts of challenges face mums who want to breastfeed in these areas?

Prompts: Are these challenges different to those faced by women in more affluent areas? If so how? Why?

The BPS service

What is a peer supporter?

How did you come to be involved?

Prompts: Who are the peer supporters? What sorts of things about them are important?

What are the aims of the XXX BPS service in this area?

Prompts: How do you know if you are meeting these aims? What kinds of things do you do in order to meet these aims? Are your aims the same for all mothers?

How would you describe your role as a peer supporter?

Prompts: How do you support mums? What kinds of things does your role entail?

How would you explain how the service fits into other local health and community services?

The first contact

How does the first contact with mothers targeted by the service take place?

Prompts: When does it take place? How do you engage mothers in conversation? How do you feel when making that contact? Do you approach the first contact in the same way for all mothers (those in target areas and others)? Why is having a similar/different approach important?

What kinds of things to you talk about during the first contact?

Ongoing contact

How do you arrange the next contact?

Prompts: Who decides when the next contact will take place? How is this decided? What goes through your mind when arranging contacts? How do you feel about the process? Do you approach ongoing contact in the same way for all mothers (those living in target areas and others)? Why is having a similar/different approach important?

What kinds of things do you talk about during other contacts?

What are your aims for ongoing contacts?

Service development

Has the service developed or adapted in order to meet the needs of mums living in the target areas? If so, how?

Do you do anything differently when you are supporting mums living in target areas/those part of target groups?

Prompts: What kinds of things do you do differently? Why are these things important? How did doing these things/working this way come about?

What have you learned about the lives of women living in the target areas through your role as a peer supporter?

Prompts: How does this knowledge inform your work?

Own role

How has being a peer supporter affected you personally?

How are you supported in your role?

Prompts: What is the aim of supervision? What sorts of things do you discuss?

Recommendations

Thinking about the target areas/groups, what adaptions/developments to the service would you like to see in the future?

Prompts: Why would these be needed? Important?

Closing

Are there any other ways that the XXX BPS service has adapted/developed for areas of deprivation that you think are important and we have not talked about?

Is there anything that you might not have thought of before that has occurred to you during this interview?

Is there anything you would like to ask me?

Thank you for taking part in this study.

Clarify what participant wants re being contacted again and findings of study. Confirm that I will make sure this happens.

Interview schedule for peer support supervisor/co-ordinator/programme manager (phase two interviews).

University of Central Lancashire

An exploration of targeted breastfeeding peer support

Interview schedule for peer support supervisor/co-ordinator/programme manager.

Welcome, introductions, check participant is comfortable.

Key topic areas:

Exploring own role in the XXX (org name) BPS service

How would you explain your own role in the XXX BPS service in XXX (County)?

Prompts: What kinds of things do you do? What kinds of things are you responsible for? What does your role entail?

Exploring the context

What is feeding a baby like in the areas targeted by the XXX BPS service in XXX?

What sorts of challenges face mums who want to breastfeed in these areas?

Prompts: Are these challenges different from those faced by women in more affluent areas? If so how? Why?

The BPS Service

What are the aims of the XXX (org name) BPS service?

Prompts: Why are these aims important?

What are the main impacts of the service?

Prompts: What are the impacts for women? For peer supporters? For health professionals?

How does the service fit into other health and community services for mothers?

Service adaption and development

Has the BPS service developed or adapted to meet the needs of mums in the target areas? If so, how?

Prompts: How have these adaptions taken place? What examples can you think of?

Why were these adaptions /developments needed? Why are they important?

Do the peer supporters use different approaches when working within the target areas/with target groups?

Prompts: What kinds of approaches/adaptions do they use? Why are these needed? How did these adaptions develop? How did you learn about them?

Recruiting and training peer supporters (explore if relevant to their role)

How do you recruit and train peer supporters to work in these areas?

Prompts: What is important when deciding who to recruit and train? Why is this important?

How are peer supporters supported within the service?

Supervision (explore if relevant to the role)

What is the function of peer support supervision in your service?

Prompts: What happens at a supervision session? Why is supervision important/not important? How do you share or use information you learn about through supervision with others within your organisation? (explore organisational structure and the sharing of ground level knowledge).

Recommendations

Thinking about the areas/groups targeted by the service, what kinds of adaptions/developments to the service would you like to see in the future?

Why would these be needed? Important?

Closing

Are there any other ways that the XXX BPS service has adapted/developed for areas of deprivation that you think are important and we have not talked about?

Is there anything that you might not have thought of before that has occurred to you during this interview?

Is there anything you would like to ask me?

Thank you for taking part.

Clarify what participant wants re being contacted again and main findings of study. Confirm that I will make sure this happens.

Interview schedule for community health professionals (phase two interviews).

uclan
University of Central Lancashire

An exploration of targeted breastfeeding peer support

Interview schedule for Community Health Professionals.

Welcome, introductions, check participant is comfortable.

Key topic areas:

Perceptions of infant feeding in this area

How would you describe the infant feeding culture in the areas targeted by the XXX (org name) BPS service in XXX (County)?

What sorts of challenges face mums who want to breastfeed in these areas?

Are these challenges different to those faced by mothers in more affluent areas? If so, how?

The BPS Service

What are the aims of the service?

Prompts: Why are these aims important?

What are the main impacts of the service?

Prompts: What are the impacts for women? For peer supporters? For health professionals?

Who are the peer supporters?

How effective is the service for women who are known to be less likely to breastfeed?

What else is needed?

How does the service fit into other health and community services?

Service development

Has the BPS service developed or adapted to meet the needs of mothers in the target areas/groups? If so, how?

Prompts: Why have these adaptions /developments been needed? Been important?

Own experiences of the XXX BPS service.

Please explain your experiences of being a community staff member where this service is running.

Prompts: Has it changed anything you do? Have you had any interaction with the peer supporters? What kind of feedback have you had from mums?

Recommendations.

What adaptions/developments to the service would you like to see in the future?

Prompts: Why would these be needed? Important?

Closing.

Are there any other ways that the XXX BPS service has adapted/developed for areas of deprivation that you think are important and we have not talked about?

Is there anything that you might not have thought of before that has occurred to you during this interview?

Is there anything you would like to ask me?

Thank you for taking part.

Clarify what participant wants re being contacted again and main findings of study. Confirm that I will make sure this happens.

Interview schedule for infant feeding co-ordinators (phase two interviews).

uclan
University of Central Lancashire

An exploration of targeted breastfeeding peer support

Interview schedule for Infant Feeding Co-ordinators

Welcome, introductions, check participant is comfortable

Key topic areas:

Perceptions of infant feeding in the area

How would you describe the infant feeding culture in the areas targeted by the XXX (org name) BPS service in XXX (County)?

What sorts of challenges face mums who want to breastfeed in these areas?

Are these challenges different to those faced by mothers in more affluent areas? If so, how?

The XXX (org name) BPS service in XXX (County)

What are the aims of the service?

Prompts: Why are these aims important?

What are the main impacts of the service?

Prompts: What are the impacts for women? For peer supporters? For health professionals?

Who are the peer supporters?

What kind of feedback do you have about the service from health professionals/others?

Service development

Has the BPS service developed or adapted to meet the needs of mothers in the target areas? If so, how?

Prompts: Why have these adaptions /developments been needed? Why are they important? How have these adaptions/developments taken place? How do you know about them? What sorts of examples can you give?

How does the service fit into broader infant feeding strategy?

How does the service fit in with infant feeding strategy for the area as a whole?

What kinds of outcomes are you looking for? Why are they important?

What is your vision for the future of the service in this area?

Recommendations

What adaptions/developments to the service would you like to see in the future?

Why would these be needed? Important?

Closing

Are there any other ways that the XXX BPS service has adapted/developed for areas of deprivation that you think are important and we have not talked about?

Is there anything that you might not have thought of before that has occurred to you during this interview?

Is there anything you would like to ask me?

Thank you for taking part in this study.

Clarify what participant wants re being contacted again and findings of study. Confirm that I will make sure this happens.

Interview schedule for commissioners (phase two interviews).

University of Central Lancashire

An exploration of targeted breastfeeding peer support

Interview schedule for service commissioners

Welcome, introductions, check participant is comfortable

Key topic areas:

History of BPS in area

Please can you tell me about the history of breastfeeding peer support services in XXX (County).
Prompts: How has the service developed / adapted over time? Why have these adaptions/developments been needed?

The service today

What are the aims of service currently commissioned?
Prompts: Why is the service needed? What are the expected outcomes of the service? Why are these important?

How has the service developed/adapted to meet the needs of women living in areas of deprivation?

Prompts: How did you know these developments were needed? How did the developments take place? How do you know about them?

How does the service fit in with broader infant feeding strategy?

The commissioning process

How does the process of commissioning take place?
Prompts: What sorts of evidence or information do you use to help you make decisions in the commissioning process? How do these help you? Why are these important?

What kind of feedback do you receive from the commissioned organisation? How does feedback take place? How is this helpful/unhelpful to you?

Recommendations

Thinking about the areas targeted by the service, what developments / adaptions to the service would you like to see happen in the future? Why would these be important?

Closing

Are there any other ways that the XXX BPS service has adapted/developed for areas of deprivation that you think are important and we have not talked about?

Is there anything that you might not have thought of before that has occurred to you during this interview?

Is there anything you would like to ask me?

Thank you for taking part in this study.

Clarify what participant wants re being contacted again and findings of study. Confirm that I will make sure this happens.

Observation schedule for observation of peer support supervision session (phase two, observation).

uclan
University of Central Lancashire

An exploration of targeted breastfeeding peer support

Phase 2: Observation schedule for peer support supervision session.

Before session starts introduce self, go through info sheet, consent forms and give chance to ask questions. Only proceed with observation if everyone consents.

Key observation areas:

Room lay out / set up

How is the room set up? By whom? (who sits/stands where? Movement?).

What is the welcome like? Look for the body language, eye contact, the atmosphere etc.

Opening – at the start of the session

Who opens the session? How is this done?

Who is in control?

Is there an agenda? If so, how is it explained?

Look for body language, eye contact, tone of voice, is everybody paying attention? etc.

Main activities of the session

What is happening? What is the interaction about? What seems to be the point of the interaction?

Who is talking? Who is silent? Who is listening?

Watch body language, eye contact, tone of voice etc.

Which direction is information / knowledge flowing?

What sort of information/ knowledge is it?

Who seems to be in control of the interaction?

What is agreed to happen as a result of the interaction? Who will do what and why?

Repeat the above as session progresses i.e. there might be several different interactive activities going on as session proceeds Possible things to look out for: Reflection on practice based incidents? Sharing of practice based experiences? Encouragement/care of each other? Discussion of adaptions / developments to practice – and on what basis these decisions are made? Organisational updates? Plans for future? Communication of up to date formal knowledge of breastfeeding?

Closing – at the end of the session

Who controls the close of the session?

How is this done?

Any preparation / work / things to think about over the coming month?

End of observation

Thank everybody for allowing me to observe the session.

Ask if there is anything they would like to ask me.

Clarify who wants to be sent the main findings. Confirm that I will make sure this happens.

Be available in case somebody wants removal of a specific comment.

Appendix 13. Feedback sheets to phase one key strategist participants

This appendix provides the feedback sheets that I gave to phase one key strategist participants. Any amendments the participants required are highlighted in yellow.

Index to appendix 13:

Organisation A

Overall Summary

Organisation ‘A’ arose from a longer established breastfeeding organisation nearly forty years ago. Small and informal with minimal hierarchy, it was established as a membership organisation running its own telephone helpline, and as somewhere where mothers could obtain breastfeeding training. These remain its main activities today. The voluntary nature of all members results in a lack of pressure to provide ongoing salaries, ensuring freedom from commercial pressures, and adherence to the WHO International Code of Marketing of Breastmilk Substitutes. The idea at the core of the organisation is that through commitment to the provision of mother to mother support, primarily via a helpline and webchat (one to one online chat), women can help each-other. This help fills some of the perceived gaps left by health service provision, and contributes to the organisation’s overall aim that all women might be able to fulfil their own infant feeding goals. Although supporters may also volunteer in local breastfeeding groups where they live, the organisation does not have its own network of breastfeeding groups, and is not directly involved in the volunteers' local face to face work. When opportunities arise that align with its aim, size and scope, the organisation responds. For example, working in partnership with another organisation to run a national helpline, and developing training packages for health professionals. However, commissioned peer support service contract opportunities are not pursued. The organisation strives to train women from all communities to work as telephone helpline and online webchat volunteers, and a fund providing free and reduced cost training for volunteers has been established. The scope of online support has developed over recent years so that today, a broad spectrum of ever evolving social media platforms are used to help form connections with women from a wide demographic and range of backgrounds.

Strategies used in the context of socio-economic deprivation

The organisation does not work 'on the ground' in areas of deprivation, however, it uses three broad approaches to meet the needs of mothers living in these contexts. These approaches are; *facilitating women's access to individual support*, then, when women are in contact with the organisation, an approach of *supporting change at an individual level*, and *providing a pool of supporters reflective of all women*. These approaches, and their associated rationale, strategies and actions will be outlined below.

Facilitating access to individual support

Rationale: Mothers living in contexts of deprivation are less likely to contact the organisation than other mothers. Searching for these mothers online can make contact happen. Contact will mean mothers receive breastfeeding support, feel welcome in the organisation, and may become more involved in future.

Strategy: Proactively searching for mothers online by:

- Using a wide variety of social media not just the usual ones to look for mothers by trying to find the online groups they join i.e. Instagram and Pinterest, not just face book.
- Asking mothers with whom online contact has already been established where to go to find and connect with more mothers (i.e. asking on the under-represented breastfeeding families online group).

Strategy: Reducing barriers to access of support by:

- Making the website and all breastfeeding information on it compatible with smart phones.
- Making sure images used on the website and any publications reflect diversity.

Supporting change at an individual level

Rationale: Every mother has her own individual situation (this is true in all contexts). Utilising a mother centred approach means that the peer supporter will tune into the mother’s particular circumstances and provide relevant information. The mother will feel listened to, respected, and not judged. When a peer supporter gives information in a non-directive manner, the mother will find her own solutions to her own issues and have a positive experience of support.

Strategy: Use a mother centred approach by:

- Training all supporters to listen, respect mothers, give mothers relevant evidenced based information, be non-directive, use their own breastfeeding experiences if relevant. Provide suggestions.

Strategy: Provide sensitive support by:

- Training all supporters to recognise the impact of stresses that can cross over, accumulate and impact upon infant feeding (i.e. financial stress, housing stress, post-natal depression etc).

Providing a pool of supporters reflective of all women

Rationale: Mothers living in contexts of deprivation do not have money spare to pay for training. The rationale for creating a pool of supporters reflective of all women is unclear.

Strategy: Reduce barriers to peer supporter and breastfeeding counsellor training by:

- Providing a fund mothers can apply to providing free or reduced cost training.

Organisation B

Overall Summary

Organisation ‘B’ was established in America in the 1950’s. The UK arm of the organisation is an affiliate of the broader organisation, and has its own strong identity. In the UK, the organisation aims to provide quality breastfeeding information and support to mothers at a community level, to raise awareness of the value of breastfeeding, and to change societal perceptions so that breastfeeding is seen as relational and the norm. The organisation is organised so that specialist areas of knowledge are easily accessible, however it is not strongly hierarchical, and everyone is a volunteer. This means the organisation's integrity is upheld, and there is no pressure to pay salaries. In the past there have been two types of supporter; mothers with at least one years' experience of breastfeeding train to breastfeeding counsellor (BFC) level. Once trained, BFCs run a national helpline and respond to the needs of their communities; running community groups, managing local online support groups (reading posts, monitoring responses from other mothers, providing additional information and specialist support if needed), and providing one to one support to mothers. Historically, the organisation set up a separate programme to facilitated the training of peer supporters (PS) who were mothers with at least three months breastfeeding experience who had undertaken a short six to twelve-week breastfeeding training course. Mother to mother support, seen to encompass that given by both PS and BFC, is **the** way the organisation has and does pursue its aims. The PS programme was commissioned by health care trusts to provide training to local health professionals in areas of deprivation with low breastfeeding rates, which in turn enabled health professionals to train local mothers as PS. This acted to raise the profile of breastfeeding within the community. The PS programme ceased to be financially viable and was laid down several years ago. However, the strategic decision was taken to continue to seek to provide a community-based resource of mother to mother support in areas where there is none, especially in socio-economically deprived communities where mothers do not have access to support by enabling local mothers to train as BFCs. Since funding ceased several years ago, the organisation has not been able to continue with this work. However, the strategic decision was taken to continue to seek to provide a community-based resource of mother to mother support in areas where there is none, especially in socio-economically deprived communities where mothers do not have access to support by enabling local mothers to train as BFCs. When grants are available the organisation seeks to establish new groups in this way.

The organisation is an empowering organisation; it seeks to empower these (and all) BFCs to work collaboratively at a local level and take up opportunities that arise. This is evidenced by the way that such BFCs have sought innovative ways of working to support women in their communities including on occasion continuing to train peer supporters outside of the main organisation. The strategies described below used in a context of socio-economic deprivation concern the practices of one such breastfeeding peer support scheme.

Strategies used in the context of socio-economic deprivation in a current peer support scheme operating outside of organisation B.

The following broad approaches are used in this context; the scheme works by *facilitating access to support*, and then when mothers are in contact with the scheme by, *supporting change at an individual level*. Furthermore, the scheme works by *supporting change at a community level*, and by *utilising the experiential knowledge and trusted status of local mothers.* These approaches along with their associated rationale, strategies and actions will be outlined below.

Facilitating access to support

Rationale: Mothers living in contexts of deprivation are less likely to contact the scheme than other mothers. If contact can be facilitated it will mean mothers receive breastfeeding support, are enabled to meet peer supporters, and feel welcome both in the scheme and in Org B.

Strategy: Collaborate closely with the NHS by:

- Having the NHS team (which includes members who started as mothers and peer supporters in the scheme, but have now become employed by the NHS) visit all mothers who initiate breastfeeding on the post-natal ward and then in their homes in the first few days.
- Having the NHS team accompany mothers to the breastfeeding group and introduce them to peer supporters once they feel confident and ready.
- Having a voluntary organisation 'B' BFC who is also at the same time employed as part of the NHS team (two jobs, one voluntary, one paid NHS job). This means she can be present at both NHS and organisation 'B' groups and can communicate with mothers engaging with both.

Strategy: Reduce barriers to support by:

- Providing local online support platforms (perceived as less risky than face to face support).
- Encouraging very wide membership of online support platforms.
- Making sure group meetings are welcoming and informal.

Supporting change at an individual level

Rationale: Every mother has her own individual situation (this is true in all contexts). Utilising a mother centred approach means that the peer supporter tunes into the mother's particular circumstances and provides relevant information. Information is given in a non-directive manner, meaning the mother is empowered to find her own solutions to her own issues. This approach means the mother has a positive experience of support; she feels listened to, respected, and not judged. BFC's are trained to a higher level, enabling them to use evidenced based formal knowledge of breastfeeding as well as drawing upon their own and other mothers' experiences. Meanwhile, peer supporters have undergone less training. They are encouraged to use their own experiences, and to signpost to other information sources.

Strategy: Use a mother centred approach by:

- Training all supporters to use active listening skills, be respectful, give information in a non-directive manner, and be non-judgemental.
- Enabling peer supporters to use their own experiences as part of this approach (as well as directing mothers to evidenced based information).
- Enabling BFC to use only evidenced based information as part of this approach.

Supporting change at a community level

Rationale: The community environment in which breast feeding takes place is important. Changing it so it is more supportive of breastfeeding will help more mothers fulfil their breastfeeding goals. In contexts of deprivation breastfeeding may not be viewed as important. There may be low breastfeeding rates and little community knowledge of breastfeeding. This means that mothers who do breastfeed can feel isolated with few opportunities to meet other breastfeeding mothers. Provision of opportunities (e.g. groups) for mothers to come together results in a sense of feeling normal, belonging, and a growth in confidence and self-esteem. This in itself constitutes community change. The community environment can be changed by the provision of mothers with breastfeeding knowledge and experience, both in the form of the presence of an organisation 'B' group and BFC in the community, and in the form of active recruitment and training of peer supporters (as part of an NHS scheme). These actions can be seen as a community resource. When this resource is provided more informal conversations about breastfeeding take place, more information is shared, more needs are met, and ownership of breastfeeding moves from health professionals towards community women. A by-product of trying to effect community change is that local women take up educational opportunities and develop personally.

Strategy: Provide social support for breastfeeding women by:

- Working with the NHS to provide community breastfeeding groups.
- Providing specific organisation ‘B’ community breastfeeding groups, both face to face and online.

Strategy: Provide a community resource of mothers with knowledge about breastfeeding by:

- Having traditional group meetings, having the BFC available to help any mother, and being known for being present in the community.
- Working with the NHS to train lots of peer supporters (using a curriculum based on the organisation’s core principles, but delivered through an NHS role).
- Training peer supporters who would like to become BFCs and supporting them through this process.

Utilising the experiential knowledge and trusted status of local mothers

Rationale: In some areas of deprivation sometimes some community mothers may not see information about breastfeeding delivered by health professionals as credible because health professionals are not enacting it themselves. Mothers who are local and who are/or have recently been breastfeeding themselves are trained as peer supporters. They are able to deliver information with credibility because mothers identify with them and respect their experiential knowledge. Because of status and power differences between mothers and health professionals, mothers may not always tell health professionals their true concerns. Mothers trust other mothers and can have honest, trusting conversations with them. Providing mother to mother support can therefore enable more honest, trusting relationships and result in more needs being met.

Strategy: Provide peer supporters who are trusted by:

- Training local women, who community women identify with.
- Empowering peer supporters to have lots of informal conversations about breastfeeding in the community.
- Training peer supporters to recognise breastfeeding normality and if they encounter any situation that falls outside this, know how to direct mothers to health professionals and further appropriate support as needed.

Organisation ‘C’

Overall Summary

Organisation ‘C’ arose from a longer established organisation around twenty years ago. In order to avoid all conflicts of interest, and to uphold the international code of marketing of breastmilk substitutes, sponsorship is not accepted. Breastfeeding peer support is the organisation’s main activity. It has a particular concern for those women least likely to breastfeed, and ensures that peer support training is free at the point of delivery. The organisation aims to increase awareness about the value of breastfeeding to women, families, and society as a whole. It aims to do this by providing quality support and information to women, families and health professionals, by positively influencing community attitudes towards breastfeeding, by inspiring women to support others in their communities, and by raising awareness about breastfeeding and its work at a national political level. At its naissance, founder members provided voluntary support in their local areas. Over time, they were asked to train health professionals, and commissioned to provide breastfeeding peer support projects in areas of deprivation. Increased commissions, growth in membership, working with another organisation to run a national helpline, and providing high quality infant feeding information for health professionals, have necessitated increased formalisation. Today, resources for commissioned projects are reducing. If a commission comes to an end, or a peer supporter moves to a new area, peer support can continue by way of collaborative working with local health professionals, however, without careful strategic planning of how peer support will fit in with other services (including the roles of peer supporters trained to work alongside health professionals, and those trained to a higher level able to work more independently with supervision), and some level of ongoing support, the resource of peer support can quickly become lost. The organisation retains its long-term commitment to areas of deprivation, and is seeking innovative ways to continue to provide the support that is needed. For example, by looking for ways of continuing to train peer supporters when less money is available.

Strategies used in the context of socio-economic deprivation

The organisation employs the following broad approaches in this context; it works by *facilitating access to support*, and when mothers are in contact with the organisation by, *supporting change at an individual level*, by *supporting change at a community level,* and by *utilising the experiential knowledge and trusted status of local mothers.* These approaches along with their associated strategies and actions will be outlined below.

Facilitating access to individual support

Rationale: Mothers living in contexts of deprivation maybe less likely to ask for help than other mothers. If contact can be established it results in mothers receiving breastfeeding support, feeling welcome in the organisation, and knowing that their peer supporter is genuinely interested in them. If contact can be made within the first 2-3 days after birth, support can be provided when it is most needed. Contact is more likely to be made if a mother’s preferred media is used.

Strategy: Provide pro-active early support by:

- Providing antenatal contact.
- Peer supporters pro-actively approaching mothers on post-natal wards.
- Peer supporters being present in neo-natal units.
- Training peer supporters with communication skills which enable them to quickly demonstrate to mothers their genuine interest in them and their situations.
- Providing pro-active early telephone support.
- Providing pro-active early home visits.

Strategy: Provide tailored support by:

- Providing a range of support options across a range of different media for example,
- Text contacts.
- Facebook contacts.
- Home visits.
- Providing local online group support.
- Providing peer supporters who are present in the community generally.
- Providing face to face community breastfeeding groups.
- Providing a national website with accessible breastfeeding information.

- Providing a national telephone helpline.
- Providing national webchat service.
- Providing special services (i.e. drugs in breastmilk information service).

Strategy: Reduce barriers to support by:

- Providing peer supporters who live within the communities (very close by).
- Providing helplines in different languages e.g. Bengali, Polish and Welsh.
- Making sure the helpline is open at times when health professionals might not be available (i.e. Christmas).

Supporting change at an individual level

Rationale: Every mother has her own individual situation (this is true in all contexts) and is able to breastfeed no matter what her circumstances. There may be pressures acting as possible constraints upon her however, such as the needs and desires of other family members, or immediate practical issues such as unsuitable housing for example. If peer supporters refuse to place limits upon mothers' abilities, and at the same time recognise the possible constraints they may face, they will offer empowering yet sensitive support. This type of support can be achieved by utilising a mother centred approach whereby the peer supporter tunes into the mother's particular circumstances and provides relevant information. Information is given in a non-directive manner, meaning the mother is empowered to find her own solutions to her own issues. This approach means the mother has a positive experience of support; she feels listened to, respected, and not judged. This results in her attitude to breastfeeding becoming more positive, which contributes to wider community attitude change.

Strategy: Use a mother centred approach by:

- Training peer supporters to listen, respect mothers, be non-directive, be non-judgemental, to use both experiential and high quality evidenced based independent information as needed/able, explain the source of the information to mothers.
- Providing continuity of peer supporter if possible (so avoid the need to explain the situation multiple times).

Strategy: Do not place limits on women, but recognise possible constraints upon them by:

- Training peer supporters to be mindful of the competing pressures and demands mothers may have to negotiate when resolving infant feeding issues.
- Developing training encompassing responsive feeding practices including information on safe and responsive bottle feeding.

Supporting change at the community level

Rationale: The community environment in which breast feeding takes place is important. Changing it so it is more supportive of breastfeeding will help more mothers fulfil their breastfeeding goals. In contexts of deprivation breastfeeding may not be viewed as important. There may be low breastfeeding rates and little community knowledge of breastfeeding. This means that mothers who do breastfeed can feel isolated with few opportunities to meet other breastfeeding mothers. When opportunities for mothers to come together are provided, they hear each other's stories, make new social connections, feel a sense of belonging, and grow in confidence and self-esteem. This in itself constitutes community change. The community environment can be changed both by the presence of breastfeeding groups in the community, and by the provision of mothers with breastfeeding knowledge and experience because these resources result in more informal conversations about breastfeeding take place, and a rise in the profile of breastfeeding. A by-product of trying to effect community change is that local women take up educational opportunities and develop personally. They can become ‘ambassadors’ of breastfeeding, taking their personal stories and convictions into many fields of life. This can have a wider impact in changing culture and helping to foster more enabling environments.

Strategy: Provide social support by:

- Training peer supporters.
- Providing a supportive community network both online and at face to face groups.

Strategy: Provide a long term, local, community resource of mothers who know about breastfeeding by:

- Training peer supporters.
- Providing and fostering breastfeeding groups both online and in the community.
- Empowering peer supporters to share their breastfeeding experiences generally in the community.
- Providing peer supporters as breastfeeding role models within the community.

Utilising the experiential knowledge and trusted status of local mothers

Rationale: Specific communities have their own particular challenges. When a mother knows her peer supporter comes from her own community and understands the specific pressures of breastfeeding in their particular place, a trusting relationship results. Power and status differences between mothers and health professionals can result in low levels of trust between health professionals and some mothers. However, many mothers speak highly of their health professionals, yet the time health professionals may have available to spend with them may be lacking. The relationship between a mother and a local peer supporter can be more equal and trusting. This trust enables the peer supporter to provide timely, accessible support. Mothers may have to deal at short notice with issues that challenge their and their family's basic safety and security. These things must be given higher priority than infant feeding issues. Providing trusted local peer supporters who can support quickly means these other needs can begin to be met, and infant feeding issues addressed.

Strategy: Provide peer supporters who are trusted by:

- Training local mothers who live within the community.
- Training local mothers who have experience of breastfeeding in that particular place.

Strategy: Equip peer supporters to help meet diverse needs appropriately by:

- Training peer supporters so they are able to help address a wide range of other issues (i.e. housing, fire safety, etc).
- Make sure peer supporters have close links with other services (i.e. Children's Centres, health professionals, and a wide range of others).
- Supporting peer supporters using regular supervision.

Organisation' D'

Overall Summary

Organisation 'D' is a large organisation that began in the 1950's by providing women with information and education about natural childbirth. Since then it has developed by training ante-natal teachers and breastfeeding counsellors, and by becoming a membership organisation with local volunteer branches. Today, the main aim of the organisation is to support parents in their transition to parenthood. This is realised by way of providing accurate evidenced based impartial information, education, information about available services, and social support. Projects delivering peer support for breastfeeding are just one of the ways in which the organisation seeks to achieve its aim. They form one part of a suite of possible services and interventions the organisation can be commissioned to provide. For example, perinatal mental health peer support services. Provision of BPS is responsive to demand from commissioners and local volunteer branches of the organisation (which may fundraise in order to pay for breastfeeding peer support training if they feel it is needed in their community). Taking up opportunities to deliver commissions has resulted in the organisation delivering services in areas of social and economic deprivation, although recently this funding has reduced. Over recent years the organisation has become more professional, formalised, and strategically led. For example, an assessment of what the organisation is doing well and what it could do better has taken place.

Strategies used in the context of socio-economic deprivation

The organisation employs the following broad approaches in this context; it works by *facilitating access to support*, and when mothers are in contact with the organisation by, *supporting change at an individual level*, and also by *utilising the experiences of local women.* These approaches along with their associated strategies and actions will be outlined below.

Facilitating access to individual support

<u>Rationale: Mothers living in contexts of deprivation maybe less likely to contact the organisation for breastfeeding support than other mothers. By reaching out to them, contact can happen. Contact means mothers receive breastfeeding support in the way they want it. Continuity of peer supporter may better enable further contacts.</u>

Strategy: Pro-actively contacting mothers by:

- Obtaining a data sharing agreement with the NHS.
- Running an opt out service whereby all mothers who initiate breastfeeding are telephoned 48hrs after birth unless they expressly indicate they do not want to.
- Trying to make telephone contact at 48hrs. If no answer, sending a text message with full contact details and all support and information options.

Strategy: Reducing barriers to access to support by:

- Providing many different routes to access the service in addition to the 48hr pro-active phone call (see below).
- Making sure a mother knows she can text the service at any time, and a peer supporter will phone her back.
- Providing the option for a health professional to refer a mother to the service at any time.
- Providing the option for a mother who has not engaged with the service to opt back in at any time (she can send a text which triggers a phone call from a peer supporter).
- Providing home visits.
- Providing a face book page with breastfeeding information.
- Providing community based support groups.
- Providing a helpline mothers can call to speak to a breastfeeding counsellor (open till midnight).

Strategy: Tailoring communication and support options to the preferences of the mother by:

- Learning about the communication preferences of different mothers by trying out different methods i.e. trying texting, trying phone calls.

- Implementing what has been learned through these experiences i.e. use text contact and face book private messaging for young mothers under 20.
- Offer a range of support options (i.e. text, phone, home visit).
- Providing continuity of peer supporter in particular circumstances, for example, for mothers under 20 make sure a home visit team member makes the first phone call and tries to arrange a home visit at that time (the mother may not answer the phone again).

Supporting change at the individual level

Rationale: Every mother has her own individual situation (this is true in all contexts). Utilising a mother centred approach means that a peer supporter can tune into a mother’s particular circumstances and provide relevant good quality evidenced based information which the mother can use to make her own informed decisions. The communication skills associated with this approach mean the mother has a positive experience of support; she feels listened to, respected, and not judged. This approach fosters a mother’s internal motivation making her more likely to stick to her infant feeding choice.

Strategy: Use a mother centred approach by:

- Training peer supporters to:
    - Listen actively
    - Be respectful
    - Be non-judgemental
    - Be non-directive
    - Give relevant evidenced based information.
- Make sure the mother initiates contact and is in control of the conversation.

- Allow the mother to use the information given to make her own decisions.
- Support the mother no matter what her decision.
- Provide peer support supervision sessions to update knowledge and provide general support.

Utilising the experiences of local women

Rationale: A mother's internal motivation can be fostered by seeing other breastfeeding mothers. Such mothers can inspire her to try it for herself. Peer supporters can act as role models in this way. The educational qualifications gained by local mothers are a by-product of training them as peer supporters. It can be difficult to know what services are available in the community. Providing opportunities for social support enables mothers to find out about relevant community services and to make friends. Friendships allow mothers to share their early parenting experiences which enhances their capacity to care for their babies. Unclear if there is further rationale for training local women as peer supporters.

Strategy: Provide role models by:

- Training mothers who have recent experiences similar to the women they will be supporting.
- Training mothers who come from their community.

Strategy: Provide social support by:

- Providing community groups.

Appendix 14. Reflexivity

In this appendix I give an account of my personal and professional background, outline the outcomes of my pre-data collection ‘values’ interview, and explain the two subjective ‘I’s identified through my subjectivity audit.

My personal background

I grew up in a modern housing estate with my parents and younger brother. I went to the local comprehensive school which I loved. I knew we were fairly privileged because my dad used to tell us stories of his own childhood such as having to wear shorts made from ladies skirts his mum had bought from jumble sales, having to share a bike with his twin brother, and the lengthy times his own father spent out of work. I went to University, got married when I was 21 and trained to be a nurse, but I couldn’t wait to become a mum. When I had my first baby none of my friends had babies, and none of the new friends I made through having my baby breastfed. In fact, I hadn’t realised how important breastfeeding was to me until I started doing it. I would not stop, yet I was lonely. After my second baby my local Sure Start midwife ran BPS training and I joined in. I applied for a grant which funded attendance at a three-day UNICEF BFI course and the set-up of a breastfeeding group in my town. Over the next five years more PSs were trained and we started keeping records monitoring the percentage of women who initiated breastfeeding attending our group. No matter what innovative schemes we came up with, we were unable to engage with more than 30 to 40% of initiating mums. I decided to undertake a masters study exploring why women who initiate breastfeeding do not access community group-based peer support, which I completed in 2014.

My professional background

After my third baby was born I did not return to part time nursing. As outlined in chapter 1 (Introduction), I worked in paid and voluntary employment with a small local third sector breastfeeding organisation. I undertook breastfeeding counsellor training by correspondence with the Association of Breastfeeding Mothers from 2005-7. My involvement with other national third sector breastfeeding organisations was minimal because none had a presence in my area. However, my pre-conceived ideas about them were that they drew in women I generally found a little bit irritating. Occasionally a mum might come to our breastfeeding group who had also attended one of their groups in a city about an hour away. Typically, she would have read a huge amount about breastfeeding and parenting, be quite intense, and would soon be returning to a well-paid job (such jobs are quite thin on the ground in my area). In my head I had been calling these mothers ‘takers’ because they used the breastfeeding group as a service, but often gave little back. My pre-conceived ideas about national third sector organisations then, were that they were probably a bit posh, and that I would not have wanted to attend their meetings even if I had known about them when my own children were little. Before I started my study I expected that mothers living in areas of deprivation might be put off by this middle class reputation.

I had always been interested in health inequalities. When I worked as a nurse both in the main hospital and in a small minor-injuries unit I couldn’t help questioning why some people kept coming back, and why children from certain parts of the town came in more frequently than others. I enjoyed reading about health inequalities and joined online forums about them. During my research masters I undertook a six-month one day a week internship with the county public health department. As mentioned in chapter 1 (Introduction), I also attended an international breastfeeding conference where I learned about the work of some national third sector breastfeeding organisations, and met some of their representatives. My overall impression was that these organisations maybe more focussed on the detail of helping women with breastfeeding rather than on the population as a whole. If health inequalities were mentioned, there seemed to be a focus on educating people. I struggled to reconcile this with what I had learned about health inequalities from my reading and internship experience.

I have experience of volunteering for, working for, and holding a directorship of a small local third sector breastfeeding organisation. I have some limited experience of setting up peer support services in areas of deprivation and managing voluntary peer support across a County. I also have experience of working as a health professional.

My ‘values’ interview

Through my ‘values’ interview I realised that my work with the local small third sector organisation had led me to recognise that there may be many competing interests at play within such organisations, and that I had started to question their role in society. I also realised that over a period of time prior to commencing this study my ideas about what kinds of knowledge are useful in infant feeding support had changed. Previously I found it easy to see value in formal breastfeeding knowledge, however the value of experiential and embodied knowledge had since come to the fore. Understanding and reflecting on this prompted consideration of how and why my attitudes to the importance of the context of women’s lives had changed. I felt this change had resulted from my supportive interactions with women, my experiences of trying to make local peer support services accessible and relevant to more mothers, reading about health inequalities, and undertaking my Masters study. The context of mothers’ lives had become increasingly important to me. The conversation raised my consciousness about the ideas, values and beliefs I bring to the study, and provoked further reflection on my own attitudes and beliefs about different groups of people, their lives, needs and my own responses when supporting.

My two subjective 'I's. These were identified through undertaking a subjectivity audit as explained in chapter 5 Methods 1, section 5.5.4.

The social model of health 'I'

I noticed that my feelings of frustration, anger and upset were often in response to hearing people blaming mums, to people not recognising the importance of a mother's context and wider environment, to people expressing a narrow focus on the need to educate mothers, and when mums were not respected or valued as individuals or as a societal group. I realised that a lack of value and respect for a mum seemed to accompany lack of recognition of the difficult things that might be present in her environment. This made me recognise that I adhere to the social model of health; I believe a complex and broad range of social, economic, environmental and cultural factors strongly influence health and well-being. Knowing that the social model of health 'I' is engaged in this study has helped me to recognise that some people do not share this model. It has made me careful not to over-emphasise times when others do share it, especially during phase two analysis. The following forms an example of subjective writing that helped me identify this 'I';

Reflection 19.7.18: Just done an interview with a peer supporter. When I asked her what she had learned about the lives of the mums in the target areas through her role, she said she hadn't learnt much because that's not her job. Her job is to support them with breastfeeding. I felt shocked, upset and frustrated. Why was she not interested in the lives of the mums? Does she not think their broader situations are relevant? How does this fit with being woman-centred?

Once I had identified that I believe the social environment is really important I used this self-knowledge to question the theories I was constructing during data analysis. For example, I theorised that if the organisations were to focus more on what PSs knew about women’s wider environments, this knowledge would help them make their services more relevant for women. If they used the contextual knowledge they had, they could better develop their services. But I was careful about accepting this theory and searched for data to disconfirm it. This could just be me and my own beliefs coming to the fore. What evidence did I have that services needed further development? Surely data suggested that women liked them? Was there any data suggesting services were not sensitive to women’s experiences or lives? Was there any need for PSs to think about contextual issues if they were already doing a good job? I went back to my data and explored these questions. I identified that there were areas where gathering and using contextual knowledge had the potential to help improve services, particularly in relation to service access and breastfeeding in front of others. Several of my women participants had dropped out of services or not got into services because of various things in their wider social environments. This suggested that if PSs were to take systematic notice of women’s wider social environments, they might be able to make changes to their services to enable better access and engagement. I also noticed that around the issue of women’s feelings about breastfeeding in front of other people there was a disconnect. PSs seemed to feel this was a smaller issue than women, and did not seem to recognise that women’s housing situations could mean they were breastfeeding in front of other people in their own homes so that this was not necessarily an issue of ‘out and about’.

The Community Action ‘I’

Reviewing my subjective writing made me realise that I have quite an investment in the idea of community action. I love hearing about community links and informal helping, and the idea of volunteering and building community. I enjoyed it when participants talked about the same kinds of beliefs. Realising this has made me pay close attention to the extent to which participants hold similar views and to look very carefully at the evidence for this and be sure not to overplay it. I also thought back and considered for how long I have been interested in community type action. Over many years when I have found an issue I have felt needed addressing I have tended to try to do something about them myself using a community approach. The following is an example of writing that helped me recognise my community action ‘I’;

Reflection 17.9.18. I have been reflecting on my findings and starting to consider what kinds of actions could potentially be put in place to improve things at the study sites. One idea I have had is that it might be good to make some kind of theoretical tool that could be used at supervision that would help peer supporters think about and capture what they know about women’s wider contexts. And my immediate thought is if I were to try the same thing in my home town, how could I find a grant that would allow me to make this happen? Could it be done on a voluntary basis? And it is always through some kind of voluntary, third sector route that I see my way of being able to make a difference, make a change in the world.

Learning that I am personally invested in community action sensitised me. Realising that community action might be my default response made me realise it must be a deeply held belief and that I really need to watch the potential impact of this part of myself on my data and analysis. When phase two findings suggested PSs at both sites felt their role involved facilitating change at the individual, social group and community culture level, I was aware that I have a bias towards the social group and community culture change side of things. This made me extra careful to make sure I did not over-emphasise data demonstrating this aspect of their work.

Appendix 15. Excessive participants' letter

University of Central Lancashire

Maternal and Infant Nutrition and Nurture Unit (MAINN),
School of Community Health and Midwifery,
College of Health and Wellbeing,
Preston.
PR12HE.

Date to be added.

Dear

Thank you very much for offering to take part in my study looking into how targeted breastfeeding peer support services have developed in your area. Unfortunately, because so many people responded, it has proved impossible for me to interview everybody.

I am very grateful for your interest, and if you would like to have the main findings of the study sent to you, please email me on the address below and I will forward them to you in due course.

Many thanks once again,

Louise Hunt.

Louise Hunt, MSc, BSc.
PhD Student,
Maternal and Infant Nutrition and Nurture Unit (MAINN),
School of Community Health and Midwifery,
College of Health and Wellbeing,
University of Central Lancashire, Preston,
Lancashire, PR1 2HE

Lhunt5@uclan.ac.uk

Appendix 16. Table showing how phase two participants were recruited and their interview mode

Table showing how phase two participants were recruited

Site One Participants.

Participant Role	Pseudonym	Method of recruitment	Interview type chosen
PSs (n=4)	Kerry	Through manager	Face-to-face
	Sarah	Through manager	Telephone (T)
	Jade	Through manager	T
	Ellen	Through manager	T
Mothers who had not engaged with service (n=5)	Carrie	HV clinic	T
	Alana	HV Clinic	T
	Avisa	HV Clinic	T
	Jess	Snowball Sampling	T
	Kristi	Snowball Sampling	T
Mothers who had engaged with the service (n=5)	Tracey	Via Org 'D' community group	T
	Maggie	Via peer supporter	T
	Lauren	Via peer supporter	T
	Kiera	Via HV clinic	T
	Tahmina	Via HV clinic	T
Peer support manager (n=1)	Jackie	Via direct email.	T
Health Visitor (n=2)	Cara and Phillipa	Via IFC	T
Community Midwife (n=1)	Tash	Via IFC	T
Infant Feeding Co-ordinator (n=1)	Joanna	Via direct email	T
Commissioner (n=1)	Cathy	Via email to public health head of department	T

Site 2 Participants

Participant role	Pseudonym	Method of recruitment	Interview type chosen
PSs (n=5)	Penelope	Via peer support co-ordinator	Telephone (T)
	Bridget	Via peer support co-ordinator	Face to face (F)
	Nina	Via peer support co-ordinator	F

	Verity	Via peer support co-ordinator	T
	Janine	Via peer support co-ordinator	T
Mothers who had not engaged with the peer support service (n=4)	Paige	Snowball sampling	T
	Cerys	Snowball sampling	T
	Gemma	Snowball sampling	T
	Kizzy	Snowball sampling	T
Mothers who had engaged with the peer support service	Brooke	Recruited by me at an org C breastfeeding group	F
	Carrieann	Recruited by me at an org C breastfeeding group	F
	Jane	Recruited by me at an org C community baby group	F
	Naziha	Recruited by me at an org C community baby group	T
	Cara	Recruited by me at an org C community baby group	T
Peer support manager/Peer support co-ordinator (n=20	Penny (peer support co-ordinator)	Via direct email	F
	Melissa (manager)	Via direct email	T
Health visitor (n=2)	Maria	Through IFC	T
	Suzie	Through IFC	T
Infant feeding co-ordinator (n=1)	Jenny	Via direct email	T
Commissioner (n=1)	Mary	Via email to head of public health departmet.	T

Appendix 17. Lone worker policy

RISK ASSESSMENT FORM	uclan University of Central Lancashire

Risk Assessment For	Assessment Undertaken By	Assessment Reviewed
Service / School: Community Health and Midwifery. (PhD field work interviews and observations)	**Name:** Louise Hunt (Research Student)	**Name:**
Location of Activity: Public community based venues such as children's centres, libraries, and health clinics. These public places are in areas of deprivation in East Lancashire and Gloucestershire.	**Date: 15.11.17.**	**Date:**
Activity: Participant semi-structured interviews. Observations of peer support supervision sessions. Visits to Children's Centres or other community venues in order to give study information to potential participants.	**Signed by Dean of School, Head of Service or nominee:** Debbie Kenny	

Date of activity: 1.12.17 – 30.11.18. **REF:**	 **Date 20/11/17**	

List significant hazards here:	**List groups of people who are at risk:**	**List existing controls, or refer to safety procedures etc.**	**For risks, which are not adequately controlled, list the action needed.**	**Remaining level of risk: high, med or low**
Danger of getting lost while lone working in unfamiliar areas.	Research student	Take time to plan route to and from interview/observation/recruitment location beforehand including where to park car, or which bus route to take, and times and cost of buses. If possible visit the day before, or use google earth to familiarise self with area. Time all travel to take place during day light as far as possible. Use sat nav in car and/or phone to be sure of location. Have a suitable paper map to hand at all times. When using car, make sure AA cover is in place and car has plenty of fuel. When using buses, have copy of bus timetable to hand, have numbers of local registered taxi companies, the post code and full address of the venue, and enough money for a full taxi fare to a more familiar public location to hand at all times (i.e. train station). Make sure mobile phone is charged.		Low

List significant hazards here:	List groups of people who are at risk:	List existing controls, or refer to safety procedures etc.	For risks, which are not adequately controlled, list the action needed.	Remaining level of risk: high, med or low
Danger from meeting in unsuitable public places when conducting interviews.	Research Student and / or interview participant.	Arrange interviews to take place in children's centres/libraries/other public community venues and ensure others are in the building, but that privacy can be maintained through the use of a specific room. If a participant wants to meet at another public place, familiarise self with the venue/ location prior to the interview, and ensure it is suitable. If the venue suggested causes any concerns, rearrange the interview to a different venue.		Low
Danger from carrying out the interviews at unsuitable times.	Research students and/or participants	Arrange interviews to be undertaken during office hours to ensure that other people are in the building. If in any doubt that other people may not be present, re-arrange interview for a different time or suggest a telephone interview. Ensure have the contact details of security on my mobile phone and inform other members of staff of location, and times of interview.		Low
Danger of participant becoming angry or aggressive during interview.	Research student, participants, and children's centre/library staff.	Perform a rapid risk assessment before entering allocated interview space. If anything causes concern, make an excuse and leave. Ensure where possible to sit close to the door with my back to it. Keep my voice low and calm. Inform the participant approximately how long the interview will take and where possible stick to this. Avoid language and /or actions which could be interpreted as judgemental, aggressive or an		Low

List significant hazards here:	List groups of people who are at risk:	List existing controls, or refer to safety procedures etc.	For risks, which are not adequately controlled, list the action needed.	Remaining level of risk: high, med or low
		invasion of privacy and /or personal space. Continue to risk assess and remain alert throughout. If feel threatened or concerned, make an excuse and leave.		
Danger of being duped into meeting somebody who is not a bonafide participant.	Research Student	Once have contact details of participant, call the phone number to check the correct person answers. If have a land line number, check the number corresponds to correct address by using the phone book or online search.		Low.
Danger no-body will know if student is in any kind of difficulty.	Student.	Email a schedule of interviews to supervisors before the interview day including addresses and postcodes of interview locations. On the day make sure supervisors know plans including where and when interviews are scheduled to take place. Fully charge mobile phone and keep it with me at all times. Check in with supervisors using mobile phone before and after each interview. Make sure supervisor aware of anticipated next check in time. If an interview overruns and there is no reason for concern, text supervisor with a new checking back in time. Where possible however, stick to planned timings. Ensure supervisors are aware of necessary course of action if		Low.

List significant hazards here:	**List groups of people who are at risk:**	**List existing controls, or refer to safety procedures etc.**	**For risks, which are not adequately controlled, list the action needed.**	**Remaining level of risk: high, med or low**
		I have not checked in within the agreed time frame (i.e. call police).		
Danger that the risk assessment is not adequate.	Student.	Ensure the risk assessment is reviewed with supervisors after the first interviews, and update/amend as appropriate.		Low.

Appendix 18 Table showing job role and time in post for peer supporter and professional participants.

Site 1			
Participant group	**Participant code**	**Job role**	**Time in post**
Peer supporter	S1PS1	Peer supporter (home team)	3 years
Peer supporter	S1PS2	Peer supporter with some management responsibility (hospital and telephone team)	8 years with organisation
Peer supporter	S1PS3	Peer supporter (hospital)	1 year
Peer supporter	S1PS4	Peer supporter with some management responsibility (home team)	Over ten years with organisation
Health professional	S1MW1	Community Midwife	6 months as community midwife.
Health professional	S1HV1	Health visitor	4 years
Health professional	S1HV2	Health visitor	5 years
Health professional	S1IFC	Infant feeding co-ordinator	10 years
Commissioner	S1COM	Commissioner	2 years
Peer support service manager	S1MAN	Peer support service manager	8 years with organisation

Site 2			
Participant group	**Participant code**	**Job role**	**Time in post**
Peer supporter	S2PS1	Peer supporter in rural area (providing text and group-based support)	1 year
Peer supporter	S2PS2	Peer supporter in rural area (providing text and group-based support)	2 years
Peer supporter	S2PS3	Peer supporter in rural area (providing group-based support)	1 year
Peer supporter	S2PS4	Peer supporter and volunteer co-ordinator in city (providing group-based support)	6 months
Peer supporter	S2PS5	Peer supporter in city and admin assistant (providing support at hospital clinic)	8 years
Health professional	S2HV1	Health visitor (city)	3 years
Health professional	S2HV2	Health visitor (rural)	2 years
Health professional	S2IFC	Infant feeding co-ordinator	10 years
Commissioner	S2COM	Commissioner	2 years

Peer support co-ordinator	S2PSCOORD	Peer support co-ordinator. Also provided group-based and clinic-based peer support in city	More than 10 years
Peer support service manager	S2MAN	Peer support service manager	4 years