Healthcare practitioners' confidence in providing breastfeeding/ breastmilk feeding support to fathers: A grounded theory study

by

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ABSTRACT

The provision of breastfeeding/breastmilk feeding support is important to optimise a mother's chance of ongoing success to meet her infant feeding goals. Breastfeeding rates in the UK are among the lowest in the world. In the current climate within the UK NHS, the impact of staff shortages and increasing workloads means that the role of the father in providing breastfeeding/ breastmilk feeding support is crucial. Mothers value support from the father, but the training received by healthcare practitioners in the UK focuses on how to advise and support the breastfeeding mother; thus, the role of specifically supporting the father is inadequately addressed. This results in fathers feeling overlooked, ignored, or excluded from infant feeding discussions by healthcare practitioners. From a counter perspective, however, there is evidence that some healthcare professionals actively seek to educate and offer strategies to help the fathers provide breast/breastmilk feeding support. A possible, and to date, unexplored explanation for these differences may relate to healthcare practitioner's confidence. Therefore, the aim of this study was to explore healthcare practitioner confidence in providing breastfeeding support to the father.

This study used a constructivist grounded theory methodology. A total of 13 healthcare practitioners working in the East of England were purposively recruited to participate in the study; the participants included five midwives, two maternity support workers, and six health visitors. Data was collected through individual interviews and one group interview. Data analysis used the constant comparative method. Initial and focused coding generated four categories. These categories were confidence comes from having and using knowledge, confidence comes from having and gaining experience, tuning into the father, and the challenges of providing breastfeeding support to the father. Ongoing analysis led to the theory of 'drawing on and engaging practical wisdom through the 'use of self' to explain healthcare practitioners' confidence to provide breastfeeding support to the father. This theory illustrates how healthcare practitioners' confidence came from practical wisdom that arose from their knowledge and experience and using their attributes that defined their personal and professional self. Practical wisdom enabled the participants to tune into the father and deal with the challenges they faced in trying to provide a service to the father in the absence of any available support strategies. The implications of the findings and recommendations for policy, practice, education / training, and research are also offered.

This study contributes to the wider body of knowledge related to the provision of breastfeeding support. This study provides a more unique contribution in terms of how practitioner confidence influences clinical practice and provides strategies into how effective partnerships can evolve between parents and healthcare practitioners despite the challenges faced by healthcare practitioners working within maternity and health visiting services in the UK.

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GLOSSARY OF ABBREVIATIONS

ABCDE	Airway, Breathing, Circulation, Disability, Exposure
BFI	Baby Friendly Initiative
CPR	Cardiopulmonary resuscitation
EBP	Evidence-based practice
GP	General practitioner
IBCLC	International Board Certified Lactation Consultant
NCT	National Childbirth Trust
NHS	National Health Service
NHS HRA	National Health Service Health Research Authority
NICE	National Institute for Health and Care Excellence
NMC	Nursing and Midwifery Council
PHN	Public health nurse
PPI	Patient and public involvement
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-Analyses
RCM	Royal College of Midwives
SBT	Simulation-based training
STEMH	Science, technology, engineering, medicine, and health
UNICEF	United Nations Children's Fund
UK	United Kingdom
WHO	World Health Organization

CHAPTER ONE: INTRODUCTION

This thesis presents the findings of a constructivist grounded theory study of healthcare practitioners' confidence in providing breastfeeding / breastmilk feeding support to the father. This study is relevant as the healthcare practitioners such as midwives and health visitors are in a key position to engage with the father, through the relationship they have with the mother who is the principal user of their services.

In this chapter I explain the origins of the study and introduce my professional and personal rationale for undertaking this study, with further insights into the assumptions I bring to this study detailed in section 4.3.1. I provide a short overview of the background of the key concepts in this study, namely the provision of breastfeeding / breastmilk feeding support to the father and the confidence of the healthcare practitioners in providing this support. A short introduction to the chosen methodology and methods is provided before identifying the aim and objectives for this study. This chapter concludes with an outline of the structure of the thesis.

1.1: Personal and professional rationale for the study

I have worked within midwifery practice and education for over 35 years in the United Kingdom (UK). For 20 years I have also had a focus on breastfeeding support, 11 years as an International Board Certified Lactation Consultant (hereafter referred to as lactation consultant) working within a National Health Service (NHS) funded breastfeeding support clinic for mothers and babies in an urban setting. Throughout my career I have always sought to include and involve the father in the care provided to the woman and her baby, strongly believing in family-centred care. I came to realise that I was confident in providing fathers with breastfeeding support either directly in face-to-face encounters or indirectly by providing sources of information the mother could share with the father and encouraging his presence at the next visit. Working within breastfeeding support clinics I noted that there was a variation in the practice of other healthcare practitioners in providing breastfeeding support to the father. During the clinics I also noted that fathers often did not attend with the mother, especially when the baby was only days or weeks old, and the father could possibly be on paternity leave. On discussing this with the mothers, they often replied that the father

had been told by healthcare practitioners that the clinic was for the mother and baby, thus implying that the father would not be welcome.

When fathers did attend the breastfeeding clinic, I was able to include them in the discussions with the mother. However, many expressed surprise at being drawn into the conversation and being asked about their experience. The fathers reported wide variation in the level of engagement and support from the healthcare practitioners who were caring for the mother and baby. Some reported feeling overlooked, ignored, or excluded by healthcare practitioners which resulted in a lack of information or support. This, in turn, could make them feel inadequate and unprepared for supporting their partner, generating a sense of failure or additional worry. Later when reading the literature, I noted echoes of my conversations with fathers reported in studies (referred to within sections 1.2.1 and 2.4.2).

These informal discussions prompted me to consider why the fathers had experienced this variation in response from healthcare practitioners. Informal discussions with other breastfeeding mothers and colleagues working in breastfeeding support suggested that while healthcare practitioners had a level of confidence and competence to engage with and support breastfeeding mothers, this did not always translate to providing support for the father. Their focus appeared to be primarily on the mother-baby dyad.

For this study I deliberately focused on men being the significant partner of the breastfeeding woman. Current UK birth statistics indicate that most families comprise of a mother and father who are either living together or have a commitment to raise their family from separate addresses (Office for National Statistics, 2019). It was also considered that the care and support for same sex couples was potentially different and should be the focus of a separate study. As breastfeeding support education and training tends to be focused on the mother and baby dyad, it was postulated that healthcare practitioners may lack confidence to engage with the father and thus not know how to provide effective support. This provided personal impetus to explore this issue further by trying to understand the general motivation and sense of assurance that healthcare practitioners may have in engaging and supporting fathers. Additionally, by adopting a positive psychology-based approach, I wanted to try and understand what works to identify transferable insights to help improve practices.

1.2: The key concepts of this study

The two key concepts within this study are breastfeeding support provided by the father and confidence of the healthcare practitioners in providing this support. This section will introduce these two concepts with further explanations provided in chapter two. Before an overview of breastfeeding support provided by the father can be provided, the term breastfeeding needs to be briefly explored.

1.2.1: Breastfeeding

The World Health Organization (WHO) (2017, no page) view breastfeeding as:

> *The normal way of providing young infants with the nutrients they need for healthy growth and development. Virtually all mothers can breastfeed, provided they have accurate information, and the support of their family, the health care system and society at large.*

This definition implies that breastfeeding is an activity in which the baby receives breastmilk directly from the breast. An increasingly popular alternative method amongst mothers is that of breastmilk feeding using a bottle after expressing their breastmilk (Bai, Fong, Lok, Wong, and Tarrant, 2017; Coffey-Glover, 2020, Clapton-Caputo, Sweet and Muller, 2020). For this study the terms breastfeeding and breastmilk feeding, and related support will be represented by using the term breastfeeding support. My reason is that the principles of support offered by a healthcare practitioner are common to both methods of a baby receiving breastmilk.

The current recommendation from the WHO is for exclusive breastfeeding[1] for the first six months of life when breastmilk is the optimal food to meet the baby's growth and development, and then continuation of breastfeeding, alongside complementary feeding, up to and beyond two years of age (WHO 2008; 2011a). Despite clear evidence that breastfeeding confers substantial health benefits, it is no longer customary in many communities, including those in the UK (Rollins et al, 2016). Since the 1960's there has been a predominant bottle-feeding culture in many nations such

[1] Exclusive breastfeeding is defined as the infant only receiving breastmilk (WHO, 2003).

as the UK (Dykes, 2006; Renfrew et al, 2007; Brown, 2015). Authors argue that this is due to breastfeeding either not being the cultural norm (Pain, Bailey and Mowl, 2001; Angel, Alexander and Hunt, 2010; Epstein, 2015; Bird, 2017) and/or many mothers experience difficulties in engaging with the physical activity of breastfeeding (McAndrew et al*,* 2012; Hinsliff-Smith, Spencer & Walsh, 2014). This is particularly evident within the UK where the WHO recommendations have not been achieved, with breastfeeding rates being amongst the lowest in the world for the last 50 years (WHO, 2010; Cheung, 2018). The final UK-wide Infant Feeding Survey conducted in 2010 identified a rapid decline in any breastfeeding from an 81% initiation rate to 67% two weeks after birth (McAndrew et al, 2012). When exclusive breastfeeding rates are considered, only 23% of mothers were exclusively breastfeeding at six weeks falling to less than 1% at six months, with eight out of ten mothers discontinuing breastfeeding before they intended to (McAndrew et al*,* 2012). Many mothers identified that they discontinued breastfeeding because of experiencing physical and psychological challenges, and not receiving appropriate and timely support to overcome the challenges (McAndrew et al, 2012). An overview of these challenges will now be presented.

1.2.2: Breastfeeding challenges

Many people within society perceive breastfeeding to be a natural activity, whilst Gonzales (2018) considers that breastfeeding needs to be reframed from this societal view of natural to that of a learned experience. The societal view that breastfeeding is a natural activity is at odds with the lack of breastfeeding role-models for women to learn from (Thorley, 2019). This lack of breastfeeding role-models leads to many mothers experiencing a tension between this societal view of natural and their personal experiences of physical pain and emotional doubt (Dykes and Williams 1999; Mozingo, Davis, Droppleman and Merideth, 2000; Hauck, Langton and Coyle, 2002; Crossley, 2009: Williamson, Leeming, Lyttle and Johnson, 2012; Spencer, Greatrex-White and Fraser, 2014; Chaput, Nettel-Aguirre, Musto, Adair, and Tough, 2016; Palmér, 2019). It is not uncommon that breastfeeding mothers face *"…physical, personal and social battles…"* to deal with their issues (Ayton, Tesch and Hansen, 2019, p.5). The physical challenges include pain, cracked nipples, fatigue (Gianni, et al., 2019), and a perception of insufficient milk (Ayton et al, 2019). Psychological and social challenges include feeling dependent on other people as a result of inadequate information (Thomson, Ebisch-Burton and Flacking, 2015), none or inappropriate infant feeding

support (Thomson, Ebisch-Burton and Flacking, 2015), failure, loneliness and isolation (Ayton et al, 2019), social stigma (especially relating to breastfeeding outside of the home) (Grant, 2016; Morris, Schofield and Hirst, 2019; Sheehan, Gribble and Schmied, 2019), and a lack of partner and family support (Ogbo et al, 2016). Other reasons for the cessation of breastfeeding include conflicting or non-evidence based advice from healthcare practitioners (Graffy and Taylor, 2005; Blixt, Johansson, Hildingsson, Papoutsi and Rubertsson, 2019; Taylor, van Teijlingen, Ryan and Alexander, 2019), a feeling of being overly scrutinised and judged by healthcare practitioners (Taylor et al, 2019) and a lack of local support due to cuts in services (Griffiths, 2017).

Breastfeeding support by healthcare practitioners is key to help women address and overcome their breastfeeding challenges (United Nations Children's Fund United Kingdom (UNICEF UK) Baby Friendly Initiative, 2019a). In the UK, breastfeeding support is offered within NHS settings by midwives, health visitors, lactation consultants, maternity care assistants and nursery nurses, as well as through the activities of voluntary organisations such as the National Childbirth Trust, La Leché League, Breastfeeding Network and Association of Breastfeeding Mothers. It is common practice for healthcare practitioners' working in the UK to receive training to provide care and support to breastfeeding mothers (UNICEF UK Baby Friendly Initiative, 2019b). The experiences of healthcare practitioners supporting breastfeeding mothers is discussed further in the next chapter.

It is argued that breastfeeding in terms of success or failure is not the sole responsibility of the mother (Rollins et al, 2016), and that partner and family support play a vital role. There is also evidence to indicate that mothers prefer breastfeeding support from the father over a healthcare practitioner (Mannion, Hobbs, McDonald and Tough, 2013). Brown (2016) found that mothers wanted realistic messages about breastfeeding from healthcare practitioners and for breastfeeding messages to be targeted at the father. However, several research studies have found that fathers feel inadequate (Chen et al, 2010), incompetent (Brown and Davies, 2014), and unprepared for a support role and the challenges a breastfeeding mother may face (Sherriff, Hall and Pickin, 2009; Sherriff and Hall, 2011; Bennett, McCartney and Kearney, 2016). Fathers also report feeling overlooked, ignored, or excluded by healthcare practitioners (Goodman, 2005; Clifford and McIntyre, 2008; Tohotoa et al, 2009; Rempel and Rempel, 2011; Brown and Davies, 2014). This results in the fathers not receiving support from healthcare practitioners (Barclay and Lupton, 1999), not

being targeted in infant feeding support strategies (Abbass-Dick, Stern, Nelson, Watson, and Dennis, 2015), and not receiving specific practical advice to undertake a supportive role (Brown and Davies, 2014).

This sense of exclusion by healthcare practitioners, reported by many fathers, may be a result of practitioners' focus on the exclusive mother-baby dyad thus denying fathers' the knowledge they desire, and in turn disempowering a potentially important ally (Moore and Coty, 2006; Sherriff et al, 2009; Mitchell-Box and Braun, 2012; Brown and Davies, 2014). This notion of the exclusivity of the mother-baby dyad appears to be deeply ingrained within healthcare practitioners and fits with societal view of what constitutes women's work in relation to childbirth and early days care encompassing breastfeeding (Mannion et al, 2013).

In the current UK context healthcare practitioners are working within a multi-cultural society while the NHS faces increasing demand in the context of financial constraint, staffing issues, and increasing inequalities (NHS, 2019a). Within the maternity services, many experienced midwives are retiring without being replaced by an equal number of new graduates (Royal College of Midwives, 2018). The profile of women accessing the maternity services is also changing, with a rising maternal age as more than half of women in England using the maternity services are over thirty (Royal College of Midwives, 2018). In addition, more than half of women in England accessing the maternity services are obese and thus requiring high-risk care (Royal College of Midwives, 2018). Health visiting services have also seen a decrease in health visitor numbers over recent years, and the Institute of Health Visiting has launched an evidence-based blueprint to rebuild health visiting services with their Chief Executive Dr Cheryll Adams (2019, no page) stating that:

> *The current status of health visiting is not serving families well, based as it is on universally delivered process outcomes which risk "ticking the box, but missing the point". There remains a persistent gap between what the evidence tells us, and the profession aspires to achieve, and what is currently able to be funded and provided since the year on year cuts to public health budgets starting in 2015.*

Maternity and health visiting services are increasingly finding it challenging to meet the needs of families and are relying on parents using a wider range of resources to meet their needs (Institute of Health Visiting, 2018). To receive timely and responsive

support and assistance for breastfeeding, the NHS provides information about voluntary organisations to fill the gaps and meet needs (NHS, 2019b). Within a resource limited service, rather than maintain the 'status quo', healthcare practitioners need to reframe their thinking and embrace the wider community for breastfeeding support. If healthcare practitioners acknowledge that breastfeeding is a complex interaction of biological, psychological, and sociological factors and embrace this into their practice then a new type of holistic approach is possible; one that goes beyond the mother-baby dyad. Engaging the father and equipping him with knowledge, skills, and confidence to support the breastfeeding mother is one way of achieving this new type of holistic approach. Heaney and Israel (2008) suggest that such an approach of including the father could be seen as a form of social influence with the intent of motivating the father to change his attitude or behaviour if that is needed, as well as meeting the needs of the father to provide breastfeeding support (Tohotoa et al, 2009; Rempel and Rempel, 2011; Brown and Davies, 2014).

Breastfeeding and its related aspects are discussed in greater depth in chapter two. As identified in section 1.1, there is a need to understand how healthcare practitioners engage with the father and what part confidence plays in such engagement before providing breastfeeding support tailored to the father can become the norm. In the next section the second concept of this study, confidence, is introduced to ensure there is common understanding when reading this thesis.

1.2.3: Confidence

Confidence is a concept that is inherent in everyday life influencing how a person functions on a personal and professional level (Craig, 2006). Confidence is considered to be a necessary requisite for healthcare practitioners to fulfil the requirements of their role. Khar (2019) considers that confidence has widespread consequences for the health service as it enables the healthcare practitioner to create strong relationships with patients / clients and build trust, have an enhanced level of communication with patients / clients and other staff, and deliver a stronger professional performance. The Nuffield Trust (2020) also consider that confidence is a key element of the practitoner-patient relationship, along with trust. Healthcare practitioners need to feel and demonstrate confidence in their interaction with and delivery of care to their patients / clients and significant supporters (Bedwell, 2012; Price-Dowd, 2017; Makarem et al,

2019). This is in order for service-users to feel confident that everyone caring for them is skilled and competent, and which in turn can help to influence their attitudes and behaviours (Price-Dowd, 2017). The quality of the service-user experience is influenced by the confidence of the practitioner (Owens and Keller, 2018). I chose to focus on confidence of healthcare practitioners in their interaction with the father in order to gain a deeper understanding what influences confidence and how healthcare practitioners demonstrate confidence.

Confidence is broadly considered to be a sense of certainty about one's own abilities and qualities and the ability to succeed (Zedeck, 2014; Collins Dictionary, 2020). Within the literature, papers use the terms confidence and self-efficacy interchangeably (Davies and Hodnett, 2002; Crooks et al, 2005; Bedwell, McGowan and Lavender, 2015), perhaps because of the difficulty in describing and explaining confidence and its foundations. This diffciulty may be explained by Bandura (1997, p.382), who has suggested that: *"Confidence is a catchword rather than a construct embedded in a theoretical system."*

Self-confidence and self-efficacy are often used as synonyms for confidence (Holland, Middleton and Uys's, 2012); with self-efficacy drawn from Bandura's Social Cognitive Theory (Bandura, 1977). However, others argue that confidence is a broad general sense of self-assurance based on an appreciation of one's own abilities or qualities whilst self-efficacy is task/field specific (Stankov, Kleitman and Jackson, 2014). Bandura (1977) suggests that the presence of self-efficacy is an indicator of a person's confidence. This is demonstrated in the activity of healthcare practitioners by Perry (2011) who suggests that it can be inferred that possessing and exercising confidence enables a healthcare practitioner to demonstrate self-efficacy in specific aspects of their role. Both confidence and self-efficacy centre on belief. Confidence is a strong belief (that may be positive or negative) in something or somebody whilst self-efficacy focuses that belief on capacity and capability to succeed in a specific situation or task.

When contemplating what I wanted to explore about healthcare practitioners providing breastfeeding support to the father, I was not seeking to explore just one specific activity but rather a range of behaviours and beliefs. When I was discussing my study with an experienced practitioner, she also commented that the term 'self-efficacy' was likely to confuse or frighten prospective participants whereas the term 'confidence' was

likened to everyday personal and professional language. In addition, by favouring the term confidence rather than using the term 'self-efficacy' I was aiming to avoid providing participants with a bias or clues as to what was being sought. Later, during my study, I read a paper that supported my position on the use of the term confidence. Bogo, Regehr, Baird, Paterson and LeBlanc (2017, p. 705) in their research on social work practice acknowledge that *"…'confidence' is a more widely understood term than self-efficacy."* For this study, confidence is defined as *"the ability to feel sure of something at a given time in a given circumstance".* This concept is considered further in section 2.5.

1.3: Chosen methodology and methods

To explore healthcare practitioners' confidence in providing breastfeeding support to fathers, a scoping review was undertaken; this is discussed fully in chapter three. Due to the absence of any studies on my chosen focus, the decision was made to use an interpretivist methodology of constructivist grounded theory for this study. Grounded theory is an appropriate choice in an area where no previous studies have been undertaken (Charmaz, 2014). Grounded theory is characterised by an inductive, comparative methodology with systematic procedures to guide data collection, analysis, synthesis, and conceptualization with the intent to generate a theory (Charmaz, 2001). The iterative process of data collection and analysis enables the development of an underlying theoretical framework that explains the processes identified (Charmaz and Bryant, 2010). Constructivist grounded theory has evolved from the traditional methodology devised by Glaser and Strauss (1967). Mills, Bonner and Francis (2006, p.31) consider that constructivist grounded theory championed by Charmaz has reshaped *"… the interaction between researcher and participants in the research process".* Within this methodology there is a clear recognition of how the researcher plays an active role, with both the participants and researcher acting as the co-constructor of knowledge (Charmaz, 2014). Constructivist grounded theory provided me with a methodology to produce rich, in-depth descriptions and theoretical understandings of the underlying processes of healthcare practitioner confidence in providing breastfeeding support to the father. I recruited healthcare practitioners from the maternity and health visiting services who provided antenatal and postnatal care and support to the mother, as they were the most likely practitioners to encounter the father. Data collection was achieved through eight individual interviews and one group interview of five participants.

1.4: Organisation of the thesis

An overview of the thesis has been presented as follows:

Chapter two provides the background context to my study. Here I provide insights into breastfeeding trends, reasons for and impact of cessation of breastfeeding, and breastfeeding issues and challenges. Next, I describe breastfeeding support from both healthcare practitioners and the father's perspective. The key concept of confidence is then explored to determine what it is and what a difference it makes. These discussions set the scene for the rationale for the study.

Chapter three presents the process and findings of the initial scoping review to determine whether there were any previous studies into healthcare practitioners' confidence in providing breastfeeding support to the father. The lack of available research provided a clear justification for this study, and the aim and additional objectives of the study are detailed.

Chapter four presents the theoretical methodology for this thesis. I explain the decisions and their rationale in relation to the choice of research paradigm, epistemology and ontology, theoretical perspective, and methodology. Several qualitative research designs were considered before the rationale for the choice of constructivist grounded theory is provided.

Chapter five describes the methods used for this constructivist grounded theory study. The process from recruitment to authentication of the data analysis is detailed. A reflexive discussion is threaded throughout to illustrate the challenges I faced in undertaking this study.

Chapter six offers an introduction to the findings from this study. It introduces the participants and an overview of the four categories that emerged from the data analysis.

Chapter seven is the first of four chapters presenting the categories. In this chapter the category ‘Confidence comes from having and using knowledge’ describes the influence of training and knowledge generating confidence.

Chapter eight presents the findings of the second category ‘Confidence comes from having and gaining experience’. It presents the findings related to work experience, personal breastfeeding attitude and experience and lack of experience

Chapter nine describes the third category of ‘Tuning into the father’. It centres on how the healthcare practitioners sought to understand and value the father’s perspective and how they used strategies to engage and encourage the father.

Chapter ten describes the fourth category ‘the challenges of providing breastfeeding support to the father’. Insights into the challenges of providing a service to fathers, the lack of a formal breastfeeding support strategy and resources for the father, and recommendations for training and practice are detailed.

Chapter eleven presents the rationale for undertaking a further review of the literature when using constructivist grounded theory. This review followed the completion of concurrent data collection and analysis and helped to identify papers that would assist in positioning my study and clarify its contribution to my emerging grounded theory.

Chapter twelve presents the substantive theory from this study. This chapter discusses the theoretical explanation of the actions and processes grounded in the four categories presented in chapters seven to ten and the influence of the further review of the literature in chapter eleven that highlighted two key theoretical concepts which led to the identification of the substantive theory ‘developing and engaging practical wisdom through ‘use of self’. This substantive theory is presented to explain healthcare practitioner confidence in providing breastfeeding support to the father.

Chapter thirteen starts by presenting the key findings from this study and identifies if the findings have answered the aim and objectives of the study. To discuss these

findings in relation to the key concepts of practical wisdom and use of self, the discussion draws on Edmondson's (2005) view of the components of practical wisdom - knowledge, experience and reflection to consider how each influences confidence. It then moves on to discuss how the key elements of the theory - practical wisdom and use of self can be recognised in practice. Within this chapter I offer the original contribution to knowledge derived from this study. The implications arising from the findings are identified along with recommendations in the areas of policy, practice, education and training, and research. The strengths and limitations of this study are discussed before offering a conclusion.

Chapter fourteen concludes this thesis by offering my reflexive journey over the last six years and beyond.

CHAPTER TWO: BACKGROUND: THE KEY CONCEPTS OF BREASTFEEDING AND SUPPORT, AND CONFIDENCE

2.1: Introduction

This chapter provides background information on the key concepts within this study - breastfeeding support and confidence. To explore breastfeeding support, the trends in breastfeeding and the reasons for and impact of breastfeeding cessation are outlined. The discussion then moves onto the support of breastfeeding for the mother and baby with a focus on provision from healthcare practitioners and the father to provide a framework for this study. Following this the second key concept of confidence is expanded on. The chapter daws to a close with the rationale for the study.

2.2: Trends in breastfeeding

Within the introduction to this thesis, section 1.2.1 provided the statistics from the last UK Infant feeding survey. Breastfeeding rates reached a nadir in the 1970's with a breastfeeding initiation rate in England and Wales of 51% in 1975 and this marked the start of a resurgence, although improvement in breastfeeding initiation was relatively slow until 2000 (Crowther, Reynolds and Tansey, 2007) when the breastfeeding initiation rate had increased to 71% (Hamlyn, Brooker, Oleinikova and Wands, 2002). The increase in breastfeeding initiation is attributed to several national initiatives, i.e., Joint Breastfeeding initiative (Henschel, 1989), introduction of the UNICEF UK Baby Friendly Hospital Initiative in 1994 (UNICEF UK Baby Friendly Initiative, 2019a), and the Infant Formula and Follow-on Formula Regulations 1995 to support the WHO International Code of Marketing Breastmilk Substitutes[2] (WHO, 1981).

Since 1990 there has been a continual rise in breastfeeding rates in the UK (see Figure 1) (White, Freeth and O'Brien, 1992; Foster, Lader and Cheesbrough, 1997; Hamlyn et al*,* 2002; Bolling, Grant, Hamlyn and Thornton, 2007; McAndrew et al*,* 2012). Despite the improvements noted, these breastfeeding rates do not meet the WHO (2003) recommendations for exclusive breastfeeding until six months of age.

[2] The International Code of Marketing of Breastmilk Substitutes is an international health policy framework to regulate the marketing of breastmilk substitutes to protect breastfeeding. Published in 1981 by the World Health Organisation in 1981, it is a voluntary code of practice (UNICEF UK Baby Friendly Initiative, 2019c, no page)

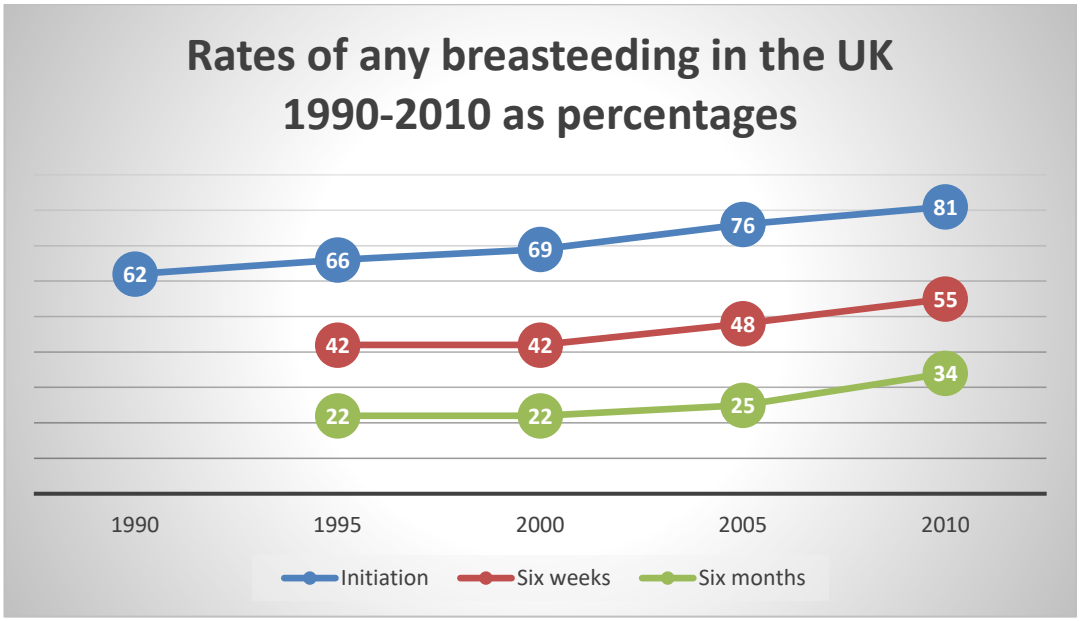

Figure 1: Rates of any breastfeeding in the UK 1990-2010 as percentages

In an effort to increase breastfeeding rates in the UK, maternity and health visiting services use the UNICEF UK Baby Friendly Initiative Standards to drive forward best practice in the clinical care and support of breastfeeding mothers and babies, and the training of the workforce (UNICEF UK Baby Friendly Initiative, 2019a). The Baby Friendly Hospital Initiative was introduced in the UK in 1995 and has continued to evolve from the 'Ten Steps to successful breastfeeding' and a 'Seven point plan for sustaining breastfeeding in the community' into a comprehensive service that aims to support mothers with infant feeding (UNICEF UK Baby Friendly Initiative, 2019a). The 'Ten Steps to successful breastfeeding' was a set of management policies and clinical procedures for maternity services to improve and sustain appropriate breastfeeding-related practices within maternity units (World Health Organization, 2020). The community services later had the 'Seven point plan for sustaining breastfeeding in the community'. Both these initiatives were designed to promote, protect, and support breastfeeding (UNICEF UK Baby Friendly Initiative, 2019a). As the evidence base increased there was a review in 2012 of the Baby Friendly Initiative Standards and new standards were issued to replace the Ten Steps to successful breastfeeding and the Seven Point Plan for sustaining breastfeeding in the community (UNICEF UK Baby Friendly Initiative, 2012). The Baby Friendly Initiative standards have continued to evolve to include the emphasis on the development of close, loving relationships to ensure all babies have an optimal start to their life (UNICEF UK Baby Friendly Initiative, 2019a), as well as the provision of care within neonatal units and children's centres and

the provision of education in universities, alongside that in maternity and community services (UNICEF UK Baby Friendly Initiative, 2019a). In 2019 across the UK 100% of births in Scotland and Northern Ireland, 78% of births in Wales and 58% of births in England occur within fully Baby Friendly Initiative accredited maternity services (UNICEF UK Baby Friendly Initiative, 2019d). This shows that progress is being made but there is still room for improvement in the quality of services with only 62% of maternity services and 72% of health visiting services having achieved full Baby Friendly accreditation along with 21 children's centres and 12 neonatal units in the UK (UNICEF UK Baby Friendly Initiative, 2019d). There is still significant progress to be made within the education sector with only 47% of midwifery courses and 15% of health visiting courses in the UK having achieved full accreditation (UNICEF UK Baby Friendly Initiative, 2019d).

Although there has been a significant improvement in breastfeeding initiation rates in the UK over recent decades, the breastfeeding continuation rates do not compare favourably to other developed countries. The first national infant feeding survey in Australia was conducted in 2010 and found an overall 96% initiation rate, with 15% still exclusively breastfeeding at six months (Australian Institute of Health and Welfare, 2011), and in 2014-15 the exclusive breastfeeding rate at six months had risen to 24.7% (Australian Bureau of Statistics, 2017). In contrast Sweden has consistently maintained a breastfeeding initiation rate of over 95% since the mid 1980''s (The National Board of Health and Welfare, 2017). Sweden experienced a small decline in exclusive breastfeeding in the first four months after birth from 2004-2014 but this decline has now halted (The National Board of Health and Welfare, 2017). In 2015 a total of 84.2% of all babies were receiving breastmilk at four months of age, with 51.2% being exclusively breastfed. At six months these statistics had dropped to 63.2% of all babies were receiving breastmilk, with 14.6% still being exclusively breastfed (The National Board of Health and Welfare, 2017). The statistics of exclusive breastfeeding from both Australia and Sweden are comparable and highlight that there is still room for improvement in the UK. The decrease in any breastfeeding during those first six months and more particularly exclusive breastfeeding can be attributed to several factors, which is discussed in the next section.

2.3: Reasons for and impact of breastfeeding cessation

Breastfeeding cessation may be regarded as the consequence of multiple biopsychosocial issues rather than solely a biological inability (Neifert, 2001; McAndrew et al, 2012) which reinforces the WHO (2003) view that virtually every woman is biologically able to breastfeed. Williamson et al (2012) identified that some mothers experience a tension between the societal view of breastfeeding as natural and their personal experiences of breastfeeding not being natural. The reasons for cessation are complex and can be divided into maternal sociodemographic factors, maternal perception of their confidence to breastfeed, physical breastfeeding issues, and the influence of the artificial formula milk industry. These reasons are discussed in more depth as follows.

2.3.1: Maternal sociodemographic factors

Whilst it is the mother who undertakes the physical activity of breastfeeding her capability to breastfeed is influenced by her background, culture, and support network (Brown, 2017). The Infant Feeding Surveys in the UK provide evidence that the sociodemographic factors of increased age and having a stable and supportive relationship status are consistently associated with a higher rate of initiating and continuing with breastfeeding (White et al, 1992; Foster et al, 1997; Hamlyn et al, 2002; Bolling et al, 2007; McAndrew et al, 2012). These findings from the UK are mirrored in numerous studies in other developed countries such as America (Taveras et al, 2003; Mathews, Leerkes, Lovelady and Labban, 2014; Pitonyak, Jessop, Pontiggia and Crivelli-Kovach, 2016), Australia (Hauck, Fenwick, Dhaliwal and Butt, 2011; Ogbo et al, 2016; Ogbo et al, 2019), and Italy (Colombo et al, 2018). Taveras et al (2003), in a prospective cohort study of 1007 mothers who initiated breastfeeding in America, identified that being a single mother or being a young mother was more likely to be associated with higher discontinuation rates in the early weeks than being in a supportive relationship. Other studies also identify the negative impact on breastfeeding rates of being a young mother, although the studies vary in the age that they used as the qualifying parameter of being labelled as a young mother (Taveras et al, 2003; Hauck et al, 2011; Mathews et al, 2014; Ogbo et al, 2016; Colombo et al, 2018; Ogbo et al, 2019).

Mothers who stopped breastfeeding earlier demonstrate connections between their younger age and leaving formal education with the minimal educational qualifications achievable (Taveras et al, 2003; Mathews et al, 2014). In turn being young without significant educational qualifications can be associated with lower income (Mathews et al, 2014; Ogbo et al, 2016; Ogbo et al, 2019) and single parent status (Taveras et al, 2003; Mathews et al, 2014). These factors may relate to early cessation of breastfeeding in several ways such as lower educational attainment limiting the mother's confidence and/or ability to access and use relevant breastfeeding information and resources or increase the need to return to work earlier to keep a job and achieve greater financial security for her family, or due to having limited or no support from a partner finding breastfeeding challenges more difficult to overcome. Taveras et al's study (2003) found that 47% of their mothers in Sacramento, America had returned to work or school by 12 weeks after birth, thus creating challenges to continue breastfeeding. Pitonyak et al (2016) identified that combining a return to work outside the home with breastfeeding was more likely when employers were supportive of breastfeeding. Both these studies (Taveras et al, 2003; Pitonyak et al, 2016) were undertaken in America where paid maternity leave is not universal and many mothers will return to work in the first two to four weeks after birth.

Even if there are favourable sociodemographic factors such as being an older mother, being in a supportive relationship, and being well educated with a good level of income, maternal perception of her breastfeeding experience is a significant factor in being able to negotiate any challenges or issues she and / or her baby may experience. This is now discussed.

2.3.2: Maternal perception of breastfeeding success and support

Maternal perception is a powerful tool in either increasing or decreasing their confidence and self-belief in breastfeeding. Oosterhoff, Hutter and Haisma (2014) argue that for many mothers the reality of breastfeeding is different to their expectations, with early experiences negatively impacting on maternal confidence and self-efficacy. Their qualitative study interviewed eight first-time mothers both during pregnancy and after the birth. These eight mothers expressed positive intentions during pregnancy but then reported inadequate knowledge postnatally, not fully

understanding how breastfeeding worked or having specific skills to prevent breastfeeding problems. A study by Taveras et al (2003) with 1007 mother and baby pairs found that many mothers express a lack of confidence to breastfeed, which in turn could mean that they are more vulnerable to forms of support from their family and friends' network that could further undermine them.

The type of support offered to and received by the breastfeeding mother will determine how the mother perceives her breastfeeding experience. Maternal perception of support is more positive when that support enabled her to maintain a sense of independence in her decision making and self-efficacy in her breastfeeding skills (Cutrona and Russell, 2017; Davidson and Ollerton, 2020). Non-directive support draws on a model of shared decision-making that recognises the mothers needs and agenda (Stewart, Gabriele, and Fisher, 2012) and is perceived by the mother as responsive to her needs. Breastfeeding success is more likely when the mother perceives that her partner is providing responsive support (Mannion et al, 2013; Abbass-Dick et al, 2015; Rempel, Rempel and Moore, 2017). The influence of the father in providing breastfeeding support is discussed further in section 2.4.2.

Maternal perception and her psychological state are important factors as there can be a link to her degree of intention and commitment to continue breastfeeding. Two issues that can impact maternal perception are perceived breastmilk insufficiency and challenging infant behaviour (Peacock-Chambers, Dicks, Sarathy and Brown, 2017). Peacock-Chambers et al (2017) undertook a prospective qualitative study after recruiting 20 mothers from culturally diverse backgrounds in urban low-income areas of America. They interviewed the women at two weeks and six months to deepen the understanding of the sociocultural drivers of maternal behavioural intentions and their subsequent behaviour in relation to breastfeeding. Peacock-Chambers et al's (2017) data suggested that breastfeeding decisions are influenced by the mother's perceptions of the degree of control she has over her milk supply and her baby's behaviour. Of the 20 mothers who participated in this study, 19 gave birth in a Baby Friendly hospital with care practices designed to support breastfeeding mothers and babies. Despite the availability of support and advice only 29% of these mothers were exclusively breastfeeding at six months. Those mothers who stopped breastfeeding or changed to mixed feeding involving a combination of breast milk and artificial formula milk, were noted to draw on their observations of infant behaviour and trial a variety of

strategies before deciding to change to or include artificial formula milk. There was acknowledgement that these mothers faced challenging and conflicting demands. Their perception of their baby's behaviour caused them distress, anxiety, and fear which in turn affected how they responded and how they made decisions re the exclusivity of their breastfeeding (Peacock-Chambers et al, 2017). In a qualitative study by Cortés-Rúa and Díaz-Grávalos (2019) 15 first-time mothers, who stopped breastfeeding before they had planned, expressed anxieties about their baby's behaviour which often led them to misinterpret crying and fussiness as hunger, which in turn led them to doubt their ability to satisfy the baby. Maternal concern with the level of anxiety over night-time crying and fussiness was found to be associated with the introduction of artificial formula milk feeds in a study by Redsell et al (2010). This study by Redsell et al (2010) found if the mother is reassured that the baby is no longer hungry, because they could visualise the amount of milk the baby received, they became more comfortable with persistent crying. Crying is a challenging baby behaviour that evokes fear in mothers and their natural response is to offer a feed to calm the baby (Gatti, 2008). Such maternal anxieties over baby behaviour may reflect a lack of confidence in appropriately interpreting baby behaviour that does not match the information from family, baby care books or websites (Redsell et al, 2010). It has also been demonstrated that even when healthcare practitioners can evidence adequate intake of breastmilk for the baby, mothers can lack confidence in this information as they use a different set of criteria to assess the baby, such as satiety cues (Gatti, 2008; Kent, Hepworth, Langton and Hartmann,2015). When a mother perceives a lack of control over breastfeeding due to challenging infant behaviour and/or concerns about breastmilk production it can lead to distress and a decrease in confidence and her self-belief in her body's ability to function (Peacock-Chambers et al, 2017).

Maternal perception may be influenced by the predominant family culture she lives in. When that family culture promotes the use of artificial formula milk as the norm, those mothers wishing to breastfeed can perceive family culture to be unhelpful in their efforts to continue breastfeeding (Alianmoghaddam, Phibbs and Benn, 2017a, 2017b; Lavender, McFadden and Baker, 2006). Alianmoghaddam et al (2018) suggests that such a culture undervalues breastfeeding and creates a discouraging environment that may be difficult for the mother to endure thus leading to earlier breastfeeding cessation than she planned. Bick, MacArthur, and Lancashire (1998) noted that the provision of childcare from female family members from an early stage of breastfeeding may also

undermine breastfeeding and maternal perception leading to earlier cessation. This may be due to the female family members using their lack of breastfeeding knowledge and experience or a negative breastfeeding experience on which to base advice giving to the new mother. Maternal perception of herself and her baby can also be influenced by a lack of consistent advice, encouragement, and support from healthcare practitioners, with a detrimental effect on her confidence and breastfeeding efforts (Mozingo et al, 2000; Oakley, Henderson, Redshaw and Quigley, 2014).

The consequences of early cessation of breastfeeding extends beyond the loss of physical health benefits for mother and baby. Mothers have expressed shock at the difficulties they face with breastfeeding and find that struggling, or even failing to breastfeed affects them psychologically (Dykes and Williams, 1999; Mozingo et al, 2000; Hauck et al, 2002). The maternal psychological response to breastfeeding problems is impacted by the physical changes she experiences because of the lack of sleep, tiredness and exhaustion which characterises early postnatal weeks and months (Williamson et al, 2012). These breastfeeding issues / problems will now be discussed.

2.3.3: Breastfeeding issues / problems

A mixed methods study of 1437 mothers who initiated breastfeeding in Denmark by Feenstra, Jørgine Kirkeby, Thygesen, Danbjørg and Kronborg (2018) showed that a mother who has lower maternal self-efficacy and self-perceived knowledge can be more vulnerable to breastfeeding challenges. This study focused on the first three weeks after birth showing that up to 40% of mothers experience early breastfeeding problems that were associated with the mother, the baby, or a lack of support from the healthcare practitioners. The breastfeeding challenges that the mothers in Feenstra et al's study (2018) experienced are like many other studies over recent decades. These studies highlighted challenges that included nipple pain/trauma (McCann, Baydar and Williams, 2007; Odom et al, 2013; Colombo et al, 2018); breast engorgement and/or pain (Hauck et al, 2011; Odom et al, 2013; Schafer et al, 2017), perceived lack of breast milk (Avery, Duckett, Dodgson, Savik and Henly, 1998; McCann et al, 2007; Hauck et al, 2011; Odom et al, 2013; Colombo et al, 2018), concerns about maternal or infant health (Odom et al, 2013; Ogbo et al, 2016), unsettled baby (Hauck et al, 2011), concerns about infant weight loss or gain (Forster, McLachlan and Lumley, 2006;

Hauck et al, 2011; Odom et al*,* 2013), and admission of the baby to a neonatal unit (Forster et al, 2006). For many mothers the answer to their physical breastfeeding problems is to stop breastfeeding and start using artificial formula milk. The influence from this industry will now be discussed.

2.3.4: Influence from the artificial formula milk industry

The artificial formula milk industry has urged mothers to replace breastmilk with artificial formula milk since the nineteenth century (Rosenberg, Eastham, Kasehagen and Sandoval, 2008). As an industry, the manufacturers have engaged in advertising and marketing strategies that purposely target mothers and which ultimately has had a negative impact on breastfeeding rates (Kaplan and Graff, 2008). The influence of the artificial formula milk industry is prevalent in three key aspects of breastfeeding practice - initiation, continuation, and exclusivity (Kaplan and Graff, 2008). Howard et al (2000) argued that exposure to the manufacturers' material during pregnancy increased the likelihood of breastfeeding cessation in the first two weeks after birth. This is a time when many mothers will experience breastfeeding problems and in the absence of suitable and/or sufficient support mothers will seek an alternative solution (Odom et al*,* 2013; Feenstra et al, 2018). Sobel et al (2011) conducted a survey of 5219 households with infants under two years of age in mixed sociodemographic areas in the Philippines to examine the association between artificial formula milk advertising and infant feeding practices. The mothers were asked to recall where they had seen or heard artificial formula milk advertising. Overall, 75% of the mothers recalled such advertising; 68% via television, 16% via radio and less than three per cent in a hospital or health centre. Sobel et al (2011) found that nearly 60% of mothers were more than twice as likely to use artificial formula milk if they could recollect specific advertising messages, whilst 16% were four times more likely to be using artificial formula milk if they had received a recommendation from a doctor. An earlier study by Rosenberg et al (2008) utilized data of 3895 women from the 2000 and 2001 Oregon Pregnancy Risk Assessment Monitoring System (PRAMS) population-based survey of postnatal women found that two-thirds of mothers initiating breastfeeding were being supplied with commercial hospital discharge packs containing samples of artificial formula milk. The authors suggested that healthcare practitioners were giving mothers mixed messages, as they were simultaneously encouraging breastfeeding whilst enabling the mothers to receive a discharge pack containing artificial formula milk. The authors do not make it

clear if the women birthed in Baby Friendly accredited hospitals, although the women reported practices such as skin-to-skin contact with the baby following the birth and rooming in where their baby stays beside their bed rather than a separate nursery (Rosenberg et al, 2008).

In the UK advertising of the artificial formula milks used for babies in the first six months of their life is banned under the Infant Formula and Follow-on Formula (England) Regulations (2007). However, advertising is permitted for artificial formula milks used by babies / infants over six months of age. Advertising of artificial formula milks is common on television and in consumer magazines targeted at mothers and parents of young babies/infants, as well as in some healthcare journals. In March 2019 in the UK, the British Medical Journal announced a ban of the publication of artificial formula milk advertisements (Godlee, 2019). This action by the British Medical Journal was important as it upheld the principles of the International Code of Marketing of Breastmilk Substitutes (WHO, 1981). The purpose of this health policy framework is to protect breastfeeding by regulating the marketing of breastmilk substitutes (WHO, 1981). Prior to the implementation of the International Code of Marketing of Breastmilk Substitutes (WHO, 1981), the artificial formula milk company representatives could access all healthcare practitioners. When healthcare organizations are seeking initial accreditation or re-accreditation of the UNICEF Baby Friendly status, they are required to demonstrate that they are upholding the International Code of Marketing of Breastmilk Substitutes (WHO, 1981).

A study by Dykes, Richardson-Foster, Crossland and Thomson (2012) undertook an evaluation of the Infant Feeding Information Team in North West England as they were implementing the WHO Code of Marketing of Breast-milk Substitutes. The healthcare practitioners identified that there were broader issues that affected their ability to support mothers with artificial formula milk feeding. These issues involved lack of access to robust information about the different brands of artificial formula milks (whilst still seeing advertisements in professional journals), a lack of information about the different brands of artificial formula milk to give to the mothers, and a lack of time to demonstrate safe techniques for making up feeds and sterilising feeding equipment. This caused the healthcare practitioners to feel frustrated, undermined and disheartened when set against the backdrop of existing professional, sociocultural and political agendas impacting their ability to support mothers with their infant feeding

choices and/or practices (Dykes et al, 2012). The support of breastfeeding needs to be seen against the backdrop of wider sociocultural issues as well as the robustness of the healthcare system.

2.4: Supporting breastfeeding

Support is a wide-ranging concept that is defined within the Cambridge Dictionary (2020a, no page) as to *"agree with and give encouragement to someone or something because you want him, her, or it to succeed; to help someone emotionally or in a practical way."* Breastfeeding mothers can expect to receive support from their family and friends and healthcare practitioners. Social support from family and friends has been highlighted as a key influence on the mother's feeding intention and breastfeeding initiation and continuation rates (Ingram, Johnson and Greenwood, 2002; Grassley and Eschiti, 2008; Heinig et al, 2009; Dunn, Kalich, Fedrizzi and Phillips, 2015; Emmott and Mace, 2015; Furman, Killpack, Matthews, Davis and O'Riordan, 2016). Whilst there is recognition of the value of support from family members such as the grandmother, the emphasis for this thesis is on the baby's father as the key ongoing supporter of mother and baby in the UK. Mothers have consistently reported that their breastfeeding decisions are significantly influenced by a partner who is supportive of breastfeeding, rather than being negative or ambivalent (Ekström, Widström and Nissen, 2003; Swanson and Power, 2005; Hauck, Hall and Jones, 2007; Clifford and McIntyre, 2008; Fagerskiold, 2008; Susin and Giugliani, 2008; Tohotoa et al, 2009; Rempel and Rempel, 2011; Mannion et al, 2013; Hunter and Cattelona, 2014; Abbass-Dick et al, 2015; Wallenborn, Masho and Ratliff, 2017).

It is also widely acknowledged that healthcare practitioners have a role to play in supporting the breastfeeding mother-baby dyad (UNICEF UK Baby Friendly Initiative, 2019a). Skilled help has a positive impact on both the initiation and duration of breastfeeding and the mother's physical and emotional experience of breastfeeding (Battersby, 2014). This thesis will now discuss the support from healthcare practitioners before exploring support from the father/partner.

2.4.1: Support from the healthcare practitioners

Support is an inherent component to healthcare practice for nurses, midwives, and health visitors in the UK (NMC, 2018a). Within the UK there is a universal provision of care to all mothers and babies from healthcare practitioners such as midwives and health visitors before and after birth. All pregnant women are entitled to a total of up to ten visits to monitor maternal and fetal health and wellbeing, to offer antenatal information and screening, to discuss their place of birth and infant feeding decision and offer psychological support (NICE, 2008). After birth all mothers receive postnatal care based on their needs in hospital or at home from a midwife for up to 28 days, with the health visitor visits to the family starting at 10 to 14 days (Shribman and Billingham, 2009; NICE, 2008). Midwifery care for the family includes monitoring maternal and baby health and wellbeing as well as providing information about baby care, parenting, and infant feeding to both parents (NICE, 2008). Across pregnancy and the postnatal period midwives identify the woman's preference about feeding her baby, clarify existing knowledge, offer additional information, and then support the women with her method of choice (NICE, 2014). Health visitors are responsible for supporting parents by providing at least five universal home visits to monitor the health and development of the infant starting in late pregnancy through to a developmental assessment at two years (Institute of Health Visiting, no date).

Support can involve a variety of strategies and interventions such as giving reassurance, praise, information, and providing an opportunity for mothers to discuss problems and ask questions (McFadden et al, 2017). A Cochrane review on the mode and effectiveness of support for healthy breastfeeding mothers and babies (McFadden et al, 2017) concluded that breastfeeding support was more effective in areas of higher breastfeeding initiation, and that effective support could be provided by professional or lay/peer supporters, or a combination of both, particularly when it was face-to-face. Many mothers value the contribution of healthcare practitioners to their success on their breastfeeding journey (Bizon et al., 2019), particularly those healthcare practitioners who were seen as "*the 'knowledgeable friend'* (who) *normalised breastfeeding challenges* "(Burns and Schmied, 2017, p. 389). Mothers responded positively to healthcare practitioners who respected their autonomy whilst encouraging them in their quest to breastfeed (Alianmoghaddam et al, 2017b). Mothers particularly value support which is personalised to the mother's needs (Demirtas, 2012) and

focuses on empowering and encouraging her thus improving and/or sustaining the mother's self-efficacy and overall confidence to succeed with breastfeeding (Hannula, Kaunonen and Tarkka, 2008). However, this is not a universal view as other breastfeeding mothers report mixed views about the value of support from healthcare practitoners. A qualitative study of 51 mothers accessing breastfeeding support from a Baby Café[3] in a variety of urban and rural locations within England showed that many mothers believed that healthcare practitioners had given them idealistic and impracticable expectations of breastfeeding in their endeavour to promote the benefits of breastfeeding (Fox, McMullen and Newburn, 2015). This unrealistic view caused the mothers to feel doubt about their feeding choices when they faced feeding challenges such as pain and led to guilt and feelings of incompetence (Fox et al, 2015). These women often received conflicting advice from healthcare practitioners in the early days so sought help from alternative sources, such as the Baby Café. In such a venue they experienced social support from other mothers that complemented the expert advice from professionals and trained peer supporters (Fox et al, 2015). Brown (2016) found that mothers wanted realistic messages about breastfeeding from healthcare practitioners and for breastfeeding messages to be targeted at the father and other family members, thereby highlighting the significance of family networks that are important in women's infant feeding journeys.

McInnes and Chambers's (2008) narrative synthesis of 47 papers reporting research from the UK, America, Australia, New Zealand and Swededn identified that healthcare practitioners' can face significant challenges in providing effective breastfeeding support; these include time demands, limited availability, unsupportive practices and conflicting ideas from other healthcare practitioners. In a qualitative study undertaken in Scotland by Marks and O'Connor (2015), 51 healthcare practitioners participated in ten focus groups to explore their views of breastfeeding, the influences for these views and how these views and influences impacted on breastfeeding promotion. The study revealed a number of themes that help explain why practitioner support is not always viewed positively by mothers. These themes were powerlessness and pessimism, breastfeeding promotion versus coercion / education, and the function of breastfeeding promotion. Whilst healthcare practitioners' had positive opinions about breastfeeding, they did not feel that they had a strong influence over mothers due to a myriad of external influences facing the mother. Examples of these external influences were the

[3] Baby Café is a voluntary breastfeeding organisation run drop-in centre that provides support and guidance on breastfeeding. It can be staffed by a mixture of trained peer supporters, trained breastfeeding counsellors and health professionals. (Baby Café, 2020)

father/partner, grandmother, intergeneretaional family norms, and societal/cultural norms. The father/partner was perceived as being very influential over feeding decisions with concern that he saw the baby as a rival. These practitioners felt their role was one of informing rather than promoting breastfeeding (Marks and O'Connor, 2015). Arora et al (2017) also considered that the health professionals need to inform rather than promote breastfeeding given that the majority of mothers have made their decision about breastfeeding before any contact with healthcare practitioners in pregnancy. However, in reality, the skill of informing mothers is a challenging one as some mothers report feeling pressurised to breastfeed by healthcare practitioners (Alianmoghaddam et al, 2017b).

There is clear recognition that the early days and weeks after birth are crucial to establish successful breastfeeding. Due to the UK being perceieved as having a bottle-feeding culture (Bolling et al, 2007; Cattaneoetal, 2005), and despite various initiatives to improve breastfeeding initiation and continuation, for some women, breastfeeding has been perceieved as a 'give it a go' exercise (Bailey, Pain and Aarvold, 2004); thus many women already have a strong expectation of experiencing difficulties or failing due to the widespread bottle feeding culture that implicitly suggests breastfeeding is problematic (Bailey et al, 2004). Some mothers identify that they do not want to breastfeed but start because they acquiese to the dominant societal view of the benefits of breastfeeding for the baby outweigh maternal preference (Ayton et al, 2019). Many mothers may start breastfeeding in response to this societal view and in order not to experience censure and guilt for going against the majority view of what a 'good mother' does (Taylor and Wallace, 2012). This need to be perceived as a 'good mother' is reiterated in a Swedish qualitative descriptive cross-sectional study using data from online parenting forums (Wennberg, Jonsson, Zadik Janke and Hörnsten, 2017). Wennberg et al's (2017) content analysis of the forum posts identified several interesting themes, one of which was 'striving to be a good mother'. This concept of being a good mother was founded on the 'breast is best' message and that breastfeeding was the only 'real' choice and should be attempted at any cost. When mothers were not successful with breastfeeding, they reported feeling inadequate and a failure and concluded they were not 'good mothers'. Wennberg et al (2017) concluded that healthcare professionals needed to have a more open attitude towards mothers who chose to introduce artificial formula milk either alongside or instead of breastfeeding. When the mothers were informed of options other than total breastfeeding many experienced a decrease in their guilt and shame, and this led to

the potential for a combined approach of some breastfeeding supported by artificial formula milk. In 2018 there was a significant shift in the position of the UK Royal College of Midwives (RCM) (2018) who exhorted midwives to provide support and information to parents on all infant feeding choices and to respect the choice of women to formula feed.

As highlighted earlier, whilst overall breastfeeding rates have been slowly improving in the UK there are still gaps and areas that require further work and attention in order to fully meet the WHO (2003) recommendations and to ensure every mother who starts breastfeeding has the optimal experience. Any effort to promote, protect and support breastfeeding must recognise the three key people involved in breastfeeding – the mother, baby and father/partner as they are *"…the cornerstone of successful breast feeding"* (Bennett et al, 2016, p.175). The disucssion will now move onto the support for breastfeeding from the father.

2.4.2: Support from the father

In section 2.4 the importance of the father's influence on maternal breastfeeding decisions was highlighted. Cisco (2017) suggests that the need for the father to take a more central support role is increased due to the wider geographical spread of the mother's female relatives. The involvement of the father in providing breastfeeding support is influenced by several factors. Firstly, the willingness of the mother to share the experience is crucial - this notion of the breastfeeding team is clearly recognised in many studies (Rempel and Rempel, 2011; Bennett et al, 2016; de Montigny, Gervais, Larivière-Bastien and St-Arneault, 2018; Ngoenthong, Sansuriphun and Fongkaew, 2020). Secondly, the value placed on support from the father and the perception by the mother of the support she receives from the father (Garfield and Isacco, 2006; Nickerson, Sykes and Fung, 2012; Mannion et al, 2013; Alianmoghaddam et al, 2017a). Taveras et al (2003), in a prospective cohort study of 1007 mothers who initiated breastfeeding in America, found that mothers who had support from the father in the first two weeks were more likely to continue breastfeeding compared those mothers who were single. Leng, Shorey, Yin, Chan & He's (2019) descriptive correlational study of 151 fathers in Singapore identified that other factors which influenced the provision of breastfeeding support by the father included the state of the marital relationship, perceived approval from family and friends, and the knowledge

that father had of breastfeeding before and after birth. The nature of the father's involvement in providing support to the breastfeeding mother is to ensure she has a successful experience. Fathers aimed to achieve such breastfeeding success by reducing stressors for the mother, and by providing instrumental and emotional support (Rempel et al, 2017). Paternal support of and encouragement with breastfeeding is important because it has been shown to be directly related to higher maternal confidence and thus success with breastfeeding (Hauck et al, 2007; Mannion et al, 2013).

It appears that the role of the father in providing breastfeeding support centres around two areas – providing practical support and assistance and providing emotional support (Tohotoa et al, 2009; Datta, Graham and Wellings, 2012). Both aspects are valued by the mother (Emmott, Page and Myers, 2020). Providing practical support involved taking over household duties, ensuring the mother's needs for food and drink are met, looking after other children, and caring for the new baby (Ingram and Johnson, 2004; Sherriff et al, 2009; Rempel and Rempel, 2011; Nickerson et al, 2012; de Montigny et al, 2018). If the provision of practical support by the father moved away from general household chores it focused on baby care. When the father became involved in baby and infant care it was more likely to include artificial formula milk feeding the baby in an attempt to stop crying and enable the mother to have uninterrupted sleep (Ito, Fujiwara and Barr, 2013). A more recent study by de Montigny et al (2018) suggests that formula feeding the baby can help some fathers have a greater role in care of the baby and this in turn promotes their sense of fathering. Resorting to using artificial formula milk feeding may indicate that many fathers feel unprepared for a support role with breastfeeding. The reasons for such unpreparedness include limited exposure to breastfeeding (Henderson, McMillan, Green and Renfrew, 2011), a view of breastfeeding as problematic or embarrassing due to exposure of the breast both in private and public (Henderson et al, 2011), a lack of knowledge of the benefits of breastfeeding (de Montigny and Lacharité, 2004), experiencing jealousy of the mother-baby bond, and not being aware of the other ways a father-baby bond can be built and maintained (Rempel and Rempel, 2011; Chezem, 2012; Brown and Davis, 2014), and not being able to access the antenatal breastfeeding information when midwives tell the father that breastfeeding sessions are irrelevant to them (Deave, Johnson and Ingram, 2008). Equally, the use of artificial formula milk may be the father following the wishes of the mother to deal with her current breastfeeding wishes or challenges. Radzyminski and Clark Callister (2016) reported that 46% of mothers in their qualitative

descriptive study of 152 mothers in America were both breastfeeding and formula feeding their baby because their partners expressed a concern that if the mother exclusively breastfed, they would be left out of the early parenting experience.

The provision of emotional support focused on anticipation of maternal needs, encouragement, and reassurance (Rempel and Rempel, 2011; Datta et al, 2012; Alianmoghaddam et al, 2017a). This positive and active support demonstrates the father's desire to be part of the parental team as discussed previously (Rempel and Rempel, 2011; de Montigny et al, 2018). A qualitative study by Rempel and Rempel (2011) of 21 Canadian couples explored fathers' perceptions of their roles within the breastfeeding family. The fathers saw themselves as part of the breastfeeding team, being in a supportive role to the mother who was the 'star player'. Fathers in the study by de Montigny et al (2018) saw themselves as both supporters and facilitators of the breastfeeding activity. This joint approach to parenting is valuable in breastfeeding as it highlights the reality that it takes three to breastfeed (Storr, 2003: Tohotoa et al, 2009: Rempel and Rempel, 2011).

As evidence has highlighted that the father is a significant influence on maternal decision-making and mothers prefer to seek breastfeeding support from the father over a healthcare practitioner (Mannion et al, 2013), then there is a need to consider how prepared the father is for this role. As previously identified in section 1.2.2 many fathers feel unprepared for a support role and the challenges a breastfeeding mother may face because they are being not receiving information or support from healthcare practitioners (Barclay and Lupton, 1999; Lee and Schmied, 2001; Sherriff et al, 2009; Sherriff and Hall, 2011; Brown and Davies, 2014; Abbass-Dick et al, 2015; Bennett et al, 2016; Ngoenthong et al, 2020). This lack of information or support to the father may be a result of practitioners' focus on the exclusive mother-baby dyad thus denying fathers' the knowledge they desire, and in turn disempowering a potentially important ally (Moore and Coty, 2006; Sherriff et al, 2009; Mitchell-Box and Braun, 2012; Brown and Davies, 2014). This focus by the healthcare professionals on the mother-baby dyad is understandable given that the mother and the baby are direct recipients of the healthcare monitoring. This mother-baby focus is also the focus of any training the healthcare practitioner receives, such as the UNICEF UK Baby Friendly Initiative training. This training does not have specific content which focuses on how to provide information and support to the father.

The degree to which fathers are involved in actively supporting breastfeeding through emotional support is important. Many fathers may not have a positive attitude towards breastfeeding but are still respectful of the mother's decision (de Montigny et al, 2018). In a UK cohort study by Sullivan, Leathers and Kelley (2004), with 115 first-time mothers and their male partners, they found that breastfeeding was more likely if the father expressed support for breastfeeding during pregnancy. If the father had a greater expectation of exclusive breastfeeding, then the mother was more likely to achieve either exclusive or partial breastfeeding rather than stop and move onto artificial formula feeding (Sullivan et al, 2004). Emmott and Mace (2015) identified in their data from the UK Millennium Cohort study that the presence of the father signalled the provision of emotional support and in turn, this aided mothers to continue with breastfeeding. More recently in America, data taken from the Infant Feeding Practices Study II survey of 2487 mothers from pregnancy to the end of the baby's first year (Wang, Guendelman, Harley and Eskenazi, 2018) identified that these mothers breastfed for longer if they believed that the father preferred exclusive breastfeeding. The authors believed that achieving greater breastfeeding success required the father to be more involved in decisions about feeding and for healthcare practitioners to involve them through appropriate education.

An important aspect to consider is how prepared the healthcare practitioners are in preparing the father for this support role and how confident the healthcare practitioners are in supporting the father to provide breastfeeding support. Providing appropriate support to the father is not simply a case of adding on father-centred care focus to a mother-centred provision; there is a need to consider the importance of overall family wellbeing and engage in family-centred care (McInnes, Hoddinott, Britten, Darwent and Craig, 2013) that acknowledges the role of each member of that family unit. Targeting breastfeeding messages at the father requires the healthcare practitioner to have a positive attitude towards the involvement of the father in breastfeeding support. This attitude may be at any point on a continuum from very interested to total disinterest (Kaila-Behm and Vehvilainen-Julkunen, 2000). A negative attitude may be symptomatic of a need for education and training in how to engage with the father in a more meaningful manner and move away from the mother-centredness of services (Carlson, Edleson and Kimball, 2014). Exclusion of the father conflicts with the underlying principle of the public health strategy in England for healthcare practitioners to 'make every contact count' (Public Health England, NHS England and Health Education England, 2016). This notion of the exclusivity of the mother-baby dyad

appears to be deeply ingrained within healthcare practitioners and fits with societal view of what constitutes women's work in relation to childbirth and early days care encompassing breastfeeding (Mannion et al, 2013).

Having explored the concept of breastfeeding and support, this chapter will now expand on the other concept of confidence.

2.5: Confidence

Perry (2011) claims that the concept of confidence is dynamic in its nature and is highly individualized. This gives rise to a plethora of definitions which reflects Bandura's (1997, p.382) assertion that confidence is *"a nondescript term that refers to strength of belief but does not necessarily specify what the certainty is about."* Oney and Oksuzoglu-Guven (2015) suggest that despite numerous definitions there is still a lack of clarity and consensus. The one aspect on which there is agreement is that confidence is a positive or desirable quality and associated with success (Goleman, 2006).

In section 1.4 confidence was described as a sense of certainty to succeed. The Oxford English Dictionary (2019a, no page) defines confidence as "*the mental attitude of trusting in or relying on a person or thing*" and "*feeling sure or certain of a fact or issue".* These definitions imply that there needs to be a sense of trust and certainty of a person, thing, or issue. This personal sense of trust is reflected in Etheridge's definition of confidence in health professionals as

> *a belief in one's self, in one's judgement and psychomotor skills, and in one's possession of the knowledge and ability to think and draw conclusion.* (Etheridge, 2007, p.25)

In seeking to determine the definition of confidence for this study, it became clear that there are precursors to building and achieving confidence. These precursors are knowledge, experience, support, personal goals, certainty, and trust (White, 2009; Perry, 2011). Both White (2009) and Perry (2011) identify that building and using confidence is also influenced by personal attributes of emotional intelligence, emotional

competence, resilience, positive attitude, self-awareness, persistence, cognitive ability, trust and intuition. These precursors are facilitated by both external and internal influences arising from within oneself or through persuasion from an external source (Rotenstreich, 1972). Gautheir (2010) considered that confidence is also the result of recognising our abilities and boundaries and how we function within those boundaries. Recognition of one's abilities and boundaries are part of self-awareness and are in turn, influenced by the knowledge acquired from external sources (White, 2009; Perry, 2011). These precursors and personal attributes are reflected in Etheridge's (2007) definition above with particular identification of knowledge, certainty, trust, self-awareness, cognitive ability and intuition.

It is common to hear confidence referred to as being either one end of a continuum or the other – underconfident and overconfident. Yang, Thompson, and Bland (2012) suggest that under confidence arises when judgment about performance exceeds actual confidence. A lack of confidence can result in lack of engagement, active avoidance of educational subjects, discontinuation of studies, and expectation of failure (Lundberg, 2008; Sheldrake, 2016).

Overconfidence is the inclination to overvalue knowledge, capacity, or performance (Borracci & Arribalzaga, 2018). Pallier et al (2002) have described overconfidence in the following ways – overestimation of an actual performance either as a one-off or in relation to the performance of others, and as an unwarranted conviction of beliefs or knowledge. Pallier et al (2002) go onto suggest that there is a small association between cognitive ability, personality traits and the accurateness of confidence assessments. Overconfidence can lead to engagement in activities without an appropriate level of knowledge (Clayton, Henderson, McCracken, Wigmore and Paterson-Brown, 2005). In healthcare overconfidence can negatively affect clinical reasoning, decision making and patient outcomes (Holland et al, 2012), as appearing doubtful in front of patients and colleagues is perceived as a failing (Croskerry & Norman, 2008). An additional explanation is offered by Kissinger (1998) who suggests that an overconfident practitioner reduces evaluation of their practice thus missing opportunities for further learning leading to the establishment of a false sense of security.

Gist and Mitchell (1992) suggest that the measurement of confidence appears to be strongly linked to the ability to measure constructs such as self-esteem, expectancy, presence, and self-efficacy. Self-efficacy is the construct that appears to be used interchangeably with confidence in the literature despite it being different. Bandura (1994, p.71) defines self-efficacy as:

> *people's beliefs about their capabilities to produce designated levels of performance that exercise influence over events that affect their lives.*

Bandura (1982, p.122) stresses that self-efficacy is *"…not a fixed act or simply a matter of knowing what to do."* Self-efficacy is also related to how a person discerns their ability to use their cognitive, social, and behavioural skills to determine the best course of action (Bandura, 1982). Bandura (1977) suggested that four factors determined the degree of self-efficacy. These are:

- mastery experience,
- vicarious experience,
- verbal persuasion, and
- personal physiological and emotional state.

Success in personal experience involves performance accomplishment or mastery which in turn leads to an increased expectation of repeated success (Bandura, 1977). This involves gaining cognitive, behavioural, and self-regulation tools to achieve fluctuating situations (Bandura, 1995). Vicarious experience is gained through watching another person undertake the skill (Bandura, 1977). If the perceived similarity of the other person is high then there will be greater impact through the role modelling (Bandura, 1995). It could contribute to the reduction of fear of failure and a more positive expectation for future personal performance. Verbal persuasion acts as a form of external motivation. Positive words from another person can help motivate a person and act as a form of encouragement and can help to strengthen self-belief in success (Bandura, 1995). The final factor that determines the degree of self-efficacy is the personal physiological and emotional state. These states can facilitate or impair the development of self-efficacy by altering the person's receptiveness to learning or attempting the behaviour and the resilience required whilst acquiring a level of ability (Bandura, 1995).

Within the concept of self-efficacy Bandura (1977) identified that a person will undertake a specific activity with two types of expectations – efficacy expectations and outcome expectations. An efficacy expectation involves belief that a person will effectively perform a specific behaviour to generate an outcome, whilst an outcome expectation is the person's assessment that specific behaviour will lead to particular outcomes (Bandura, 1977). To be able to effectively undertake specific activities there needs to be both expectation or belief and specific capability (Bandura, 1977). A high level of self-efficacy enables a person to undertake activities that are challenging and/or require considerable physical and/or emotional energy to complete (Bandura, 1977). It is thought that having a high level of self-esteem can mitigate the stress encountered whilst working to achieve the task (Panc, Mihalcea & Panc, 2012). Self-efficacy permeates thinking, feeling, motivation and action (Bandura, 1995). Self-efficacy regulates personal functioning in four major processes – cognitive, motivational, affective, and selection. As most human behaviour is because of cognition, Bandura (1995) states that self-efficacy enables people to set goals and predict outcomes and weigh up factors that may impede or facilitate success. It is therefore grounded in a more specific reality than the more general notion of confidence. However, self-efficacy can be regarded as a reflector of confidence. Confidence and self-efficacy have the potential for a dynamic relationship, with increasing self-efficacy positively impacting confidence. An increasing sense of confidence can also facilitate a person's perception of their self-efficacy. Demonstration of self-efficacy reflects the more general concept of confidence (Carey and Forsyth, 2009). Whilst both are rooted in belief and expectation, their focus is different.

2.6: Rationale for the study

It is clear from the breastfeeding statistics presented in section 2.2 that whilst women are initiating breastfeeding in the UK, many women face significant breastfeeding issues that cannot be resolved in a timely manner. The solution for many women is to stop breastfeeding entirely, whilst other women will combine some breastfeeding with artificial formula milk feeding, an activity that the father and other family members can be involved with. Many women express regret that they stop breastfeeding before they want to, because of not being able to access the advice and support to overcome their breastfeeding challenge or issue. The father plays an important support role, and it is

clear that mother's value the support that the father/partner can provide during their breastfeeding journey, but that fathers do not feel prepared for this role. Healthcare practitioners focus on the mother-baby dyad, leaving fathers feeling excluded and ignored, and thus ill-prepared for a support role. Mothers have an expectation that information around breastfeeding is also targeted at the father / partner.

Confidence is an important attribute in providing healthcare. Healthcare practitioners are expected to have confidence to undertake the role for which they are employed. From my observations and experience in providing breastfeeding support I became aware that the provision of breastfeeding support to the father was not happening consistently. There is a need to explore whether healthcare practitioners have the confidence in providing breastfeeding support to fathers, thus meeting the needs of the father but also indirectly the breastfeeding mother. There is a need to undertake a review into what is known about healthcare practitioners' confidence in providing breastfeeding support to the father. The next chapter describes the scoping review that was undertaken before the methodology was chosen to conduct this study.

2.7: Conclusion

This chapter has presented an overview of the key concepts for this study - breastfeeding support and confidence. Support for breastfeeding is important to ensure that goals are achieved. The literature relating to healthcare practitioners indicates that they focus their support for breastfeeding initiation and continuation on the mother-baby dyad as they are the active partners in breastfeeding. Breastfeeding mothers' value the support from fathers, however, many fathers may feel unprepared for this role. Healthcare practitioners are also not necessarily engaging with many fathers in a meaningful manner from the fathers' perspective. The concept of confidence has been explored and the difference between confidence and self-efficacy highlighted. Fathers report that appropriate support enables them to undertake this important role. The provision of effective breastfeeding support to the father is not simply a case of adding on a father-friendly version of support provided to a breastfeeding mother. In order to broaden the service provided by healthcare practitioners to include fathers in their own right, there is a need to ensure that healthcare practitioners are equipped with specific knowledge and skills that will meet

the needs of the father, as well as the confidence to use them in a meaningful manner with the father. The next chapter describes the initial scoping review of the literature to ascertain the extent of literature that existed on healthcare practitioner's confidence to provide breastfeeding support to the father.

CHAPTER THREE: SCOPING REVIEW

3.1: Introduction

This chapter explains the process of undertaking a scoping review. When undertaking grounded theory research, it is the custom not to undertake a full review of the literature (Ramalho, Adams, Huggard and Hoare, 2015) as it has the potential of biasing the data collection and interpretative processes (Walls, Parahoo and Fleming, 2010). I chose to use Charmaz's constructivist grounded theory method (2014) for this study (see chapter four). Charmaz (2014) advocates a practical two-stage approach that first accounts for the requirements for scene setting and justification to undertake the study, and then later following data collection and analysis Charmaz (2014) advocates the researcher takes a critical and reflective position to assess and critique the literature in relation to their grounded theory. This critical and reflective position advocated by Charmaz (2014) is important as the researcher brings experiential knowledge to the study and thus cannot be impartial (Ramalho et al, 2015).

In line with Charmaz's (2014) approach, I undertook two major reviews of the literature; the first or initial review identified the scope of existent literature on the focus of my study and the optimal methodological approach. The second review was used to assess, and critique literature related to the results of the data analysis and emerging theory – this is discussed in more depth in chapter eleven.

3.2: Rationale for undertaking an initial scoping review

A scoping review is a method of exploring a general question or a broad overview of a topic rather than finding answers to specific questions, in order to identify the associated/related literature already published and gaps in the literature (Arksey and O'Malley, 2005; Moher, Stewart & Shekelle, 2015). Whilst a scoping review has less depth than a systematic review, it has a broader conceptual range (Arksey and O'Malley, 2005). This made a scoping review suitable in the preliminary stages of this doctoral study. It is standard practice in research that a researcher undertakes a

review of the literature to provide context for the study (Cresswell, 2012). For doctoral studies, there is also a need to demonstrate the gaps in the existing evidence and thus set out to generate new knowledge (Moxham, Dwyer and Reid-Searl, 2013).

Arksey and O'Malley (2005) suggest that the scoping review has four purposes. It enables the researcher to:

- Gain an overview / extent of research undertaken
- Determine the feasibility for a full systematic review
- Achieve a focused synthesis
- Draw conclusions and identify gaps.

This initial scoping review set out to determine the feasibility for my study and check that my doctoral study would have originality. As identified within chapter one, in this study I intended to explore healthcare practitioner's confidence to provide breastfeeding support to the father using a grounded theory approach.

3.3: Methodology of the initial scoping review

Arksey and O'Malley's (2005) framework was selected to guide this scoping review, which was undertaken in January and February 2016. It provided me, an inexperienced researcher, with a logical flow of activities to guide the scoping review. This framework comprises five stages.

- Stage 1: identifying the research question
- Stage 2: identifying relevant studies
- Stage 3: study selection
- Stage 4: charting the data
- Stage 5: collating, summarizing and reporting the results

3.3.1: Stage 1: Identifying the research question

This stage started with the identification of an initial question *'What is known from the existing literature about the confidence of healthcare practitioners in providing breastfeeding support to the father?'*

3.3.2: Stage 2: Identifying relevant studies

To identify relevant studies several activities were undertaken. These were selection of search terms, searching the literature including the use of relevant sources and search techniques, before assessing the results of these searches.

3.3.2.1: Search terms

Four key terms were used for the search – confidence, healthcare practitioner, breastfeeding and father. To ensure the search was thorough synonyms of these key terms were identified (see Table 1).

Table 1: Search terms and their synonyms for scoping review

Confidence	Healthcare practitioner	Breastfeeding	Father
Assurance	Health professional	Breast-feeding	Dad
Belief	Healthcare professional	Breast feeding	Partner
Determination	Health practitioner	Lactation	Paternal
Self-efficacy	Midwife	Infant feeding	Husband
Sureness	Health Visitor		
	Lactation consultant		
	Nurse		
	Healthcare provider		

3.3.2.2: Searching the literature

To undertake a comprehensive review of published primary studies and reviews a strategy using several sources was utilised. This strategy involved searching

- electronic databases
- reference lists
- hand-searching of key journals

Electronic databases

Table 2 identifies the databases that were used. These databases were chosen because of the nature of journals that are included within them. Cumulative Index of Nursing and Allied Health Literature (CINAHL) was the principal database chosen as it relates to a variety of fields of health care focusing on nursing and midwifery, whilst MEDLINE and EMBASE have a more medical emphasis. Due to the inclusion of the concept of confidence PsycINFO was chosen as it contains literature relating to psychological aspects of health care. The Cochrane Library is different to the other databases used because it contains six databases; those most pertinent to this study were the Database of Systematic reviews and the Central register of controlled trials. I initially searched all databases from 2000-2016 and then extended this to any year up to 2016 to ensure a more comprehensive search was achieved.

Table 2: Databases searched for scoping review
Cochrane Library Cumulative Index of Nursing and Allied Health Literature (CINAHL) EMBASE MEDLINE PsycINFO

Reference lists

Following application of specified inclusion criteria (see Table 4), those papers meeting the inclusion criteria had their reference lists checked for additional papers of interest. This was not a successful method of identifying any relevant papers relating to healthcare practitioner confidence in providing breastfeeding support to the father.

Hand-searching of key journals

In addition, a hand search of key journals was undertaken to ensure that no paper had been missed. These journals included Birth, Breastfeeding Medicine, Breastfeeding Review, British Journal of Midwifery, International Breastfeeding Journal, Journal of Advanced Nursing, Journal of Human Lactation, Journal of Obstetric, Gynecologic and Neonatal Nursing, Maternal and Child Nutrition, Midwifery, Scandinavian Journal of Caring Sciences. Papers can be missed due to a delay in updating the database, variation in the key words used to index the paper, and incomplete databases. Again,

this strategy was not a successful method of identifying any relevant papers relating to healthcare practitioner confidence in providing breastfeeding support to the father.

3.3.2.3: Additional search techniques

Wildcard symbols and truncations were also used with appropriate search terms to increase the yield of relevant papers. Examples include midw*, breast*, *feeding, lactation*. With different databases there was a need to adjust the search terms to ensure they were recognised. To optimise the search a berrypicking model (Bates, 1989) was employed. This enabled the search to evolve in response to the results and the associated reflection on the results. Additionally, no restriction was applied to time periods to identify the maximum amount of literature. A record was created of each search undertaken and the results from the five databases (see Table 3).

Table 3: Results from database search for scoping review

	Search terms	Cochrane	CINAHL	EMBASE	Medline	PsycINFO
1	Health professional OR Health practitioner OR Healthcare professional OR Healthcare practitioner OR Midwife OR midwi* OR Health Visitor OR Lactation consultant OR Nurse OR healthcare provider	21,226	452,689	303,026	205,714	147,892
2	Breastfeeding OR Breast-feeding OR Breast feeding OR breastfeed* OR Lactation OR Lactat* OR infant feeding OR infant feed*	7737	25,549	85,395	87,985	7,821
3	Father OR Dad OR paternal OR Partner OR husband	3721	47,664	134,319	107,629	121,890
4	1 + 2 + 3	182	186	163	98	76

3.3.3: Stage 3: Study selection

3.3.3.1: Inclusion / exclusion criteria

In keeping with the rigour of review methodology identification of inclusion and exclusion criteria was applied to assist in the identification of relevant literature (Khan, Kunz, Kleijnen and Antes, 2003). The PEO model was chosen as it is most suitable for use in qualitative research studies. A small modification was made to include additional criteria of type of study and language. The type of study was included in order to filter out opinion pieces and editorials that discussed confidence, support etc in relation to breastfeeding. Restriction of the papers to those published in English was a deliberate choice due to the researcher only speaking English and no budget existing for reliable translation of non-English papers. The inclusion / exclusion criteria are identified in Table 4.

Table 4: Inclusion / exclusion criteria for scoping review

	Inclusion criteria	**Exclusion criteria**
Participant	Health practitioners/ professionals in the UK (includes midwife, health visitor, lactation consultant, nurse, maternity care assistant, midwifery support worker)	Health practitioners/professionals working in NICU/SCBU. Peer supporters
Exposure	Working in the maternity or health visiting services providing breastfeeding support / information to fathers	Not providing any form of breastfeeding support / information to fathers
Outcome	Confidence	Studies that do not focus on confidence
Type of study	Peer reviewed qualitative, quantitative, and mixed method studies	Non peer reviewed qualitative, quantitative and mixed method studies. Case studies.
Language	English	Non-English

These inclusion /exclusion criteria were applied to the 705 studies identified following a search of the five databases. In order not to miss any relevant paper, I applied the

inclusion criteria in a liberal manner when undertaking the title review. This resulted in a total of 17 papers from CINAHL and PsychINFO. The three papers from PsychINFO were duplicates of papers that I had identified in CINAHL (Bergman, Larsson, Lomberg, Marild and Moller 1994; Condon & Ingram, 2011; Sherriff and Hall, 2011). MEDLINE, EMBASE and Cochrane produced no papers at title review. The abstract of fourteen papers from CINAHL database were then read and all were discarded (see Appendix 1 for details). This process is detailed in the following diagram based on the PRISMA statement (see Figure 2) (Moher, Liberati, Tetzlaff, Altman and the PRISMA Group, 2009).

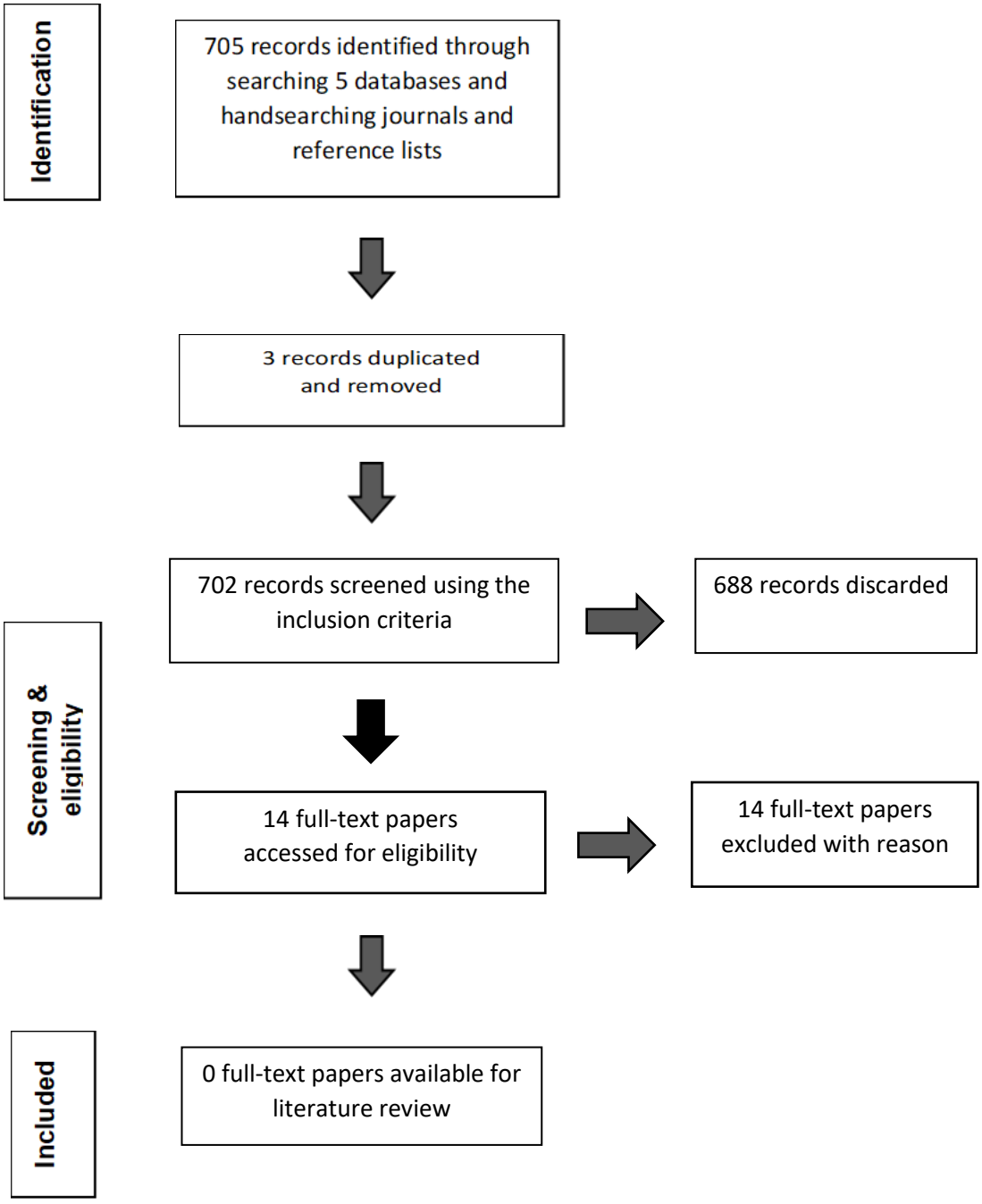

Figure 2: PRISMA flow chart for the initial scoping review of the literature

It was recognised that many of the papers could be useful for background information. The reason for discarding the identified papers was that they did not focus on the healthcare practitioner and confidence. The focus of the papers fell into several categories. A total of six papers were discarded because their focus was on the father, whilst a further three papers had their focus on the mother. Two papers focussed on breastfeeding or related practices, whilst two papers were restricted to an antenatal time period looking at antenatal education or intervention. The final paper was not published in English despite using the limiter of English language in the database searching, and thus was discarded.

3.3.4: Stage 4: Charting the data

This is the equivalent stage to data extraction in a systematic review (Arksey and O'Malley, 2005). No charting was able to be undertaken because no papers were identified that directly addressed the initial question.

3.3.5: Stage 5: Collating, Summarizing, And Reporting The Results

Due to the absence of any identified papers, there was no results / findings to collate, summarize and report. This confirmed a gap in the literature and justified the focus of my study.

3.4: Aim of the study

Due to the lack of studies on healthcare practitioner confidence in providing breastfeeding support to the father identified by the initial scoping review, the aim of this study remained as

> *To explore healthcare practitioners' confidence in the provision of breastfeeding / breastmilk feeing support to the father.*

To aid the development of a theory, in keeping with a grounded theory design, several objectives were defined as follows:

- to identify how and what influences and impacts healthcare practitioners' confidence in practice.
- to identify the social processes and actions that underpinned healthcare practitioner's confidence in practice
- to identify recommendations for training and practice.

3.5: Conclusion

This chapter has presented the process and results from a scoping review that was undertaken at the start of this study journey. It identified that no existing studies were identified and justified the pursuit of the research question. The results of the scoping review helped to determine the research approach and design that was selected for this study. This is expanded on in the next chapter.

CHAPTER FOUR: THEORETICAL METHODOLOGY

4.1: Introduction

In this chapter, I explain the decisions and their rationale in relation to the choice of research paradigm, epistemology and ontology, theoretical perspective, and methodology for this study. The final choices are justified to provide a solid foundation on which to conduct this study. This chapter uses the work of Crotty (1998) which gave me direction and strength as a novice researcher.

In this chapter, I provide an overview of what epistemology and ontology means before I present my epistemological and ontological position. Next, I present the philosophical foundations of research and the theoretical perspective adopted before describing the methodology. In choosing the methodology for this study I have appraised a range of research designs and discussed the advantages and disadvantages I considered for each design in relation to answering my research question. My rationale for the choice of constructivist grounded theory is provided.

4.2: Research paradigm

Research sits within one of two main approaches or paradigms, positivist and interpretivist, that reflect differing epistemological and ontological assumptions about knowledge and reality (Bryman, 2008a; Scotland, 2012). Willis (2007, p.8) defines a paradigm as *"…a comprehensive belief system, world view, or framework that guides research and practice in a field."* Weaver and Olson (2006) recognize paradigms to be means to connect a discipline's requirements for knowledge and its methods for producing that knowledge. Additionally, a multiplicity of terms have emerged within the literature that delineates each paradigm. To make the paradigms more understandable, there has been a simplification of terms into the quantitative and qualitative paradigms.

Crotty (1998) contends that the labelling should not be quantitative or qualitative but one of positivist and non-positivist because the distinction is at the practical level of methods used to collect data. Willis (2007) contests Crotty's view as he suggests that the distinction and thus differences come from their differing underpinning assumptions as the quantitative or positivist paradigm seeks to explain whilst the qualitative or interpretivist paradigm seeks to understand. Weaver and Olson (2006) state that neither paradigm is better than the other, the choice is dependent on the area to be studied. The characteristics of each paradigm will now be briefly explored.

4.2.1: Positivism

Positivism is regarded as the scientific paradigm, conventionally connected to the study of the physical or natural world (Cohen, Manion and Morrison, 2011), and is characterised by an objective view of what constitutes knowledge. Positivism is *"…an approach to science based on a belief in universal laws and attempts to present an objective picture of the world."* (Holloway and Galvin, 2017, p.22). There is an orientation to describing problems, predicting outcomes, or establishing relationships between variables (Cresswell, 2012). Positivism presents truth in factual form due to the cause-and-effect relationship (Scotland, 2012). There is a fixed truth and the means to establish that truth lies in the collection of reliable data that is directly measurable or observable (Ryan, 2018), and is considered to be objective and value free (Bryman, 2008b).

4.2.2: Interpretivism

Interpretivism is rooted in the nineteenth century and draws from philosophy, sociology and social psychology (Holloway and Galvin, 2017). It essentially rejected the central beliefs of positivism (Hammersley, 2013). Interpretivism uses a more flexible design that goes beyond the measurement, analysis, replication and application of knowledge through the positivist paradigm (Streubert and Carpenter, 2011), thus challenging the rigour that characterizes positivist research (Corbin and Strauss, 2015). An interpretivist approach concerns accessing a socially constructed reality by connecting with participants and discovering the world from their perspectives to create a shared meaning, by interpreting data provided by the participants (Willis, 2007: Corbin and

Strauss, 2015). Researchers are able to *"…delve into questions of meaning, examine institutional and social practices and processes, identify barriers and facilitators to change, and discover the reasons for the success or failure of interventions"* (Starks and Brown Trinidad, 2007, p.1372).

As I wanted to understand, what confidence meant for healthcare practitioners and how confidence translated into the provision of support to the father for breastfeeding / breastmilk feeding, an interpretivist paradigm gave me the opportunity to ask questions of meaning and discover the world of the healthcare practitioner in this particular activity. Having identified the research paradigm, I would sit the study within, I then examined the epistemology and ontology.

4.3: Epistemology and ontology

Epistemology is *"a way of understanding and explaining how we know what we know"* (Crotty, 1998, p. 3). Epistemology is concerned with knowledge (Cohen, Mannion and Morrison, 2007), particularly, the ways in which knowledge is created (Markey, Tilki and Taylor, 2014). Epistemological assumptions focus on the creation, attainment, and transmission of knowledge (Scotland, 2012). Knowledge is viewed objectively, as noted in the positivist paradigm, or subjectively within the interpretivist paradigm. Ontology is *"…the study of being"* (Crotty, 1998, p. 10) in terms of the nature and form of reality (Markey et al, 2014), with ontological assumptions centred on the nature and make-up of reality (Crotty, 1998, p.10).

Positivism's epistemology centres on the objective, scientific means of producing verifiable knowledge. To achieve this objectivity, researchers take an impartial and independent position to discover the absolute knowledge about an object that is both factual and descriptive (Scotland, 2012). Positivism's ontological position is one of realism (Scotland, 2012). Realism views objects as independent of those seeking to know the object (Cohen et al, 2007). This independence of the object to the knower relates to the epistemological position of objectivism. Within objectivism both the object and the seeker are independent and the knowledge that is revealed is seeking to explain relationships because the goal of positivism is to determine *"absolute knowledge about an objective reality"* (Scotland 2012, p.10). The key characteristics of

positivism when compared to interpretivism is the pursuit of a verifiable truth, impartiality, and the detachment of the researcher from the subject of the research with the aim to avoid bias (Holloway and Galvin, 2017, p.22).

The interpretivist paradigm's epistemology is either subjectivism or constructivism. Subjectivism is the belief that knowledge is subjective with no external or objective test of its truth (Harvey, 2012-20). Grix (2004, p.83) contends that the world and a person's knowledge of it does not exist independently. Subjectivism is characterized by the rejection of external or objective truth, with no acknowledgment of the interaction between the subject and object (Crotty, 1998). In subjectivism Denzin and Lincoln (2005, p.21) claim that knowledge is *"always filtered through the lenses of language, gender, social class, race, and ethnicity".* Levers (2013) considers that a subjective epistemology sees knowledge as value laden.

The alternative is constructivism in which Kelly, Dowling, and Millar (2018, p.11) consider that constructivism's epistemology focuses on *"the meaning we place on this knowledge".* Crotty (1998) perceives that constructivism focuses on the individual construction of knowledge in contrast to constructionism, which has a shared generation of meaning. Kim (2001) views constructivism as a variant of social constructionism in which individuals generate meaning through their connections with each other and the objects in the environment.

Interpretivism's ontological position is of relativism in which reality is socially constructed, and reality is acknowledged by Bernstein (1983, p.8) as *"…relative to a specific conceptual scheme, theoretical framework, paradigm, form of life, society or culture…".* A relativist ontology asserts that people can have different meanings and interpretations depending on their personal, social and cultural perspectives (Corbetta, 2003). There are multiple realities, which generate unique experiences for the individual, with the individual viewing and interpreting facts from these realities.

4.3.1: My epistemological and ontological perspective

My epistemological and ontological perspective is an amalgam of my life and experiences in a variety of roles – those of being a woman, nurse, midwife, midwifery educator, lactation consultant and now researcher. I bring a lifetime of personal and professional values that have shaped my thinking and practice. At the start of my professional career, I was a sponge absorbing new knowledge and in awe of my tutors. I believed in absolute truth because that was the basis of teaching to nurses and midwives in the 1970's and 1980's in New Zealand and England. As I gained experience as a nurse and midwife, and then started studying for my midwifery degree and then an advanced clinical practice midwifery master's degree, I questioned all that I already 'knew' in relation to the new teaching and my experience. Over the course of time, I came to realise that knowledge was a dynamic and changing entity. It caused me to restructure my knowledge base, retaining some knowledge, reshaping other knowledge whilst discarding further knowledge. My professional roles come with specific values due to the unique culture of midwifery and nursing within the UK. Within my professional roles, I need to regularly review my views and biases, to ensure that I am practising within the framework of The Code (Nursing and Midwifery Council, 2018) for my role as a midwife, and within the Code of Professional Conduct for IBCLCs for my role as a lactation consultant (International Board of Lactation Consultant Examiners, 2015). These codes promote professionalism in all undertakings linked to the roles.

My beliefs about research are summed up by Denzin and Lincoln (2013, p.10) who state that research is:

> *an interactive process shaped by one's personal history, biography, gender, social class, race and ethnicity and those of the people in the setting.*

The first aspect I reflected on was the question 'What is truth?' I concluded that truth is not objective or absolute. This meant that I was rejecting the positivist paradigm and its epistemological position of objectivism. This led me to consider the alternative paradigm of interpretivism. This felt more philosophically comfortable and congruent with my caring roles as a midwife and lactation consultant. Epistemologically I had a choice between subjectivism and constructivism. Due to the lack of acknowledgement between the subject and object, subjectivism did not fit with my personal philosophy.

Thus, I realised that my epistemology is one of constructivism as I view knowledge as a dynamic and changing entity generated through interaction between people and their world. My ontological perspective aligns to relativism rather than pragmatism as I believe that reality is constructed and that many factors shape our reality such as culture, social interaction, psychology, experience, and emotional response.

4.4: The theoretical perspective

A theoretical perspective is a *"…stance that lies behind our chosen method."* (Crotty, 1998, p.7). Philosophical foundations are important for research as they frame the views held, help shape the nature of the research, identify what is seen as meaningful evidence and justify the conclusions that are made (Denscombe, 2010). Handberg, Thorne, Midtgaard, Vinther Nielsen and Lomborg (2015) suggest that a theoretical perspective is an operational mechanism that enables a research field to become more approachable.

In considering the methodological approaches to use for this study that were consistent with an interpretivist paradigm, I also considered the theoretical perspective to ensure there was congruence. Several theoretical perspectives / frameworks are available to provide a foundation. Crotty (1998) includes symbolic interactionism, phenomenology, and hermeneutics, whilst others include feminist theory, post-structuralism and Marxist theory depending on the phenomenon being studied (Morse et al, 2009). Having explored these I decided that symbolic interactionism was the most appropriate as it fitted with a grounded theory methodology. Grounded theory had emerged as the choice of methodology and this is discussed further in section 4.5.

4.4.1: Symbolic interactionism

Symbolic interactionism is a theoretical framework arising from sociology that focuses on how society is shaped and sustained through recurring interactions among people. It takes a 'bottom up' approach to understand the person-to-person encounters that help to explain how society operates (Carter and Fuller, 2015). As a perspective, it is dependent on the symbolic meanings people give to the processes of social interaction (Tie, Birks and Francis, 2019). It arose from the work of sociologists Blumer (the

Chicago School), Kuhn (the Iowa School) and Stryker (the Indiana School) all drawing on the work of Mead. Mead (1934) believed that the social world moulded people and their behaviour so that everybody is a social construction. Blumer devised the term symbolic interactionism seeing it as *"…the peculiar and distinctive character of interaction as it takes place between human beings"* (Blumer, 1969, pp.78-79).

Symbolic interactionism can provide structure and direction to a study because of three basic premises identified by Blumer (1969, p.2) as follows:

> *1. …human beings act towards things on the basis of the meanings that the things have for them;*
> *2. …the meaning of such things is derived from, or arises out of, the social interaction that one has with one's fellows;*
> *3. …these meanings are handled in, and modified through, an interpretive process used by the person in dealing with the things he encounters.*

Symbolic interactionism is a mainstream underpinning philosophy for grounded theory, providing the lens to gain a consideration of social life by gaining *"…an understanding of the processes individuals use to interpret situations and experiences, and how they construct their actions among other individuals in society"* (Carter and Fuller, 2015, p.2).

Symbolic interactionism sees society, reality and individuals as established through interaction and thereby counts on language and communication. This view assumes that interaction is fundamentally dynamic, interpretive, and this is how people create, represent and alter meanings and actions. Charmaz (2008) claims that a key strength of symbolic interactionism is that it is both a perspective / theory and a method, which integrates to create a whole and is particularly relevant in interpretivist research. Within interpretivist research, reflection on experiences facilitates the construction of an interpretation of our world (Bryant and Charmaz, 2007). Crossetti, Goes and de Brum (2016) consider that using a symbolic interactionist perspective within grounded theory research provides for an interpretation rather than a replica of the participant's world.

4.5: Methodology

Methodology is the *"strategy, plan of action, process or design lying behind the choice and use of particular methods and linking the choice and use of methods to the desired outcomes"* (Crotty, 1998, p.3). Within each paradigm there are distinct methodological approaches. In the positivist paradigm the most recognised is that of experimental research (Maltby, Williams, McGarry and Day, 2010). The interpretivist paradigm is richer in the variety of designs available for researchers to consider; these include grounded theory, phenomenology and ethnography (Crotty, 1998). I considered these different methodological approaches to do this study before making my final decision. First, I provide a brief overview of phenomenology and ethnography and why they were considered unsuitable, and in section 4.6 I describe and provide a rationale as to why grounded theory was selected for my study

4.5.1: Phenomenology

As a research methodology phenomenology enables the study of phenomena, which Cerbone (2014) considers corresponds to experience; hence it is commonplace to see phenomenology described as a study of the 'lived experience' (Munhall, 1994). Due to its philosophical roots, there are several 'versions' of phenomenology as a research methodology. These include Husserlian phenomenology which places an emphasis on describing a person's experience without influence from the researcher's conscious thoughts (descriptive phenomenology) (Mapp, 2008), and Heideggerian phenomenology that focuses on interpreting what it means to have the experience by incorporating hermeneutics into the methodology (interpretative phenomenology) (Mapp, 2008), and interpretative phenomenological analysis that has the researcher as the analytical tool to gain description and then a shared interpretation of the experience being studied (Smith, 2004; Smith, Flowers and Larkin, 2009).

Phenomenology was not chosen for this study, as I wanted to move beyond description and interpretation of healthcare practitioners' lived experiences in providing breastfeeding / breastmilk feeding support to fathers. This was because my practice experience as a lactation consultant had already informed me that this experience was frustrating and/or lacking; thus, I wanted to uncover the actions and social processes

that were influencing healthcare practitioners' possession of or lack of confidence.

4.5.2: Ethnography

Ethnography has roots in anthropology and is concerned with understanding culture. Brewer (2000, p.10) defines ethnography as:

> *…the study of people in naturally occurring settings or 'fields' by means of methods which capture their social meanings and ordinary activities, involving the researcher participating directly in the setting, if not also the activities, in order to collect data in a systematic manner but without meaning being imposed on them externally.*

As I wanted to understand what gave healthcare practitioners confidence in providing breastfeeding / breastmilk feeding support to fathers it was not appropriate to consider an ethnographic approach. This is because I did not only want to understand the social meanings and activities of midwifery and health visiting staff in their natural working environment but uncover the processes and understandings behind their behaviour. Charmaz (2006) acknowledges that whilst ethnography provides thick description it does not provide data that can account for actions and processes. Additionally, I felt that I would not be able to use data collection methods such as non-participant observation e.g., the addition of myself within a client's home, or observations at a clinic, could potentially alter the balance of the relationship between either the midwife or health visitor and the parents. Parents accessing healthcare services can expect to meet students working with the healthcare practitioner, but the addition of a researcher has the potential to change the dynamic of the visit or even the relationship between the parent(s) and healthcare practitioner. I was also concerned about the vulnerability of the parents having an additional stranger within their visit, as they may find it difficult to refuse permission for my continued presence. As a midwife I am aware that parents can feel obliged to grant permission as they want to be helpful, even at a time that they may be experiencing additional stress and worry.

4.6: Grounded theory

Grounded theory as a research methodology emerged from the discipline of sociology, and thus because of its focus on both society and/or the individual (Goulding, 2005) is well suited to healthcare research. Grounded theory has origins in pragmatist philosophy and symbolic interactionism; the latter providing its theoretical foundation (Bryant, 2009; Handberg et al, 2015). Sociologists Glaser and Strauss (1967) are credited with the conceptualisation of grounded theory with their initial publication *The Discovery of Grounded Theory.* Their work was considered a breakthrough as it offered another choice to the dominant positivist paradigm and renounced many of the typical positivist practices of the time (Bryant, 2009).

Grounded theory involves a number of techniques including data collection, coding and memo writing, use of constant comparative method, theoretical coding, theoretical sampling, theoretical saturation and theoretical sensitivity (Hood, 2007; Urquhart, 2013). These techniques enable researchers to pursue answers to how, when and why questions as well as probe the meaning of certain behaviours (Charmaz, 2006; Corbin and Strauss, 2008). Grounded theory not only takes the meaning but seeks the processes that give rise to that meaning and this is what differentiates it from other interpretivist designs. It is an organised approach of analysing and collecting data to develop middle-range theories, characterised by inductive inquiry with a comparative, iterative, and interactive method (Charmaz, 2012).

Grounded theory is characterized by a combined approach to data collection and analysis; this is called constant comparison. This method has evolved and refined over the decades but essentially has retained three levels of constant comparison which are identified by Glaser and Holton (2004) as:

1. Codes are compared to codes
2. Codes are compared with emerging categories, and
3. Categories are compared with one another.

It is within the constant comparison of the data that the iterative nature of the methodology is seen. Bassett (2010) indicates that this process requires the numerous methodical reprising of the data until a deep and consistent understanding emerges;

within this process there is both flexibility and an ability to change in response to emerging data until the end point of rich, focused, and relevant data. This coding process enables the data to be opened or broken up and then reconfigured in a more abstract and conceptual form (Mills et al, 2006). In seeking abstraction, the researcher is moving beneath the apparent to pursue implicit meanings (Mills et al, 2006). Since its inception by Glaser and Strauss (1967) grounded theory has evolved, and these different forms will be explored as follows:

4.6.1: Classic grounded theory

Classic grounded theory is associated with Glaser and Strauss (1967). This approach essentially utilised a 'laissez-faire' approach in the conduct of the study and in the development of a theory with the researcher, independent and objective, waiting for the theory to emerge from the data (Kelle, 2005). This 'laissez-faire' approach did not provide detailed guidance on how to use grounded theory as a research method (Hunter, Murphy, Grealish, Casey and Keady, 2011). Further criticism centred on this approach appearing to sit within a positivist paradigm with an objectivist epistemology whilst using a coding procedure that is associated with an interpretivist paradigm (Bryant, 2002; Kelle, 2005). In classic grounded theory the researcher needs to collect the data with an open mind; this means not undertaking a review of the literature or creating questions prior to data collection to prevent against preconceived ideas (Glaser, 1992). Whilst comparative analysis was already embedded in social research, Glaser and Strauss ensured that constant comparison became the key for grounded theory (Urquhart, 2013).

Differing views led to Strauss splitting from Glaser and working on an evolved version of grounded theory with Corbin. These deep differences particularly related to the process for data collection and analysis (Evans, 2013). Glaser believed that the direction Strauss and then Strauss and Corbin were taking grounded theory in was restricting the ability to develop concepts due to the greater degree of structure within the process (Urquhart, 2013). Glaser continued alone with his clarification and promotion of what he perceived as the true grounded theory.

4.6.2: Straussian grounded theory

This was the first evolution of classic grounded theory from its scientific and conceptual origins to one that was more interpretative (Bryant, 2002). Strauss and Corbin (1994) held a relativist ontological position that contrasted with the realist position of Glaser. Strauss also wanted to make grounded theory more explicit to researchers. On his own and then working with Juliet Corbin he refined the coding procedure. This restyling of classic grounded theory took a more prescriptive position by adding more processes to coding and structuring the data (Evans, 2013). The two-stage coding procedure of classic grounded theory became a four-stage procedure (Strauss and Corbin, 1990), and while this was an attempt to make handling the data more explicit, many researchers felt that the reverse happened (Partington, 2002).

A key change in this grounded theory approach was how the researcher was seen to be actively involved rather than the passive observer of classic grounded theory (Hunter et al, 2011). This involvement also extended to how literature was handled. Strauss and Corbin (1990) moved away from Glaser's position of avoiding a review of the literature to take a position that at any stage an 'appropriate' review could be undertaken to stimulate questions and guide theoretical sampling; although with a caveat that the nature of the review should not be so comprehensive as to bias the researcher.

4.6.3: Constructivist grounded theory

Charmaz was a sociology student of both Glaser and Strauss and brought ideas from their teaching to influence how she developed her own version of grounded theory (Rieger, 2019). Charmaz (2006) developed constructivist grounded theory viewing individual experiences as a social construction, thereby differing from the positivist / post-positivist paradigms of the former grounded theory approaches, whilst retaining the purpose of all grounded theory forms to construct a theory. Constructivist grounded theory has a subjectivist epistemology and a relativist ontology (Mills et al, 2006).

4.6.3.1: Features of constructivist grounded theory

Charmaz's (2014) view that research findings are constructed rather than discovered implies a different position for the researcher compared to classic or Straussian grounded theory. A unique feature of constructivist grounded theory is the shared experience between the researcher and participants. This reciprocity, or *"the practice of exchanging things with others for mutual benefit"* (Oxford English Dictionary, 2019b, no page), helps to highlight the researcher's role in interpreting the data. In constructivist grounded theory, the relationship between the researcher and participant moves from one of hierarchy to parity, thus recognising their unique contributions to the construction of the data. The researcher and the participants co-construct the data, as the researcher has to acknowledge *"…that their interpretation of the phenomenon itself is a construction"* (Charmaz, 2006, p.197). Meaning is created due to the mutual interaction between the researcher and participant (Charmaz, 2000). To be able to exemplify the participant voice the researcher takes an emic position as opposed to the etic position seen within classic grounded theory. Emic refers to *"the insider's view of reality"* whilst an etic perspective is *"the external social scientific perspective on reality"* (Fetterman, 2008, no page). Glaser (2012) argued against the promotion of the researcher to such a central position claiming that it created a bias where the interpretation would be forced rather than emerge. This illustrates the different philosophies and practices between Glaser and Charmaz. Charmaz (2014, p.239) states that the resultant theory "*depends on the researcher's view; it does not and cannot stand outside of it"*. Therefore, the researcher's position is not neutral, but fully engaged whilst being mindful of not imposing their own subjectivity in preference to the data. The technique to address the researcher's subjectivity is the use of reflexivity, and it is through the judicious use of reflexivity that the integrity of the data is upheld. Charmaz (2014, p.344) defines reflexivity as:

> *the researcher's scrutiny of the research experience, decisions, and interpretations in ways to bring him or her into the process. Reflexivity includes examining how the researcher's interests, positions, and assumptions influenced his or her inquiry.*

The methods within constructivist grounded theory are less rigid than the objectivist form of grounded theory developed by Glaser and Strauss. Data collection and analysis use a constant comparative approach in line with other forms of grounded theory (see section 5.7). Charmaz (2014) reduced the primary coding process in

Straussian grounded theory back to two steps again – initial or open coding followed by focussed coding. Charmaz (2014) also claims that this coding process is more intuitive and interpretative than either classical grounded theory or Straussian grounded theory. Charmaz's method constructs the meaning rather than waiting for it to emerge, and her approach to coding incorporates the use of gerunds. This is not unique to constructivist grounded theory as Glaser (1978) was writing about how they enable the researcher to remain close to the data and identify the processes. Gerunds are verbs rather than nouns, and enable the researcher to identify actions (Charmaz, 2006). They are identifiable because they end in *ing*.

Theoretical coding in constructivist grounded theory is like that of classic grounded theory. Charmaz (2014, p.150) refers to this as *"…a sophisticated level of coding that follows the codes you have selected during focused coding."* The purpose of this stage of the process is to help theorize the focused codes and demonstrate the conceptual connections between categories. Charmaz (2014) advises against using theoretical codes in an automated manner as it can stifle creativity in abstraction. Constructivist grounded theory enables the development of multiple core categories compared to the single category sought in classic grounded theory.

Another point of difference from classic grounded theory is the review of the literature. Charmaz (2014) advocated the need for an initial review and concurred with Strauss and Corbin that the review of the literature should be undertaken after the theory emerges. Strauss and Corbin (1990) recognised that the researcher was unlikely to be ignorant on the literature concerning the study focus, so considered a review alongside their personal and professional knowledge was appropriate. Charmaz (2014) suggests using the literature to lay foundations in the early part of a study/thesis and then weave in the literature as appropriate, but particularly in discussion of the emergent theory. She claims that having a critical appreciation of the relevant literature aids development of theoretical sensitivity.

4.6.4: Summary of grounded theory

These three approaches to conducting grounded theory are distinctly different due to their differing philosophical positions, but also their different approaches to coding and

their rejection or use of existing literature to frame the study (Kenny and Fourie, 2015). The diversification of grounded theory methods has been criticised with May (1996) claiming it has led to over dilution whilst Becker (1993) saw a lack of adherence to the essential aspects. Latterly Dunne (2011) claims it has led to ambiguity. However, despite the criticisms, grounded theory continues to flourish, as there is common ground in the adherence to the four main tenets of grounded theory. These are detailed by Walker and Myrick (2006) as:

1. The requirement for conceptualisation and theory development
2. Theories need to be grounded and evolve from social reality
3. The researcher must approach the topic with an open mind
4. The use of theoretical sampling

4.7: Choice of specific methodology for this study

Having considered a range of interpretivist methodologies I decided on constructivist grounded theory; this choice was the consequence of many factors. Further to identifying my constructivist epistemological position and my ontological position of relativism, constructivist grounded theory was a logical choice. My position is one of midwife, lactation consultant and midwifery educator working within a university, who has developed a strong passion in all three areas. My observation as a lactation consultant of the difficulty fathers were experiencing in supporting breastfeeding mothers was the catalyst for this study. My role as a midwifery educator identified that the answer to the problem did not necessarily lie in plying the fathers with more information or sources of help but, to examine how they were getting this information. This meant examining the action and processes of healthcare practitioners, whose world I belonged to as a midwife. Being a midwife and lactation consultant gave me an insider perspective that could be both a benefit and a drawback. However, I believed that having an emic perspective of being a midwife and lactation consultant would have advantages over the etic perspective of being a researcher alone. Within professional practice it is now the norm to work in partnership with service users (Department of Health, 2000). It felt natural to work in a more participatory manner in the co-construction of meaning, and thus I was drawn away from the passive, objective and detached researcher characterised in the objectivist grounded theory of Glaser and

Strauss (1967) towards the constructivist approach by Charmaz (2014).

My experience as a midwifery educator and fledgling researcher had identified that the research into breastfeeding support had not encompassed the healthcare practitioners' perspective on confidence in providing breastfeeding / breastmilk feeding support to the father in order to sustain the continuation of breastfeeding in the UK. As a lactation consultant I was experiencing this lack of investment in the fathers. I felt compelled to 'change the world'. As there was no previous research into the identified area and no clear theory that explains the how and why healthcare practitioners are confident in providing breastfeeding/ breastmilk feeding support to fathers I knew that this was an area I could contribute to. Grounded theory methodology is suitable when there is a lack of research undertaken in the area (Charmaz, 2014).

In deciding on the research design to use, I appraised both phenomenology and grounded theory. Phenomenology, and particularly interpretative phenomenological analysis, would have been appropriate to use if I was just looking to document healthcare practitioner's experiences, as it would have given me a rich description. As I wanted to move beyond description and interpretation, it appeared logical to utilise grounded theory as it gave me the opportunity to generate a theoretical and conceptual perspective of the process by which healthcare practitioners gained confidence and explore the processes behind their confidence or lack of it. My passion as a midwife, midwifery educator and lactation consultant in the last stage of my career spurred me onto wanting a 'eureka' moment. Whilst reading related literature, I encountered Star's writing (2007) on living grounded theory and was powerfully impacted by the following statement:

> *I sought a methodological place that was faithful to human experience, and that would help me sift through the chaos of meanings and produce the eureka of new, powerful explanations.* (Star, 2007, p.77)

With constructivist grounded theory I found my methodological place that I hoped would lead me to my eureka of new and powerful explanations.

4.8: Conclusion

This chapter has documented the various aspects I considered in determining the methodology for my study. It was a journey characterised by the weighing of relative merits of different elements of Crotty's (1998) scaffolding and a deeper look into myself as a person, healthcare professional, and researcher. The journey led to me choosing a specific variant of grounded theory; how I then used constructivist grounded theory is described and discussed in the next chapter.

CHAPTER FIVE: METHODS CHAPTER

5.1: Introduction

The previous chapter discussed the epistemological, theoretical, and methodological basis for this study. This chapter describes and discusses the methods used for this constructivist grounded theory study of healthcare practitioner's confidence in providing breastfeeding / breastmilk feeding support to fathers. As identified in section 1.1, I had informal discussions with the key players that this research is focused on – namely the fathers and healthcare practitioners. Patient and public involvement (PPI) in the design and conduct of health-related research has gained greater recognition over the last decade. PPI can provide vital insights to ensure that the experiences of patients are central in deciding what research to undertake and how the research should be undertaken (National Institute for Health Research, 2014; Mann, Chilcott, Plumb, Brooks and Man, 2018; Biggane, Olsen and Williamson, 2019). In the UK it is usual for publicly funded studies to need evidence of PPI (National Institute for Health Research, 2014). Hughes and Duffy (2018) describe different types of PPI including undefined involvement with limited or no involvement, and targeted consultation that is limited and does not involve the nature or design of the study. For this non-publicly funded study I informally spoke to fathers during their attendance at the breastfeeding drop-in clinic I worked within, when I was identifying and prioritising the focus of the study; this may arguably be considered to 'targeted consultation' as described by Hughes and Duffy (2018). As stated in section 1.1, the fathers provided me with feedback of evidence of the variation in the level of engagement and quality of support from healthcare practitioners and provided the foundation and justification of the need for the study. Further involvement of fathers was not considered necessary due to the focus being on healthcare practitioners. The potential for further PPI in future studies is referred to in the recommendations in section 13.5.4.

Due to the nature of my relationship with the participants in this study, I include a section on reflexivity in this chapter. Throughout this chapter where applicable I have illustrated the processes I went through with evidence of reflective extracts, and methodological and analytical memos.

5.2: Participants and setting

The participants for this study were recruited, from either a maternity service (midwives and maternity care assistants/maternity support workers) or a health visiting service within the East of England. I purposively chose these areas due to my work commitments as a midwifery educator and lactation consultant. As a midwifery educator in a local university, I have a working knowledge of all the maternity services linked to the university. I therefore chose the maternity service that I was not visiting on a weekly basis (as a link lecturer[4]) to reduce the impact of my educator role on my researcher role. I work in a specific community area as a lactation consultant, so chose to recruit in another community area where I had no formal links. I hoped that such choices would encourage the healthcare practitioners to talk to me more freely.

All maternity service practitioners were recruited from within an acute Trust service in the East of England, 50 miles north of London. It is a socio-economic, ethnic, and culturally diverse city with a population of approximately 143,653 and an ethnic mix of 66% White British, 11% British Asian and Chinese, 3.2% mixed race, 1.7% Black British, 1.5% White other, 1.4% White Irish and 1.6% other (www.ukpopulation 2018.com). More than 40% of the workforce has a higher education qualification; this is more than twice the national average. The maternity service provides care for the city in addition to a large part of the county and adjacent localities in bordering counties. The annual birth rate is in excess of 5,300 births. As is the norm for England, the maternity service provides care from early pregnancy to labour and birth and then the postnatal period of between 10-28 days after birth before handing care of mother and baby to the health visiting service. This care involves providing postnatal breastfeeding support.

The health visiting service practitioners were employed by a community Trust and were all based within the north of a county in the East of England. This city has a population of 202,110 (www.peterborough.gov.uk). The ethnic make-up of the population is 82.5% White British, 11.7% Asian, 2.3% Black, 2.8% mixed and 0.8% other races. The health visiting service provides a universal health service for all children from birth to

[4] The link lecturer role is designed to provide support to students and their practice supervisors/assessors whilst students are on placement

five years and their parent(s)/career(s) as identified in the Healthy Child Programme (Shribman and Billingham, 2009). The main foci of the service are:

- Contact and support during pregnancy;
- New-born visits at 10-14 days after birth;
- Drop-in clinics;
- Breastfeeding support;
- Ongoing support and advice for health issues for child and their parents;
- Support provided in child's home, general practitioner surgery, health centre, community facility or Children's centre.

5.3: Recruitment

To facilitate recruitment within each Trust, a local collaborator was identified to act as the gatekeeper; in both Trusts, the local collaborator was the Infant Feeding Lead. Following ethical approval from the Health Research Authority and the University of Central Lancashire (see section 5.8.3 for a fuller discussion) and access being granted by the Trust Research and Development departments, contact was made with the local collaborators to brief them about the study and discuss arrangements for recruitment. For the initial recruitment phase, the collaborator in each Trust identified healthcare practitioners who worked in the relevant areas (e.g., postnatal ward, community midwifery teams, and health visitor teams). The collaborator then independently determined which healthcare practitioners to include in this initial recruitment phase and addressed the pre-prepared recruitment packs contained in plain sealed envelopes. This ensured that I did not know which healthcare practitioners were approached, avoiding any possibility of perceived or actual coercion from myself to participate in the study. The local collaborators either sent or took the recruitment packs to the work base for the identified healthcare practitioner. The recruitment pack contained an invitation letter (see Appendix 2 and 3), participant information sheet (see Appendix 4), and consent forms for either an individual interview (see Appendix 5) or focus group (see Appendix 6). The recruitment process was self-selecting, whereby the healthcare practitioners were asked to contact me directly if they would like to participate. Those healthcare practitioners who were interested in participating then contacted me by their choice of a telephone call or email.

Initially I was concerned that for some healthcare practitioners receiving a recruitment pack in person from a staff member in a higher grade or specialist post may put pressure on them to agree to participate. I was reassured that this was not happening as the contacts from healthcare practitioners to myself did not match the recruitment packs distributed by the local collaborators. In total 35 recruitment packs were given to the local collaborators for distribution, and I received nine individual contacts and one contact on behalf of the community midwifery team.

At the initial contact, I reiterated the aims and purpose of the study and if the participant was still willing to participate, I ascertained if they wanted to undertake an individual interview or a focus group. I then arranged a mutually suitable time and place for the interview to take place. Within the maternity service there was a small variation in recruitment, as the team leader of a community midwifery team was approached by the local collaborator and asked to share the study information with her team. All the members of the team (four midwives and one maternity support worker) received the recruitment packs. The community team leader contacted me to say that the whole team wanted to participate and asked if they could do a group interview. Prior to the start of the focus group, I checked that each member of the team had read the recruitment pack, gave them an opportunity to ask questions and then collected the consent forms.

Overall recruitment was challenging, sporadic and slow due to a multiplicity of issues. These included the impact of workload constraints for both the local collaborators and the healthcare practitioners and a period of sickness for one collaborator. In addition, there was a further delay in distribution of recruitment packs in the maternity service due to an external agency assessment occurring within the service[5]. I experienced challenges due to my midwifery educator role workload in being able to contact healthcare practitioners by telephone in a timely manner due to the limited times they may be in an office setting. Contact via email avoided this limitation.

Recruitment of hospital-based midwives for individual interviews was not very successful. I surmised that this reflected a national picture of the maternity services

[5] The maternity service was undergoing an assessment for accreditation of the UNICEF UK Baby Friendly Award.

identified by the Royal College of Midwives (RCM) in 2017. In this report, the RCM identified that workplace stress was a common occurrence attributable to the size of individual practitioner workloads, impact of the shortage of staff, and feeling frustrated at not being able to give the care they wanted to provide (RCM, 2017). I did consider that the healthcare practitioner's reticence could also reflect the lack of support they offered fathers and/or a lack of confidence in providing breastfeeding support to the father; and linked to the stress within their workplaces the healthcare practitioners were reluctant to admit to doing 'less than a good job'.

Following ongoing recruitment efforts and discussion with my supervisory team recruitment stopped after eight months in order to manage the study's timeline. The implications of this limitation to response are discussed further in section 5.5.1.

5.4: Sampling method

In line with grounded theory methodology recruitment, I utilised two sampling methods – purposive and theoretical. Purposive sampling is discussed here, whilst the theoretical sampling will be discussed within the data collection (section 5.5.1) to appreciate how initial insights were shaping recruitment decisions.

5.4.1: Purposive sampling

In the initial recruitment phase, purposive sampling was utilised. Purposive sampling relies on the researcher being able to identify the group of possible participants who are knowledgeable about the topic being researched (Polit and Tatano Beck, 2013). To fulfil the aim of this study, recruitment of healthcare practitioners who were likely to have knowledge about and experience of supporting fathers with breastfeeding/ breastmilk feeding advice and support was necessary. Inclusion and exclusion criteria were developed and applied to achieve recruitment of healthcare practitioners who worked in either the maternity or health visiting services.

Inclusion criteria included:

- English speaking healthcare practitioners working within the maternity service (midwives and maternity care assistants / maternity support worker) providing antenatal and/or postnatal care;
- English speaking healthcare practitioners within the health visiting service (health visitors and nursery nurses) who work with families in the community monitoring child health and development;
- Practitioners aged 18 or older (to ensure that they are working without age-related restrictions within the service and could give direct consent for the study).

The exclusion criteria included:

- Healthcare practitioners in the maternity service who exclusively only work in high-risk antenatal/intrapartum areas e.g., fetal medicine, antenatal day assessment unit, or delivery unit as they would not provide typical antenatal and/or postnatal care to the women and their families.

Purposive sampling provided data for initial analysis that gave rise to rudimentary codes and then tentative categories. As data collection and analysis progressed, and in line with the grounded theory approach adopted for the study, the sampling changed from purposive to theoretical in order to confirm or refute emerging codes and categories.

The next section discusses the data collection utilised in this study.

5.5. Data collection

Data collection is the important stage of the research process to elicit answers to the research questions posed. Flick (2018, p.6) defines data collection within the interpretivist paradigm as:

> *the selection and production of…material for analyzing and understanding phenomena, social fields, subjective and collective experiences and the related meaning-making processes… data collection also is applied to discover and describe issues in the field or structures and processes in routines and practices.*

Within grounded theory, the procedure for data collection is iterative and progresses in response to data analysis (Charmaz, 2014) unlike other designs such as phenomenology or ethnography. Data collection is intertwined with data analysis utilising the constant comparison method as discussed in section 4.6. Data collection and analysis continues until there is saturation of the identified categories that have emerged during the analysis (Charmaz, 2014). In this study data collection was aiming to understand the phenomenon of healthcare practitioner's confidence in providing breastfeeding support to fathers and, to discover and describe the actions and processes behind their confidence. The data collection methods used together with the rationale for my choices are detailed below.

5.5.1: Data collection methods

Bernard (2002) identifies that interviews are a standard data collection method for interpretive methodological designs. However, Lambert and Loiselle (2008) contend that rigour increases when there is clear consideration of the correlation between the aim of the study, the epistemological assumptions of the data collection method, and the insights that are then gained into the phenomenon by that method. In grounded theory research it is accepted, that data collection uses individual interviews or focus group interviews (Charmaz, 2014; Polit and Tatano Beck, 2013). Guest, Nameya, Taylor, Eleya and McKenna (2017) conducted a review of fifteen published papers to assess the merit of using either individual interviews or focus group interviews, or a combination. Their review spanning publications from 1982 to 2016 concluded that, whilst there is no absolute consensus and merit is seen in each method, the concurrent use of both individual interviews and focus group interviews produce comparable data and conclusions. Following considerations surrounding epistemological match, insight into the phenomenon and the technological and practical issues, I decided to offer the participants in this study a choice in data collection - between individual face-to-face interview and a focus group interview; hereafter these will be referred to as individual interview and group interview.

From my experience as a healthcare practitioner, I was aware that practitioners were used to face-to-face encounters in their daily work life, and equally that many of them would have encountered group/team meetings to discuss practice based/service issues. As I recognised that any interview may be stressful to a participant (Vogt, Gardner and Haeffele, 2012) I offered a choice of venue and timing to ensure the participant felt as relaxed as possible. I wanted to make participation as open as I

could and to ensure that healthcare practitioners could choose the data collection format that they felt more comfortable with (Birks and Mills, 2015). I was also aware through my personal experience that some healthcare practitioners think they have little to offer to a research study. I therefore considered that participation in a focus group could offer them an opportunity to participate without being the 'centre of attention' in an individual interview.

5.5.1.1: Venue

When considering the setting for the interview I would use, I took into consideration the NHS as a workplace environment. I was aware that there are many challenges in accessing busy healthcare practitioners in NHS settings due to staffing numbers and workloads. I briefly considered offering the format of Voice over Internet Protocol technologies, such as Skype. I also knew that the midwifery and health visiting services have an almost exclusively female work force, and it has been identified that females may have a less favourable attitude towards the use of technology, either in their belief of its usefulness or their own self-efficacy (Cai, Fan and Du, 2017). This was confirmed during an informal exploration with healthcare practitioners I worked with in my role as a lactation consultant. Following discussions with Information Technologists within my workplace and healthcare practitioners within both the maternity and health visiting services, I decided that the practicality of facilitating such interviews within maternity unit settings and health visitor open plan offices was not technologically, practically or ethically feasible and unlikely to be acceptable to the healthcare practitioners.

All participants chose either an individual interview or a group interview in their workplace; this was from the choice of venue of either their workplace or a local educational institution. This choice was given to promote convenience for the participants and to meet the aim of undertaking interviews in an appropriate social context to create a more 'grounded' study (Wimpenny and Gass, 2000). Either venue was able to offer the participants both visual and auditory privacy so that they could feel able and free to discuss the issues in a confidential setting. I made myself available during early mornings, late afternoons, evening, and weekends to accommodate participants who wished to be interviewed at the beginning or end of their working day, or on a day off. All participants opted to undertake the interview during their normal working hours.

Whilst I am familiar with clinical sites and office settings, I was mindful that I needed to allow myself sufficient time to access the venue ahead of the participants and be ready to engage with the participant when they arrived (while allowing for delays in travel). This was important to show respect to the participants and that they were accommodating participation in the research study within their working day. To achieve this, I ensured I had a full address for the health visitor bases, details of parking, and had undertaken a Google map search for the location and potential routes. On the day of the interview, I checked the traffic conditions noting the presence of roadworks or traffic incidents and planned a departure time that accounted for these conditions. In the maternity unit, my identity badge gave me swipe card access to the birth centre but within the health visiting locality office, I needed to wait to gain access to the health visitors due to local building security procedures. Furthermore, as the participants were in their workplace the priority of delivering the service occasionally meant that there was a delay in starting the interview whilst the participant finished the work in hand.

The venues for the maternity practitioners' individual interviews and group interview was a private room within the birth centre. The maternity practitioners worked in the birth centre or used the birth centre as a team base, making the birth centre a familiar environment. The birth centre room provided visual and auditory privacy during the interviews. I conducted the health visitor interviews in a separate room from their usual open-plan office space at their base. However, this proved challenging as despite a 'Do not disturb' sign placed on the door of a booked room interruptions still occurred. When this happened, I would recap where the participant and myself were at in the interview and allowing the participant to gather their thoughts before proceeding. On listening to audio recording after the interviews these interruptions did not negatively interrupt the flow of the interview with the participant picking up immediately when the interview restarted. The first health visitor interview was in a room immediately adjacent to the open-plan office, which resulted in a lack of visual privacy due to two of the walls of the room being windows. Careful positioning of the chairs helped create a sense of separation from the visual distractions of the main workspace. A reflective memo I wrote after the interview concluded was:

> *I had some concerns about the interview venue – that is the actual physical space I met with the health visitor. It was a separate office adjoining the main open-plan office. The problem was the high degree of visibility due to the*

office being made up of windows on three of the sides of the room. Am I worrying unnecessarily as the health visitor appeared very comfortable in the space? (28/09/17)

5.5.1.2: Individual interviews

Interviews are essentially more than simply asking questions and getting answers. Rubin and Rubin (2011) suggest that interviews are potent and flexible tools that collect rich data necessary for interpretative inquiry. Interviews can be considered as a conversational exchange of views between at least two people on a topic of shared interest (Kvale and Brinkman, 2008). Interviews may appear unsophisticated due to their conversational nature, but this is an illusion, as they require the use of a range of communication skills (Brinkman, 2013). Fontana and Frey (2000) suggest that an interview is a negotiated accomplishment of both the participant and interviewer that is shaped by the context and condition within which it occurs.

Within interpretivist studies, the degree of structure of an interview/focus group can vary with either an unstructured or semi-structured format being favoured (Polit and Tatano Beck, 2013). Semi-structured interviews are the most common as they enable the use of general guiding questions and probes, whilst being flexible enough to pursue noteworthy aspects (Stubert and Carpenter, 2011). Charmaz (2006) considers that semi-structured interviews are a good fit for constructivist grounded theory as this degree of structure enables the researcher to explore the participant's stories in depth whilst probing assumptions, interpretations, and meanings.

Constructivist grounded theory also utilises intensive interviewing with elements of informational and investigative interviewing strategies and the strategy can alter as the study progresses (Charmaz, 2014). The purpose of using an intensive interviewing style is to "…*create and open an interactional space in which the participant can relate his or her experience"* (Charmaz, 2014, p.57). Intensive interviewing is characterized by being participant focused with gentle guidance from the interviewer who uses open-ended questions with the addition of following unanticipated topics, views and actions (Charmaz, 2014). For this study I decided to use a semi-structured intensive style aided by an interview guide so I could stay faithful to Charmaz's methodology and approach all participants in the same manner, whilst still enabling probing of responses

to be undertaken by having the interview guide as an aide memoire (Holloway and Galvin, 2017). My choice of interview structure and format was also guided by my novice status as a researcher and the desire not to waste healthcare practitioners' time by not being able to collect all the data that could be relevant from the interviews.

Interview guides are an important tool in data collection. Creating appropriate and sensitive questions to guide the interview is important (Banner, 2014). Fundamental to obtaining relevant responses is asking the 'right' questions in the beginning (Brayda and Boyce, 2014). Rubin and Rubin (2011) stress the importance of adequate preparation to ensure questions are suitable and not leading. An interview guide was developed which was then was critiqued by my lead supervisor. This led me to revise or discard leading questions and to develop a small number of focused open–ended questions based on the aims of my study (see Appendix 7).

I then piloted this revised interview guide with a colleague, with whom I have a good working relationship and whom I knew would provide a valuable professional critique. This pilot interview provided an invaluable opportunity to receive feedback on the nature of the questions used to initiate the discussion and the probing questions used thereafter, and feedback on my interview skills. My colleague's feedback was very positive and did not result in any changes to the interview guide. I used the same interview guide for both the individual interviews and the group interview. For convenience, this is referred to as an interview guide for both the individual interviews and the group interview.

5.5.1.3: Group interview

The focus group for this study was a group interview (Frey and Fontana, 1991). A group interview is a special type of focus group where discussion is facilitated between the members, in a nonthreatening environment, to gather opinions and views about a topic (Krueger and Casey, 2014). Thus, the group interview can be a combination of group interview and collective discussion (Kamberelis and Dimitriadis, 2013). They are valued for the ability to generate insights into a previously un-researched area (as in this study) due to the synergism, snowballing and stimulation that is possible within a group-based discussion (Stewart and Shamdasani, 2015). A group interview can

facilitate spontaneous interaction between group participants, which enables them to consider and respond to contributions and thus build a richer source of data than is possible in individual interviews (Stewart and Shamdasani, 2015). This may also be in part due to the sense of security a group setting can provide for some participants (Kitzinger, 2006), with less inhibited members 'breaking the ice' for those who appear more inhibited (Wilkinson, 1998). Conversely, the group setting may be restrictive for some participants who feel they cannot express a view that is different to the majority of the group or who feel intimidated by a dominant or opinionated member, leading to either non-contribution or conformity (Carey and Asbury, 2012; Stewart and Shamdasani, 2015).

There is some loose agreement about the optimal number for a focus group to facilitate effective generation of data with variation between four to twelve members (Kreuger and Casey, 2014; Stewart and Shamdasani, 2015). Barbour (2014) contends that a maximum of six to eight members is preferable in social science research compared to the larger numbers utilised in marketing research, due to the volume and complexity of data that can be generated. Kitzinger and Barbour (1999) do suggest that fewer than six members is still viable; a benefit when midwifery and health visiting teams in the chosen localities for my study were less than six people.

The group interview was conducted within an empty room on the Birth Centre. As previously identified the group interview was comprised of five members of the same midwifery team. The initial contact with me had come from the team leader (see section 5.3). Thus, when I arrived at the pre-arranged time for the group interview, I again outlined the aim and purpose of the study, and advised that they would not be able to withdraw their data due to the group-based nature of the discussion. No member of the community midwifery team chose to withdraw from the group interview and all signed consent forms before it started. The birth centre was their meeting point at the beginning of each working day. The group interview was scheduled immediately after the daily planning meeting to distribute the workload and discuss issues. The team leader had generously allocated ninety minutes for the group interview. There were two interruptions during the group interview whilst the team leader had to respond to urgent phone calls, as she was on call, but this did not interrupt the flow of discussion amongst the remaining team members.

The five practitioners in the community midwifery team who elected to participate in the group interview had worked together for many years; this engendered familiarity and an openness with each other. A challenge I encountered arising from the participant's familiarity was how they launched into an interactive discussion immediately I posed the first question. At times, this caused me to feel that I was undertaking 'structured eavesdropping' (Powney, 1988) rather than skilled facilitation. The group appeared so at ease with each other it made it difficult for me to ask probing questions as they maintained a lively and interjecting conversation between themselves. I got the conversation back on track by using several strategies. I used the pauses in their conversation to interject to summarize the discussion to that point to ensure I was correctly interpreting their conversation, or to ask probing questions to expand the discussion. I also used these opportunities to actively direct questions towards members of the group who had not contributed as much to the discussion. Throughout the group interview, I was checking the interview schedule, referred to in section 5.5.1.1, to identify what their discussion had covered and what questions needed to be put directly to the participants. On reflection, I realised that my experience and confidence as a midwife and lactation consultant enabled me to know when to interject and when to let the conversation run. Brinkman (2013) recognises that focus groups can be dynamic and more akin to daily conversations. However, I found similar to others, that the participants familiarity with each other offset the challenge of trying to establish rapport between group members and the risk of some participants not wishing to contribute (Kreuger and Casey, 2014; Stewart and Shamdasani, 2015).

5.5.1.4: Conducting the individual interviews / group interview

After initial introductions had been made, I sought to put the participant at ease by a brief conversation about their working day. Johnson and Rowland (2012) suggest that this 'small talk' is part of a larger strategy to start the conversational style of the interview to create rapport and trust. The opening questions are also important, as is the non-verbal communication - these are discussed below. After a short conversation I then moved the discussion onto the individual interview/ group interview because I was mindful of the potential impact of taking time out of a working day for the participants. I thanked the participants for their willingness to contribute to the study before recapping the purpose of the study and going through the consent form reiterating their rights as participants to ensure they understood all the sections. All participants were then asked to sign the relevant consent form (see Appendix 5 and 6).

Before I started to ask questions from the interview guide, I asked participants to provide detail of their role (not banding) within the organisation (e.g., midwife, maternity care assistant, health visitor) and length of experience in that role. This data was collected as I considered that these factors may be helpful in interpreting the data in relation to healthcare practitioner confidence.

My role as the interviewer was to encourage the participants to talk freely in order to address the topic, to utilise the interview guide to elicit their views on a range of issues, and to pick up and explore additional issues as they emerged (Polit and Tatano Beck, 2013). To facilitate open discussions, I made efforts to appear open, friendly, and supportive from the initial contact through to meeting me immediately prior to the individual interview or group interview commencing. When conducting the individual interviews or group interview, I set out to be respectful, non-threatening and non-judgemental - key skills for any facilitator (Merriman, 2009), with the purpose of providing a platform for the participant's voices to be heard.

The audio-recording undertaken at each interview captured the spoken data and the silences. I am aware from personal reflection that I am a talker, and within my professional role conversations are often constrained by time. I considered that many of the healthcare practitioners I might encounter would also be aware that time is often an issue within the health service. In preparation for interviewing, I had a discussion with my lead supervisor about the perception of silence. That conversation led to me acquiring relevant tips to ensure I was not inclined to jump in too quickly to break a silence, such as 'count to ten, then repeat'. Silences in interviews are a positive feature; Bengtsson and Fynbo (2017) concluded from their studies that silence helps form the continuing creation of meaning within the interview. I found that as I moved through the interviews I relaxed and found it easier to sit back and allow the silences to occur. In the later interviews, I would find myself analysing what the participant had just said and consider the meaning behind their words during such silences.

Just as silence is important, listening is a key skill for the interviewer to have (Mann, 2016). In my professional role I am used to listening to other colleagues, students, and mothers. Despite preparation for the prospect of needing to maintain focus throughout the interview (Mann, 2016), I found that at times I had to concentrate hard. During

each interview I was mindful of my non-verbal communication. I strove to maintain an open body posture and eye contact. However, I was also aware that I needed to ensure I did not distract the participants by using such a degree of eye contact that they might construe as intrusive. Over the course of the early interviews, I honed my researcher interview skills and had an upwards learning trajectory (Johnson and Rowland, 2012) in knowing when to listen, when to interrupt and when to sit back and let the silence do the talking.

At the start of the individual interview/ group interview, after the ice breaker, participants were asked a broad question *'Tell me about your experience of supporting fathers whose partner is breastfeeding or expressing'.* The nature and focus of this opening question was to encourage the participants to recount their experiences in a manner of their choosing. The remainder of the interview was guided by the participant's responses and use of probes and/or clarifying questions such as *'How do you know what information fathers' want?' 'What information do you give to fathers?' 'What do you do to involve fathers in your visits?' 'What training has specifically increased your confidence in addressing breastfeeding with fathers?'*

I found that having the interview guide increased my confidence and enabled me to concentrate on the participants without trying to formulate questions. It took a couple of interviews before I became confident to really probe the responses. A reflective memo I wrote after the first interview showed that in an effort not to talk too much I did not do as much justice to the interviewer role as I could:

> *I listened to the first interview – relieved that the quality of the recording is good. Nice to see that the trial runs and preparation have paid off. More important is the quality of the interviewing skill. I feel that I was too passive – too accepting of the answers –appeared to be grateful for a response. Need to dig deeper and be more challenging / probing. Did I hold back for fear of asking leading questions or too many probing questions? Will be interested to see supervisor feedback. (29/09/17)*

Charmaz (2014) suggests that the interactional space between the participant and researcher in intensive interviewing style enables immediate follow-up on issues and

ideas that arise. As a relatively novice researcher I found it was challenging to know when to follow-up on issues the participant raised, as I was aware of the risk of stopping a line of thought the participant may have been following. This meant that in the early interviews I returned to an issue after a significant period of interaction. Initially this worried me until I listened to the audio recordings and realised that an earlier interruption of the participant's flow could have possibly shut down other contributions.

As the sampling went from purposive to theoretical, to follow up threads that had emerged, I added in different questions to confirm or refute what previous participants had said. An example of such a question is as follows: *'Practitioners that I have previously interviewed told me that their confidence in providing breastfeeding support to fathers is a result of a mixture of their knowledge and experience. What are your views on this?* In addition, I noted that in being responsive to different participants, I changed the order of the probing/clarifying questions; which is an acceptable practice (Britten, 2006; Birks and Mills, 2015).

All individual interviews and the group interview were audio-recorded with the participants consent. The recording device was a small digital recorder and was set up in an unobtrusive location. Audio-recording is an essential part of qualitative interviewing because it enables accurate acquisition of the verbal exchanges between participant and researcher, and the ability to generate an accurate transcript that facilitates data analysis (Silverman, 2006). It enabled me to focus on the participant's responses during the interview rather than note all key points. The presence of a reliable means of audio-recording enabled me to engage in a meaningful conversation without any concerns on accuracy of the data for future analysis.

During the discussions I made brief notes. These notes were designed to be prompts for the probing questions when a suitable pause occurred. I also made notes immediately after the interview as part of my reflexive diary (the use of a reflexive diary in discussed in section 5.7.3). Initially these were general impressions but quickly changed to identifying possible areas to follow-up on in future interviews. They also reflected my growing confidence as an interviewer for example, following the first health visitor interview I noted the following:

I was so concerned about phrasing leading questions and interrupting too much that I appear to have become too passive. It is almost as though I was so grateful to have the first interview scheduled that I forgot I had a responsibility to drive my study forward. (29/09/17).

As I progressed with the consecutive interviewing and data analysis into the theoretical sampling phase, I started to note patterns emerging during the interview. I started to recognise what they were saying in relation to codes I had already created during analysis. This was an exciting step forward in the study as noted in my reflexive diary:

Having been so recently focused on data analysis, I became very excited during the interview today because it is the first interview that I can 'see' patterns emerging in what was being said. I automatically found myself linking the participant's words to a code. It was so exciting to see some real confirmation coming out. Had to then remember to concentrate on what was being said and not on the possible analysis! (09/05/18)

The individual interviews lasted between 25-49 minutes which is appropriate in qualitative research (Polit and Tatano Beck, 2013). The longer interviews were with practitioners who had a greater number of years working in the role. The group interview took 55 minutes to complete.

5.5.1.5: Theoretical sampling

Charmaz (2014, p.199) considers theoretical sampling to *be "…strategic, specific and systematic…",* that aims to seek out and collect relevant data to expound and hone potential categories and facilitate the optimal development of an emerging theory (Polit and Tatano Beck, 2013; Charmaz, 2014). When I started theoretical sampling, I was expecting confirmation of insights that I had already found and had to revise my thinking in order that it became a tool for theoretical exploration. I had to change from basic data gathering to considering what questions I could ask that would explicitly facilitate development of the theoretical categories that I had created. It was at this stage that I changed from induction to abduction (see section 5.7.1). This change was not abrupt but rather a change in the balance between the two (Charmaz, 2014).

In this study, theoretical sampling involved making decisions about which healthcare practitioners to approach in order to confirm or refute the emergent categories identified during the purposive sampling phase. I wanted to use theoretical sampling to ascertain if similar issues were emerging across both the maternity and health visiting services, and to see if the issues were apparent in those healthcare practitioners who were less experienced. A correlation of expressed confidence and experience in the role had emerged during the purposive sampling phase, particularly in the health visiting service where there was a large number of practitioners with five or more years of experience. To create a more balanced sample, I asked the local collaborator to identify health visitors who had qualified in the last 18 months. Despite the local collaborator indicating that a few practitioners were interested, unfortunately none agreed to take part. I considered that this could be due to workload issues that other participants had referred to during their interviews. In relation to the maternity service, theoretical sampling focussed on recruiting maternity care assistants / maternity support workers as I recognised their contribution to breastfeeding support in that maternity service. Through the support of the local collaborator, I was able to recruit a further maternity support worker based in the community. I also recognised that only midwives working within a community setting had been recruited to the study, so I asked the local collaborator to focus on hospital-based midwives, with one midwife contacting me to participate in an individual interview. These two further maternity services practitioner interviews made a small contribution to theoretical sampling. Recognising this limitation, I returned to the existing data to re-examine it in light of the confirmation that had come from the two maternity service interviews. Using this approach enabled me to theorize over my findings, confirm categories, and identify links between the categories.

Towards the end of the comparative data analysis, I approached two health visitors and one midwife to undertake individual data authentication interviews and gained consent from all three healthcare practitioners. I organised and conducted the first data authentication interview to give me an opportunity to analyse my efforts undertaking a data authentication interview before arranging further data authentication interviews. The data authentication interview took place in their workplace. I discussed with them the broad focused codes that were leading into tentative categories. All healthcare practitioners agreed that they were able to relate to the coding and categories that I created. Further discussion of data authentication is in section 5.74.

5.6: Transcribing and storing data

Transcribing is the process of storing audio recordings in a written form so that the data can be coded and analysed in detail (Merriman, 2009). Transcribing is an interpretive activity that is theoretical, discerning and representational rather than a technical process (Bailey, 2008; Davidson, 2009). As transcription can facilitate the building of theoretical sensitivity (Strauss and Corbin, 1990) I elected to undertake the transcription. Brinkman (2013) reasons that transcription should be undertaken as soon as possible after the interview whilst researcher recollections of the interview are still fresh. Overall, I did manage to achieve starting the transcription within a few days, but the occasions when I did not, referring to my reflexive diary for my observations of the interview were helpful. Further discussion on reflexivity is to be found in section 5.7.3.

For this study I drew on the six-stage model by Azevedo et al (2017) of transcribing techniques that consist of prepare, know, write, edit, review, and finish. In order to prepare, the first decision was on transcription style. I decided to use an intelligent style that includes verbatim transcription of the spoken word and inclusion of pauses, non-verbal sounds indicating emotions, interjections e.g., mm, repeated words, interruptions, and encouragement. Within this step I was also able to consider whether I would transcribe off the audio-recorder or download the files to the computer. Control of the audio-recording was superior when using the downloaded version as the computer software enabled a smooth stop and start for the recording thereby ensuring that no information was missed. Step two involved becoming familiar with the recording. Bailey (2008) suggests listening twice before starting transcribing. These listening opportunities helped provide an overall impression of the interview. Step three is the transcribing onto a computer file. The process of transcribing a recording is acknowledged as a time-consuming process requiring approximately four hours for each hour of recording (Stuckey, 2014). Transcribing exceeded this time frame due to my inexperience as a transcriber. Azevedo et al (2017) suggest little attention is paid to punctuation and spelling at this stage as this is addressed in step four, the editing of the transcript. However, this proved challenging to me as a professional where accurate documentation is a requirement to practice effectively (Nursing and Midwifery Council, 2018). Following transcription, I undertook step five – a review of the transcript against the recording to check for accuracy. The final stage involved

discarding the audio recording from the recording device and storing the transcripts in a password protected/encrypted file on the University server. An example of a transcript is in appendix 12.

5.7: Data analysis

Data analysis is a complex process to elicit meaning through extensive consideration of the data to answer the research question (Merriman, 2009). Selection of data is significant because it reflects the underpinning assumptions about what will count as data. In this study, Charmaz's (2014) constant comparative analysis method was used to analyse the data, detailed as follows.

5.7.1: Constant comparative analysis

Constant comparative analysis is *"…an analytical process …for coding and category development"* (Tie et al, 2019, p.3). In Charmaz's (2014) approach concurrent data collection and analysis is used to generate codes and categories by searching for commonalities, contrasts and comparisons. This is an approach unique to grounded theory and sets it aside from the many other qualitative approaches to data collection and analysis (Birks and Mills, 2015). Another feature of constant comparative analysis is that it strengthens the mutuality between participants and the researcher by enabling a co-construction of knowledge (Charmaz, 2014; Fram, 2013). A further strength is that constant comparative analysis, if undertaken faithfully, ensures that all data are systematically compared to all other data to generate inductive analysis and theory building (Charmaz, 2014). This creates a non-linear and iterative process facilitating decision making at two levels - induction and abduction.

Induction is described as *"…a type of reasoning that begins with study of a range of individual cases and extrapolates patterns from them to form a conceptual category"* (Bryant and Charmaz, 2007, p.608). Induction was undertaken on the initial data collection and analysis obtained via purposive sampling. Abduction is defined as *"…a type of reasoning that begins by examining data and after scrutiny of these data, entertains all possible explanations for the observed data, and then forms hypotheses*

to confirm or disconfirm until the researcher arrives at the most plausible interpretation of the observed data." (Bryant and Charmaz, 2007, p.603). In this study abduction was used during theoretical sampling. Charmaz (2014) considers that abduction offers a significant way to interact with the data and evolving analysis.

5.7.1.1: Coding

Coding is at the heart of constant comparative analysis and is the vital connection between data collection and the emergence of a developing theory. Coding is essentially *"…naming segments of data with a label that simultaneously categorizes, summarizes, and accounts for each piece of data."* (Charmaz, 2014, p.111). In constructivist grounded theory codes should show actions and reveal analytic insights rather than revealing a rationale for the action. Initial codes are generated to create an analytical framework that then becomes more defined in the focused coding phase (Charmaz, 2014).

Overall, I was guided by Charmaz's (2014, p.125) strategies for coding, outlined as follows:

- Breaking up the data into their component parts or properties;
- Defining the actions on which they rest;
- Looking for tacit assumptions;
- Explicating implicit actions and meanings;
- Crystallizing the significance of the points;
- Comparing data with data;
- Identifying gaps in the data.

Due to my novice status as a constructivist grounded theory researcher and the lack of specific detail for each of the strategies for coding that Charmaz (2014) suggests, I incorporated some of the elements of Boeije's (2002) constant comparative analysis procedure. I utilised the first three steps of Boeije's (2002) constant comparative analysis procedure for this study, as follows:

- comparison of data within a single interview;
- comparison between individual interviews/ group interview within the same groups (in this study either the maternity service or the health visiting service);

- comparison of interviews from different groups (in this study comparison of the maternity service with the health visiting service).

I included these first three steps from Boeije's (2002) procedure to ensure I did not lose sight of important patterns emerging not only within a specific healthcare practitioner group but mutual patterns across both groups.

I chose to code manually which is unusual in the current technological climate. I explored the use of software to assist the process but decided that it constrained me. I found I was more open to the analytical and inductive requirements of coding using a printed transcript and pen. On reflection I realised that I had made an assumption that the data would feel more natural to me if I was using paper and pen; it appears that I am not alone in this assumption (Rodik and Primorac, 2015). Morse (2011) has challenged the benefit of using computer programmes to code suggesting that faster coding and category development may be at the detriment of thinking time which enables meaningful work to emerge.

5.7.1.1.1. Initial coding

As highlighted above, the first phase of analysis involved initial coding. I commenced coding by reading each transcript line-by-line to identify keywords, terms, phrases, ideas, and concepts. This in turn helped to identify further areas to pursue in future interviews (Charmaz, 2014). My initial attempts at coding were novice and did not build my confidence. On reflection I felt that I was looking for an instant answer, instead of exercising patience to wait for more insightful meanings to emerge. After a period of time reading, and re-reading how to undertake coding and reflecting on my previous endeavours I returned to the data and made a fresh attempt. This analysis was shared with my supervisory team, and they identified that I was actually coding using focused codes as is seen in Table 5. This example demonstrates that rather than defining a code based on the meaning of the text, I was jumping ahead to a more abstracted level of analysis.

Table 5: Example of initial coding and revision		
Transcript excerpt	**Initial code**	**Revised initial code**
Actually, they're really on board at the Antenatal visit quite often.	Engaged father	Father is already on board

I realised I was seeking out the underlying issues which held the dangers of missing the nuances made by participants. After continued practice and ongoing feedback from my supervisors I felt I was starting to make progress. In line with Charmaz's method (2014) I assigned gerunds. Gerunds are essentially verbs ending in *ing*. Charmaz (2014) also favours the use of gerunds to reveal the participants' actions. Initially I found coding with gerunds to be challenging. An example of the use of gerunds is illustrated in Table 6:

Table 6: Example of coding using gerunds		
Transcript excerpt	**Initial code**	**Coding using gerund**
Sometimes, they'll come into the room and then they'll sit and take part in the visit. I try and engage them. It's quite a skilled engagement, if you like, because I don't want them to feel uncomfortable, but I want them to feel included and so it's finding that right balance.	Engaged father: takes part Opportunity to engage Positive attitude towards father	Father taking part Ways of engaging with the father Expressing a positive attitude toward the father

In reality, I found that gerunds were actually restricting my interpretation as the codes appeared contrived and formal. I again reviewed Charmaz's writing and was reminded that *"…the English language favors thinking in structures, topics, and themes rather than thinking in actions and processes"* (Charmaz, 2014, p.124). This helped move my thinking from the hard structure to looking for the possibilities and the inferences. The breakthrough with coding came after attending a two-day constructivist grounded theory workshop run by Charmaz in July 2018. This workshop gave me the opportunity to discuss the challenges I was experiencing, to seek direct clarification from Charmaz and to interact with other researchers. As a result, I felt more able to clearly identify the rationale for using a mixture of descriptive and interpretative codes and using gerunds only if I judged that they were adding to the understanding of the actions.

I again returned to the transcripts and reviewed my initial coding and found that the original constraint of coding using only gerunds was gone because I felt I had been given permission to use a wider combination of descriptive and interpretative codes and gerunds. It also seemed to lift the restrictions on being analytical as I re-read the transcripts. An excerpt from the revision of an early transcript is in Table 7.

Table 7: Example of revision of early initial coding

Transcript	Initial coding	Revised initial coding
I actually think we're really quite poor at supporting fathers, I think we need to be better at it and there needs to be more out there for dads as well. I often when I do an antenatal visit try and encourage that a dad is there so that we can when we're talking about feeding and those sorts of things that Dad is involved right from the beginning. During my antenatals and new births and those sort of things when I talk about baby café and feeding I always invite dads to come along even if Dad is not at the antenatal I try to say to the mums, dads are welcome, come along and suss it all out prior to having your baby for the support. Apart from that I think we're a bit limited really to what else we offer them, I try and just get them involved as much as possible. If I go and do a breastfeeding support visit and Dad is there it's great because I get Dad looking and helping and looking at the attachment and those sort of things and being that second ear so that when Mum's really tired he can be like pull baby in a bit closer, just trying to get them quite involved really as much as they can be because I think their support is invaluable and I don't think we appreciate that enough really.	Poor support for fathers. More needed to support fathers. Encouraging father's presence. Involving father right from the beginning. Encouraging father's presence. Limited as to what offered to fathers. Encouraging father's involvement by getting him to help with breastfeeding support. Father's support is invaluable. Lack of value of father's role.	Identifying lack of support for fathers. Recognising room for improvement Identifying lack of support for fathers. Encouraging father's presence. Involving father right from the beginning. Encouraging father's presence. Offering early preparation of father. Recognising limited options. Providing information as means of encouragement Having a positive attitude towards father's involvement.

It was from this point that I truly appreciated and discovered the joy in uncovering new meaning in the data and started to feel that I was undertaking an iterative, comparative and interactive process (Charmaz, 2014).

5.7.1.1.2. Focused coding

Open coding was followed by focused coding to synthesise initial codes into groups or focused codes that represented the data set (Charmaz, 2014). As identified in the previous section I initially started coding and attributing focused codes. When I had reviewed how I was coding and taking a line-by-line approach instead of a more holistic approach I was able to identify the initial codes. Grouping of those descriptive and analytic initial codes then made it easier to create focused codes. When using an example I gave earlier (see Table 8 below) my first attempt at identifying an initial code was then used as the focused code; the difference was I now had a descriptive initial code to build the focused code.

Table 8: Example of revised initial and focused codes

Transcript excerpt	**Initial code**	**Revised initial code**	**Focused code**
Actually, they're really on board at the antenatal visit quite often.	Engaged father	Father is already on board	Engaged father

5.7.1.2: Creation of categories

Charmaz (2014, p.341) defines categorizing as "*the analytic step in grounded theory of selecting certain codes as having overriding significance or abstracting common themes and patterns in several codes into an analytic concept."* Categories are *"… conceptual elements of a theory"* (Glaser and Strauss, 1967, p.36). The process of constant comparison with its higher levels of abstraction facilitates the theoretical explanation and assimilation found within categories (Dey, 2007).

Merriman (2009, p.185) identifies that categories must meet a number of criteria:

- be responsive to the purpose of the research;
- be exhaustive;
- be mutually exclusive;
- be sensitizing;
- be conceptually congruent.

During the development and refinement of the categories I was constantly comparing the focused codes I had by asking what the data was suggesting. I used abstraction to

see the focused codes in a more analytical and abstract manner. In addition, I used theoretical sampling, and this was discussed in section 5.5.1.5. Initially I deliberated about naming the categories. In an effort not to repeat the conceptual leaps I had experienced with initial coding I sought to create categories that were descriptive and were fully explained by the focus codes attributed to them. Further analysis and abstraction led me to considering the category names in a more conceptual manner. For example, the first category started as 'knowledge related', then moved to 'influence of knowledge' before evolving into theoretically 'in the know'. At this point it also became clearer how a theoretical explanation was emerging.

5.7.1.3: Creation of core category and theorising

Charmaz (2014) does not define what a core category is, beyond perceiving it to be one part of the ongoing analysis of the data. This lack of clarity for a novice researcher led me to seek out definitions from other writers. Madill (2019, no page) considers a core category to be *"… the main theme, storyline, or process that subsumes and integrates all lower level categories in a grounded theory, encapsulates the data efficiently at the most abstract level, and is the category with the strongest explanatory power."*. In attempting to identify a core category I realised that I was trying to force the data. I had taken the initial codes and grouped them into focus codes. Equally I was able to group focus codes into categories. Following intense scrutiny of the relationships between all the categories and how the categories impacted each other, I concluded that I had created multiple core categories. I was expecting that whilst immersed in the writing of the findings chapters, that the physical and cognitive process of writing would augment the analytical and conceptualising process resulting in further refinement (Charmaz, 2014). This further refinement did not happen. Unusually I had four core categories and I was then led into a process of theorising (Charmaz, 2014). Charmaz (2014, p.233) opts for the term theorising as it involves *"…practical activities of engaging the world and of constructing abstract understandings about and within it."* Charmaz (2014) offers an alternative definition of theory that fits with an interpretative paradigm. Charmaz (2014, p.230) suggests that theory *"…emphasizes interpretation and gives abstract understanding greater priority than explanation."* This is in contrast to classic grounded theory (Glaser and Strauss, 1967) which seeks to analyse data to 'discover' a substantive theory that is pragmatic and explanatory in order to understand a specific phenomenon or pattern. Charmaz (2014, 232) suggests that *"…theories are rhetorical…".*

This concept of theorising appears to be a more appropriate fit with constructivist epistemology and relativist ontology that acknowledges that multiple realities can exist. It made me consider how one theory can be an absolute, when it is based on the interpreted and conceptualised views of participants at a particular time and place. However, in light of the limited theoretical sampling I was able to undertake, then a more abstract theorising process seemed more fitting. The results of theorising are presented within chapter twelve.

5.7.2: Memo writing

Memos are a written record of thoughts, ideas and insights whilst undertaking data collection and analysis (Birks and Mills, 2015, Charmaz, 2014). Charmaz (2014) considered memos to be an important tool to aid rudimentary analysis and involve creating informal analytical notes (Merriman, 2009). Memo writing is a pivotal step in a grounded theory study because it facilitates analysis of the emerging data, whilst also steering the analysis from concrete to more abstract (Charmaz, 2014). In terms of the value of memos for grounded theory research, Birks and Mills (2015) expand on this in the mnemonic:

M – mapping research activities
E – extracting meaning from the data
M – maintaining momentum
O – opening communication

As a novice researcher I found this mnemonic a useful framework to shape my activities when anticipating and undertaking memo writing. It provided structure without stifling creativity. Personally, I found writing separate reflexive notes and memos challenging in the beginning. The differences between the two became easier after undertaking further reading on memo writing. As the analysis continued, I started writing memos focused on the coding process. In the early stages I found they were reflective in nature. The following is an example:

Memo: Improving my coding technique 26/01/18
Currently I have been reviewing coding to improve my technique. I have debated again whether to code by hand or use software and considered that for me as a novice I have opted for coding a printed transcript as I feel it keeps me closer to the data. I have re-read about the theory of coding from Charmaz's book as well as others to ensure I am capturing the complete technique. I am looking to capture the key words, phrases and ideas that seem important. I am asking what does this mean? This has led me to consider why it might be important etc. In order to get a fuller sense, I have re-read health visitor transcripts and will be listening to the last interview again in order to identify the questions I need to use in future health visitor interviews.

A further example of a memo emerged whilst I was grappling with focus coding, as evidenced below:

Memo: Grappling with focused coding 16/07/18
I am trying to answer the question Charmaz poses 'What analytic story do the initial codes indicate?' To me they identify practitioners who are committed to their role providing breastfeeding support to the mother and baby that their role requires of them, but they also go beyond this role requirement to include the father. In their provision of care, there is a distinct emphasis on the family unit and recognition of the place of the father. Actually, this is more than place – it is the value of the father. The following initial codes indicate this including both mother and father, promoting father's role, valuing father's role. *This is evident in how they work to include the father by identifying their level of engagement. There is also a time constraint emerging, which is conveyed by how the practitioners engage with the father and assumptions they are operating on. This shows up in initial codes such as presuming father's feelings, presuming father's needs. It appears that they are making their presumptions using their previous experience of working with fathers and what the fathers wanted / needed etc. It appears that in order to use their limited time with fathers the HCPs are starting from a point of reasonable assumption that this father has similar needs to the majority of other fathers.*

I found that I tended to write both short reflexive notes and memos to help me reflect on the development of the coding from the initial code to the focused code, and then into category development. I tried to capture both process and product in the memos. I found writing abbreviated memos directly linked to the transcript text and/or codes helpful to enhance the analytical and interpretative process. Below is an example of a memo as I started to analyse the actions and processes from an excerpt of a transcript.

Memo: Unpacking supporting father 01/12/17		
Excerpt from transcript	**Initial coding**	**Aspects to consider further**
I actually think we're really quite poor at supporting fathers, I think we need to be better at it and there needs to be more out there for dads as well. I often, when I do an antenatal visit try and encourage that a dad is there so that we can…when we're talking about feeding and those sort of things that Dad is involved right from the beginning. During my antenatals and new births and those sort of things when I talk about Baby Café and feeding I always invite Dads to come along even if dad is not at the antenatal. I try to say to the mums, dads are welcome, come along and suss it all out prior to having your baby for support. Apart from that I think we're a bit limited really to what else we offer them. I try and just get them involved as much as possible. If I go and do a breastfeeding support visit and dad is there it's great because I get dad looking and helping, and looking at the attachment and those sort of things and being a second ear so that when mum's really tired he can like pull baby in a bit closer, just trying to get them quite involved really, as much as they can be because I think their support is invaluable and I don't think we appreciate that enough really.	Poor at supporting father More needed for fathers. Encouraging father's presence. Involving father from the beginning. Encouraging father's presence. Limited as to what offered to fathers. Encouraging father involvement by getting him to help with breastfeeding. Father support is invaluable. Lack of value of father's role.	Why are they poor at supporting fathers? Have I missed an opportunity to explore what else could be out there? Do other HCP do this? What other ways do they encourage fathers? Need to follow up if other HCPs have other ideas of support. So this is active involvement – what about the father who does not want to be 'hands on'? How do HCPs encourage father? Is this just the HCP or is this reflected by the mother? So why is there a lack of appreciation of father's role? Is this a widespread opinion?

Other comments:

It appears that there is some criticism here as HV states 'poor at supporting fathers'. Is this just restricted to breastfeeding support – shame I didn't unpack this further. This evaluation of practice is hinted at in the professional literature about the challenges HV's are facing undertaking the mandated visits and an increasing agenda to be completed. Is this simply an acknowledgment of HV focusing on mother and baby whilst trying to maintain some semblance of family-centred care. There seems to be a natural association in HV mind that father's presence at a postnatal visit equates to willingness to be involved. Is this correct – need to follow this up with future interviews. There are some regular words and patterns that are starting to appear – try and encourage, involvement, could be better.

5.7.3: Reflexivity

It is widely accepted that reflexivity is a key component to qualitative studies and has become integral for researchers using constructivist grounded theory as the researcher is a key instrument (Mruck and Mey, 2007). Reading around the topic of reflexivity at the start of this study made me realise with greater insight that I was embarking on a 'journey of learning' as a researcher to be shaped by the research and be a shaper of the research (Palaganas, Sanchez, Molintas and Caricativo, 2017). Dowling (2006) considers reflexivity to be both a concept and a process. To understand reflexivity, I first explored it as the concept and looked for definitions that would help me understand the process I would embark on. I needed to ensure I was differentiating it from reflection which is seen as retrospective thought about an event or situation that has occurred (Rabbidge, 2017). Berger (2015, p.221) suggests that reflexivity is:

> *a researcher's conscious and deliberate effort to be attuned to one's own reactions to respondents and to the way in which the research account is constructed.*

Engward and Davis (2015, p.1532) go further when they state:

> *reflexivity is a process of self-awareness and scrutiny that is bidirectional; it demands an 'other' through which we develop a more self-conscious awareness about who we are as researchers and the decisions we make in the research process and its potential relationship/impact on the other.*

At the beginning of my reflexive journey, I could relate more to the first definition of reflexivity as a concept, but as the journey evolved, I started to use the skills required for the process described by Engward and Davis (2015). Probst and Berenson (2014) suggest that reflexivity starts with a self-awareness of one's subjectivity; this process progresses because of internal processes, which are encouraged by external activities. To begin I had to explore my own assumptions, which was aided by a pre-interview with my lead supervisor. The purpose of this interview was to identify and challenge my pre-suppositions and biases, thus raising my self-awareness in the role of researcher. From this interview, I identified that I needed to stop thinking as a clinician/educator and change to that of a researcher, albeit a novice researcher. It also started to make me think about what I considered knowledge and truth; both of these aided me in the reading and writing of my epistemological perspective.

To achieve the integral requirement of reflexivity I kept a reflexive diary in which I noted thoughts and ideas, achievements and areas that challenged and baffled me throughout the doctoral study. I took some key questions from Finlay's (2012) writing on reflexivity. These included asking myself what I was doing, why was I interviewing or analysing the data in a particular way, and what influence was my approach having on the study. Early in the study I realised that I was naturally reflective, and this was a 'comfort zone' because it was a familiar activity due to my midwifery registration requirements.

I used interview based reflexive notes to record my impressions about the participants, their responses, and my performance. The following is an extract from a reflexive note written after the second interview:

> *So relieved that she was an easy person to talk to. She was such an enthusiastic practitioner – on fire! I felt that the questioning and probing went well today and I remembered feedback from my supervisor after she listened to the first interview. I feel that I am struggling to catch all the different elements that came out – maybe they will not all be this enthusiastic. Did I do her justice? – time will tell. Must not get complacent as each interview will be different. (14/11/17)*

I was comfortable writing reflective accounts following the individual interviews and group interview, but less comfortable writing a more analytical memo about data analysis. This required utilising new skills to achieve a level of reflexivity. After reading a paper by Mantzoukas (2005) I realised that I could become more reflexive by harnessing the self-reflection in a new way so I would acknowledge and make my biases transparent. Probst and Berenson (2014) acknowledge that reflexivity is effectively a critical two-directional observation occurring at the same time.

Reflexivity as a process was enhanced by regular supervision, which enabled discussions that shaped my thinking in relation to the research methodology for this study. The nature of the supervision was ever changing depending on the stage of the study and the stage of my development. Supervision was an important 'sounding board' that helped develop my consciousness about me as a researcher. My consciousness moved my thinking about the study from a position of being a clinician and educator undertaking research, to that of a researcher contemplating how the findings could impact and change practitioners and practice.

Supervision was also a vital platform for sharing interpretations of the data and having additional perspectives to hone my interpretations. As already discussed in section 5.7.1.1.1 I had made a fundamental error in the initial coding stage by creating focus codes; without sharing my coding at this early stage it would have resulted in inappropriate data interpretation. Supervision also gave me ideas that spurred me to review memos I had written and helped to deepen my thinking about every aspect of the study. Throughout the entire journey of this study I worried endlessly if I was being reflexive in the 'right way'.

5.7.4: Data authentication

For this study I chose, after discussion with my supervisory team, to adjust the usual terminology of member check to data authentication. Member check is associated with interpretivist research and is considered to be *"a method of validating the credibility of qualitative data through debriefings and discussions with informants"* (Polit and Tatano Beck, 2013, p.384). Member checking is also referred to as participant validation and is designed to increase the validity or credibility of the research and thus potentially

lead to a conclusion that the study has been undertaken with rigour (Birt, Scott, Cavers, Campbell and Walter, 2016; Chase, 2017; Iivari, 2018). Birt et al (2016) identify that member checking covers an array of activities including the return of interview transcripts to check accuracy of content, an interview or focused group using the transcript or interpreted data or returning synthesised data. They also identify that the member check interviews are congruent with the epistemology of constructivist grounded theory as the researcher and participant are co-constructors. My view of the participants as co-constructors made it more important to consider that they were authenticating the interpretation I had made of the collective data and identifying that it 'rang true' for them.

For this study I chose to conduct data authentication with an interview to check my interpretation of the data. This approach explores whether the synthesised interpreted findings have meaning with the participants (Birt et al, 2016). This avoids the potential for increasing participant discomfort of reviewing individual transcripts as they can experience *"…discomfort and distance from their own words"* (Koelsch, 2013, p.170). Due to several issues surrounding recruitment, data collection and analysis a period of fourteen months elapsed between the first interview being conducted and data authentication starting. I had expected that some participants would experience some difficulty in recalling their contributions in the original individual interviews or group interview. Koelsch (2013) also suggests it is naïve to presume participant subjectivities will remain unchanged throughout the research process. All three participants were happy with the interpretation of the synthesised data and identified that they could relate to the focused codes and categories that had emerged. No new insights were generated from these data authentication interviews.

5.7.5: Saturation

Saturation of categories occurs when *"…gathering fresh data no longer sparks new theoretical insights…"* (Charmaz, 2014, p.213). It relates to when data collection is not generating 'new' codes or categories but rather continuing to fit within particular codes and categories already identified (Olshansky, 2014). Due to the limitations I experienced with theoretical sampling (as discussed in section 5.5.1.5), my interpretation of saturation could only be considered tentative. As a result, I had to draw on the data authentication interviews I have already discussed and discussion

with my supervisory team. The participants and my supervisory team offered reflective and theoretical consideration of my categories and emerging theory. Olshansky (2014, p.22) claims that deciding when theoretical saturation is achieved *"is a judgment call".*

This notion that saturation may not be as precise as desired is reflected in Dey's (1999) contention that the terminology is imprecise, and he would prefer the alternative terminology of theoretical sufficiency. Hennink, Kaiser and Marconi (2016) claim that to achieve saturation researchers need to obtain data saturation and meaning saturation. They define data saturation as *"…the point when no additional issues are identified"* and meaning saturation as *"…the point when we fully understand issues, and when no further dimensions, nuances, or insights of issues can be found."* (Hennink et al, 2016, p.594). They contend that data saturation will occur sooner than meaning saturation. In this study I had to accept the tentative interpretations I made.

5.7.6: Achieving rigour / trustworthiness

Cooney (2011, p.18) argues that *"…process and product must both be considered when judging the credibility of a grounded theory study."* Such credibility is measured as trustworthiness rather than being linked to 'truth' or 'value' that characterises quantitative research (Chiovitti and Piran, 2003). For qualitative research findings to make a trustworthy contribution, there needs to be attention to the entire conduct of the study (Birks and Mills, 2015). Birks and Mills (2015, p.180) define rigour as the *"control of the processes employed in a research study in order to accommodate or explain all factors that can impact on, and thereby potentially erode, the value of research outcomes."*

In qualitative research Lincoln and Guba (1985; 2000) suggest that to evaluate the worth of a study, an examination of its trustworthiness is necessary. Trustworthiness involves a number of criteria - credibility, transferability, dependability and confirmability, in order to achieve similar purposes of internal and external validity, reliability, and objectivity that assess the rigour of quantitative research. Within constructivist grounded theory Charmaz (2006) refers to the alternatives of credibility, originality, resonance, and usefulness to establish the trustworthiness of the research (see Table 9). There is an important interplay between all these criteria proffered by

Charmaz (2006, p.183) as she identifies that *"a strong combination of originality and credibility increases resonance, usefulness, and the subsequent value of the contribution."*

Table 9: Comparison of criteria to assess rigour		
Quantitative paradigm	**Qualitative paradigm**	**Constructivist grounded theory**
Internal validity	Credibility	Credibility
External validity	Transferability	Originality
Reliability	Dependability	Resonance
Objectivity	Confirmability	Usefulness

5.7.6.1: Credibility

Charmaz (2014) refers to credibility as the degree of 'fit' between the claims made and the data they emerged from. I have made every effort at all stages of the research process to remain credible to the methodology. This has entailed identifying and exploring my biases, with my lead supervisor, prior to data collection and analysis. I have described the methodology in this chapter, both in terms of the participants and setting, and the process of data collection and analysis. Charmaz (2006) suggests that a first step towards achieving credibility is to have a familiarity with the data so that the essence of what the participants share is captured. During the process of data collection and analysis there was numerous returns to the data to check out the analysis, as well as sharing my interpretations with my supervisory team and being open to their challenges. I also shared my interpretations with three of the healthcare practitioners to be credible to the concept of co-construction which is an integral part of constructivist grounded theory. They identified the results of the data analysis as credible. The complete process of data collection and analysis followed by conceptualising and theorising has been an ongoing interaction trying to stay credibly close to the meanings conveyed by the participants and my own interpretation. The construction of the theorising of the interplay between confidence and practical wisdom is my attempt to portray the data with as much credibility as possible.

5.7.6.2: Originality

Originality refers to the degree to which the findings offer new insights (Charmaz,

2014). This study is the first of its kind and thus can claim originality as no previous study has explored healthcare practitioners' confidence in providing breastfeeding / breastmilk feeding support to the father, as I previously identified in chapter three. The original contribution made by this study is not spectacular but illustrates that the tension between the art and science of care provision is very real.

5.7.6.3: Resonance

The third criteria is about how the theorising resonated (Charmaz, 2014) with the healthcare practitioners. Those healthcare practitioners who chose to participate in the study felt resonance with the research question from the start. During data authentication interviews, those healthcare practitioners noted that the key findings resonated with them.

5.7.6.4: Usefulness

This final criterion refers to the contributions that can be made to the everyday lives of people (Charmaz, 2014). This became evident as I was undertaking the interviews. Many practitioners started to regard the provision of support to the father in a new light, partly because this was the first opportunity that they had to reflect on how they were using opportunities with the father and what they were providing to the father. My hope is that this study will generate a new conversation amongst healthcare practitioners and the service to determine how to provide a service that is meeting the needs of fathers and their wider families in our society. It is also hoped that this will lead to a fresh way of considering confidence in practice and enable supportive measures to be accessed and utilised to increase or enhance confidence.

5.8: Ethical considerations

This section discusses the ethical considerations I took in the planning and conduct of this study. While the process of ethical approval is fundamentally designed to protect participants from harm it is important that any research study is designed and conducted with key ethical principles in mind (le May and Holmes, 2012). The participant's interests were central to the design and conduct of this study, and were in line with Webster, Lewis and Brown's (2014) belief that good ethical research involves

anticipating and planning for the unexpected and working in a thoughtful and reflective way that always promotes the welfare of the participants before the interests of the researcher.

5.8.1: Ethical frameworks

Beauchamp and Childress's (2013) ethical framework of beneficence, non-maleficence, respect for autonomy (through informed consent, confidentiality, anonymity), and justice were used in the design of this study. Beauchamp and Childress (2013) argue that these principles should be demonstrated at all stages of the research study in order to ensure good and uphold the participant's welfare (beneficence), not doing any harm (non-maleficence) and balancing the burdens and benefits of research (justice). Embedded in these ethical principles is the respect for autonomy of participants through informed consent, confidentiality, and anonymity (Beauchamp and Childress, 2013). These principles in themselves do not offer overt direction in qualitative research (Hewitt, 2007). I had to interpret these principles in the context of my research study to address the potential for increased vulnerability to bias arising from my qualities and attitudes as a researcher, and the potentially more intrusive nature of qualitative interviewing (Hewitt, 2007).

In addition, I was also aware of the National Health Service Health Research Authority (NHS HRA) consultation on the United Kingdom Policy Framework for Health and Social Care Research (NHS HRA et al, 2017); this framework officially launched in October 2017 just after I started data collection. It contains fifteen principles that benchmark how non-interventional health and social care research should be conducted and managed within the UK (see Table 10).

Table 10: Principles that apply to non-interventional health and social care research (NHS HRA et al, 2017)	
1	Safety
2	Competence
3	Scientific and Ethical Conduct
4	Patient, Service User and Public Involvement
5	Integrity, Quality and Transparency
6	Protocol
7	Legality
8	Benefits and Risks
9	Approval
10	Information about the Research
11	Accessible Findings
12	Choice
13	Insurance and Indemnity
14	Respect for Privacy
15	Compliance

The origins of the principles in the NHS HRA framework and Beauchamp and Childress' (2013) ethical framework can be traced back to the Nuremberg Code of 1947. Since the Nuremberg Code there have been numerous publications designed to protect research participants as researchers, academics, politicians and the general public came to understand how harm could occur. Such publications are generated from the Council for International Organisations of Medical Sciences (2001), the Council of Europe (2005), the World Health Organization (2011b) and NICE (2013).

In the next section I highlight how Beauchamp and Childress's (2013) four ethical principles and the requirements of the NHS HRA were addressed in the context of my study.

5.8.2: Addressing ethical concerns

5.8.2.1: Respect for autonomy

In this study respect of participant's autonomy commenced in the recruitment process. I used a local collaborator to identify appropriate healthcare practitioners to receive recruitment packs. This indirect method of recruitment removed the potential of healthcare practitioners feeling compelled to participate when recruited by a researcher in a face-to-face setting or via a telephone call; it also enabled them to choose their preferred method of contact (i.e., email or telephone) with me. There was no deadline given for a response, which was a deliberate measure to ensure that there was no undue pressure placed on healthcare practitioners. I was aware that the participant's perceptions of my role as a researcher could influence their responses, as recognised by Holloway and Galvin (2017). However, it is also appreciated that interviewing peers can enable a more reciprocal relationship between the participant and researcher (Holloway and Galvin, 2017).

The participant information sheet (see appendix 4) and consent form (see appendix 5 and 6) also identified the voluntary nature of participation in the study and that all participants had the right to withdraw at any point after they started with an individual interview or group interview. There was also a period that elapsed between arranging the date and venue for the individual interview / group interview, and the actual data collection event. This gave the participants an opportunity to change their minds. Before interviews or the focus group started, I again checked that participants were happy to proceed and reiterated that all participants had the right to exercise their autonomy by choosing not to answer any questions I asked.

5.8.2.2. Informed consent

Informed consent reflects the principle of respect for autonomy and entails participants being fully informed of the purpose of the research, including the potential benefits and risks, without implicit or explicit pressure or inducement from the researcher before making a voluntary agreement to participate (Holloway and Galvin, 2017). It is a widely accepted practice to obtain signed and informed consent from all participants (Bryman, 2012).

In this study informed consent started in the recruitment phase. Within each recruitment pack was a detailed participant information sheet (see appendix 4) containing all relevant information in terms of aims/purpose, risks and benefits, voluntary nature of participation, confidentiality, and the right to withdraw, to enable the practitioner to determine their interest in the study. As outlined in section 5.3 the recruitment packs were distributed by the local collaborators and there was no time limit for a response to be sent. All participants opting for an individual interview chose to contact me by email. The time frame between receipt of recruitment pack and responses received demonstrated that few participants needed to deliberate over their decision, as all responses were made within a few days of receipt. The natural time lapse between agreeing to participate and data collection due to workloads also provided participants with a cooling off period. At the start of data collection in individual interview / group interview, I verbally reiterated issues within the participant information sheet and consent form including the aims of the study, right to refuse to answer any question or stop the individual interview / group interview, right to withdraw and allowed opportunities for all participants to ask questions. All participants were asked to sign a consent form to confirm they understood the basis of participation. No participant withdrew at any stage of the process. My approach to gaining informed consent from each participant is congruent with the 'ethics as process' framework (Cutcliffe and Ramcharan, 2002) in which the researcher ensures that participants give consent freely and from a fully informed viewpoint. Participants were also asked if they would like to be included in data authentication interviews. Those participants who were approached and agreed to take part in data authentication interviews, were asked again at that point if their previous written consent to this activity was still viable.

5.8.2.3. Anonymity and confidentiality

In order to promote anonymity, I avoided the labelling of any audio-recording or transcript with the participant's name. An identifier that related to the practitioner group and participant number was used e.g., H HV1 with H referring to the health visiting service and HV1 referring to health visitor 1. At the start of each individual interview / group interview audio-recording I stated the date. Transcripts were labelled with both the date and healthcare practitioner identifier. The linking of participant name and study identifier with date of data collection and their consent form was maintained separately. Prior to starting the recording, I emphasised the need to avoid using names of any colleague or patient/client; this was achieved. Following the individual interview / group interview, the audio recordings were downloaded as soon as possible

onto password protected/encrypted university computer files, and then deleted from the audio-recording device once the transcript had been completed and verified.

All data was kept secure and confidential. This was achieved by keeping paper documents (i.e., consent forms, paper copies of transcripts) in a locked filing cabinet and all digital data (i.e. digital files of transcripts and analysis files) stored in password protected/encrypted university computer files. No data was shared out of the research team (i.e., myself and my supervisors). The paper copies of consent forms were kept separately to the transcripts to reduce the linking of healthcare practitioner to transcript. In accordance with the University of Central Lancashire's requirements, data will be retained for up to five years after completion of the study on the University's secure server and then destroyed.

5.8.2.4: Beneficence

The principle of beneficence means doing 'good' in the sense that the research has to be helpful to the majority of people. The study must be conducted in a way that benefits those involved (Nieswiadomy, 2013). In my study the participant information sheet outlined that while there were no direct benefits to the healthcare practitioners, there were several possible secondary benefits. First, their involvement meant they were contributing to a research study that addressed an under explored area. Second, the potential for the findings to impact on future practice and preparation of practitioners for this aspect of their role. Finally, it could give NMC registered practitioners the opportunity to reflect on their practice and complete a reflective account form to contribute to their revalidation[6].

To remain focused on the principle of beneficence to my participants rather than the end product of a doctoral thesis, I employed reflexivity to consider my role as a researcher and my obligations to the participants. Taking such a reflexive stance towards the process enabled me to build a relationship with participants that would enable sharing of information based on trust, focus on participant priorities, and respect of their experiences (Townsend, Cox and Li, 2010).

[6] Revalidation is a requirement of registered nurses, health visitors and midwives every three years by the NMC. The practitioners need to demonstrate that they have remained current by having evidence of 450 hours practice hours, 35 hours of continuing professional development, five pieces of practice-related feedback and five written reflective accounts before having a reflective discussion with their confirmer (Nursing and Midwifery Council, 2019a).

5.8.2.5: Non-maleficence

To promote non-maleficence, all participants could exercise their autonomy as they had choice over participation and the place of individual interview / group interview in order to ensure that they felt as comfortable as possible. In addition, to do no harm, I gave consideration to the respect for and promotion of their autonomy by ensuring I obtained informed consent, and maintained anonymity and confidentiality, as discussed in section 5.8.2.3. These measures discussed in section 5.8.2.3 also promoted non-maleficence by ensuring no harm could come through inappropriate access to participants' details or data.

During the individual interviews and group interview I was mindful of observing for any distress from the participant(s) and was prepared to stop and/or terminate the individual interview / group interview if distress had become evident. I also had contact details for support mechanisms within both Trusts related to occupational health counselling service, professional organisation counselling services or the NHS Psychological Wellbeing services. None of the participants appeared distressed during the interviews despite reflections of what they might be doing differently in their interactions with fathers (as opposed to mothers) or the relative lack of interaction with the father.

I was also alert for the possibility of the revelation of poor practice during an individual interview / group interview. In such an event I had planned to encourage the participant to raise concerns with their manager and if I considered this would not be done, contacting the relevant personnel in accordance with the responsibilities of my Nursing and Midwifery Council registration. As a professional registrant, I have a professional code to follow (Nursing and Midwifery Council, 2018) which requires me to prioritise people, practise effectively, preserve safety, and promote professionalism and trust. As a researcher I saw these four areas relating to the ethical principles as outlined in Table 11. There was no disclosure of poor practice by any healthcare practitioner.

Table 11: Relation of ethical principles to Nursing and Midwifery Council Code (2018)	
Ethical principles	**Aspects of the NMC Code**
Respect for autonomy	Prioritise people
Beneficence	Practise effectively
Non-maleficence	Preserve safety
Justice	Promote professionalism and trust

If a participant had any concerns or complaints about this study the participant information sheet advised them to contact my supervisors in the first instance. They were also able to contact the University Officer for Ethics at the University of Central Lancashire. No concerns or complaints were received by my supervisors.

5.8.2.6. Justice (balancing burdens and benefits)

The principle of justice means treating people in an equal and fair manner (Orb, Eisenhauer, and Wynaden, 2000). Cognisant that I was aspiring to interview busy healthcare practitioners I wanted to reduce the burden by giving them a choice of interview venue and time, as I discussed in section 5.5.1.1. To enable the healthcare practitioners to manage their workloads efficiently I offered them a choice of which day of the week and time of the day suited them. Interviews were set up in advance, often by one to two weeks, in order not to add to their workload stress. On arriving at the venue, I always checked again with them if the time was still convenient. One interview had to be rescheduled due to the healthcare practitioner needing to take time off for her sick child. I only became aware of this when I arrived at the venue as I had begun my journey before the email was sent. To reduce stress, I emailed back the same day to reiterate that I understood the situation and was happy to reschedule at her convenience. I left it up to the healthcare practitioner to suggest a new date; she did so within a few days.

5.8.3: Ethics and governance approval

Ethical approval for this study was sought through the NHS HRA (IRAS ID 217149) and through the University of Central Lancashire's Science, Technology, Engineering, Medicine and Health (STEMH) ethics sub-committee (STEMH 649). NHS HRA

approval was granted in May 2017 (see Appendix 8) followed by University approval in June 2017 (see Appendix 9). Evidence of indemnity was supplied by the University of Central Lancashire. Following NHS HRA approval, access was granted by the NHS Community Trust for the health visiting service in June 2017 (see Appendix 10) and by the NHS Hospital Trust for the maternity service in July 2017 (see Appendix 11). This involved submitting NHS HRA approval to each of the Trust Research and Development departments to satisfy their requirements before they issued a letter confirming Capacity and Capability and then a letter of access. I was also granted a research passport to enable me to conduct interviews with staff on Trust premises. As part of this approval, I undertook the online Good Clinical Practice course provided by the National Institute for Health Research as well as Trust Induction requirements to permit me access to their premises and staff. This induction involved attendance at a Welcome to the Trust Day in the Hospital Trust and undertaking online modules for the Community Trust. In addition, I completed the lone worker risk assessment for the University of Central Lancashire; the purpose of such was to minimise any health and safety risks to myself.

5.9: Conclusion

This chapter has detailed the process I undertook to collect and analyse data for this constructivist grounded theory study. It has provided the rationale of my choices and decision making at every stage from planning the recruitment of the healthcare practitioners to the final stage of theorising. The next five chapters now present the results of my analysis.

CHAPTER SIX: INTRODUCTION TO THE FINDINGS

6.1: Introduction

This chapter is the start of series of chapters that present the findings of my study. There is an overview of the participants, and detail of their role, length of service in the role and participation in UNICEF UK Baby Friendly Initiative Training. An overview of the focused codes and how they were synthesised into four categories is then described. The four categories are then presented in chapters' seven to ten, whilst the substantive theory is discussed in chapter twelve.

6.2: Study participants

Thirteen participants were involved in the study. Table 12 provides an overview of the participants characteristics.

Table 12: Details of study participants						
Participant pseudonym	**Role**	**Time in role**	**BFI training**	**Ethnicity**	**Gender**	**Personal history of breastfeeding**
Kay	Health Visitor	5 years	Yes	White Caucasian	Female	Yes
Cora	Midwife	20 years	Yes	White Caucasian	Female	
Mia	Midwife	6 years	Yes	White Caucasian	Female	
Chantel	Midwife	11 years	Yes	White Caucasian	Female	Yes
Amy	Midwife	4 years	Yes	White Caucasian	Female	
Fay	Maternity support worker	9 years	Yes	White Caucasian	Female	
Nora	Health visitor	5 years	Yes	White Caucasian	Female	Yes
Penny	Health visitor	15 months	Yes	White Caucasian	Female	Yes
Lucy	Health visitor	3 months	Yes	White Caucasian	Female	
Viv	Maternity support worker	3 years	Yes	White Caucasian	Female	Yes
Annie	Health visitor	3 years	Yes	White Caucasian	Female	Yes
Beth	Midwife	12 years	Yes	White Caucasian	Female	
Belinda	Health visitor	29 years	Yes	White Caucasian	Female	Yes

Overall, six health visitors and five midwives registered with the Nursing and Midwifery Council in the UK and two maternity support workers took part in this study. All participants were female, and the length of service ranged from three months to 29 years.

6.3: Presenting the findings

As identified in the previous chapter I analysed the data utilising the constant comparative method from eight individual interview transcripts (six health visitors, one midwife, and one maternity support worker) and one group interview transcript (four

midwives and one maternity support worker). This analysis produced 207 initial codes which were reduced to 11 focused codes. As described in sections 4.6.3.1 and 5.7.1.1.1 it is common to use gerunds in the coding process for grounded theory as they reflect the participants actions. This use of gerunds then continued into the naming of the focus codes as I wanted to ensure that the participants actions were reflected at this level of the analysis. Ongoing analysis and abstraction then created four categories (see Table 13).

- Confidence comes from having and using knowledge;
- Confidence comes from having and gaining experience;
- Tuning into the father;
- The challenges of providing breastfeeding support to the father.

Table 13: Summary of focus codes and categories

Focus codes	Categories
The influence of training	Confidence comes from having and using knowledge
Knowledge generates confidence	
Confidence comes from work experience	Confidence comes from having and gaining experience
The influence of personal breastfeeding attitude and experience	
Lack of experience with breastfeeding support	
Understanding and valuing the father's perspective	Tuning into the father
Using strategies to engage and encourage the father	
Challenge in providing a service to fathers	The challenges of providing breastfeeding support to the father
The lack of a formal breastfeeding strategy and resources for the father	
Recommendation for training	
Recommendation for practice	

Consideration of the data led me to consider what integrated these four categories into an overarching theoretical interpretation of how the participants were able to provide

breastfeeding support to the father. This work led to the substantive theory of 'developing and engaging practical wisdom through use of self'.

The four categories (and their associated focussed codes) are presented in four separate chapters; 'Confidence comes from having and using knowledge' (chapter seven), 'Confidence comes from having and gaining experience' (chapter eight), 'Tuning into the father' (chapter nine) and 'The challenges of providing breastfeeding support to the father' (chapter ten). The order of the categories does not imply any hierarchy of importance. My aim is to present my co-construction of the participant's contributions to the interviews in a rigorous, authentic, and meaningful manner. The findings are supported by quotations from the participants; the quotations represent the ordinary, everyday insights into their interaction with fathers and families. The participants are identified by their assigned pseudonym and role to aid clarity. These quotations are used to support the analysis and interpretation of the data, and to ensure that the participant's voice is appropriately represented. In some examples the quotations have been edited to only include relevant text to support the presentation of the category. The breaks from the original text are indicated by the presence of an ellipsis (…).

In most interviews, it was not unusual to find that a response focusing on their interaction with fathers often strayed to include the mother and baby. This made interpretation a challenge and attention to the context of the discussion was necessary to maintain a focus on fathers to address the aim of my study. This point will be discussed in greater depth in chapter eight when presenting findings related to 'Confidence comes from having and gaining experience'. The predominant focus on the mother appears to reflect the organisational and professional culture these healthcare practitioners are working in; with these issues discussed further in chapter ten.

6.4: Conclusion

This chapter has introduced the participants and the four categories that emerged from analysis of their data. The following chapters now reveal each of these categories in turn starting with the first category 'Confidence comes from having and using knowledge'.

Chapter Seven: FINDINGS – 'CONFIDENCE COMES FROM HAVING AND USING KNOWLEDGE'

7.1: Introduction

This chapter presents the first of the finding's categories - 'Confidence comes from having and using knowledge'. This category was constructed from two focused codes:

- The influence of training
- Knowledge generates confidence

The presentation of these findings initially focuses on the UNICEF UK Baby Friendly Initiative training the participants received and then their ongoing updating within their employing organisation. The chapter will then move onto show how the healthcare practitioners used their knowledge to generate confidence.

7.2: The influence of training

This section presents the data that reflected the influence of training provided to healthcare practitioners. Principally, the healthcare practitioners' formal knowledge about breastfeeding and breastfeeding support was acquired through the formal two-day UNICEF UK Baby Friendly Initiative training, and therefore will be the first point of discussion. The discussion will then move onto the influence of the mandatory updating sessions on breastfeeding provided by the employing organization. Some healthcare practitioners had attended other training courses or used other strategies to supplement their knowledge, and these are also discussed.

Training of all staff is a key aspect of the UNICEF UK Baby Friendly Initiative standards (UNICEF UK Baby Friendly Initiative, 2017). The content of the course is designed to educate the practitioners on breastfeeding and common problems faced by breastfeeding mothers and babies and how to facilitate effective breastfeeding (UNICEF UK Baby Friendly Initiative, 2017). All participants were working within an

organisation that was fully accredited; thus, they had all received the Baby Friendly Initiative training either as part of the accreditation process or when they took up employment with the organisation after accreditation had been awarded[7], regardless of whether they had completed the course whilst a student.

The general opinion amongst the participants was that the UNICEF UK Baby Friendly Initiative course was a good starting point to gain confidence in providing specific breastfeeding information and support because it increased their knowledge base:

> *We have a two-day baby friendly course* [in the Trust] *… I definitely remember coming out of the initial two days knowing stuff that I didn't know before, and also probably feeling a little bit more confident about some things as well. So, yeah, certainly the initial two days definitely improved my knowledge.* (Beth, Midwife)

Lucy, a newly qualified health visitor, was able to reflect on her recent experience of having undertaken the breastfeeding course and summarised that the course gave her:

> *…a lot of good training with breastfeeding and …the norms of breastfeeding…I've definitely got a lot of knowledge around that…I think if things are going wrong and there's no obvious cause for that I might feel a bit uncomfortable.* (Lucy, Health visitor)

The UNICEF UK Baby Friendly Initiative course was perceived as adequate for the basics. Whilst the healthcare practitioners were able to recognise the positive value of the course as a good starting point, some of the participants raised specific limitations in relation to the depth of the training, the focus on mother and baby, and the lack of inclusion on learning about how to support fathers. Annie, a health visitor, showed perception about the needs of parents for breastfeeding information and her ability to provide such information. She also reiterated her own limitations due to the lack of depth of her knowledge base:

[7] Prior to 2012 services were accredited after assessment of the Ten Step programme for maternity services or the Seven-point community plan. After 2012 the accreditation was based on meeting the UNICEF UK Baby Friendly Initiative Standards (UNICEF UK Baby Friendly Initiative, 2017).

> *Being a nurse there's loads of stuff I don't know about it* (breastfeeding)*, so how can I expect the mums and dads to know all of this. I have a need for more education so I can pass it on.* (Annie, Health visitor).

Penny, another health visitor, recognised that the UNICEF UK Baby Friendly Initiative course had not "*…honed it (*her knowledge*) further. I think it's just repeated what I already knew."* Penny was different to other health visitors, as she had undertaken health visitor training after working as a community nursery nurse. Thus, she had brought knowledge acquired from that role with her. Penny also identified that the Baby Friendly Initiative training course she received did not promote opportunity to reflect on personal knowledge, assumptions, and prejudices about breastfeeding and breastfeeding support:

> *I think that's a massive gap as well because I think one without the other – the training and the experience – without actually getting in touch with how you feel personally on that level…I know it can be very intrusive but it's also quite healing to reflect on it. I think the fact that we don't touch on that and look at that …I've never been asked to do that, and I think that's a massive void in our training.* (Penny, Health visitor)

This view about the lack of depth was also reflected by Nora, a health visitor:

> *I don't think we do it* (breastfeeding) *in depth enough as a health visitor…I just think there is no emphasis on the father's role at all in anything we do and I think even in our training… there's a lot more to it than two days of training.* (Nora, Health visitor).

Nora's contribution highlights the mother-baby focus of the UNICEF Baby Friendly course. This was also reiterated by other health visitors such as Lucy:

> *I'm not sure any of it dealt with how to support fathers. I think in general we talk about how to support mums with breastfeeding, but not specifically fathers with breastfeeding.* (Lucy, Health visitor)

For some of the healthcare practitioners the gaps within the UNICEF UK Baby Friendly course were also not filled by the regular updating sessions run within their organisations. The answer for the highly motivated participants was to use their own initiative to seek out alternative sources of information to extend their knowledge of breastfeeding support beyond the remit of the mandatory training within their employing organisation. Nora, a health visitor, is one example. She undertook a year-long specialist course of monthly study days to help her prepare for the International Board Certified Lactation Consultant examination[8]. The course was undertaken at weekends outside of her usual workplace and was not a requirement for the role she was undertaking. Despite this being a specialist course, Nora highlighted that whilst there was some training on how to support fathers, this was still a small part of the content, and left her feeling unprepared as a practitioner:

> *I did my two-day UNICEF* (course) *a while ago, but I don't remember there being anything about supporting fathers. We did do more about it through my breastfeeding specialist course; there was a day on not just fathers but … families ...but again it was in the grand scheme of a year's course was a fairly minimal part, though it did come up whereas I don't remember it through UNICEF at all… I don't think I've had enough training myself on how to support dads.* (Nora, Health visitor)

Other healthcare practitioners identified that gaining knowledge of providing breastfeeding support was not restricted to formal training courses. For Penny, a health visitor, having a personal interest in breastfeeding was a strong motivator to independent learning having "*researched it myself"*. Penny's knowledge about supporting the father and his role in breastfeeding support came from her own initiatives as she identified that she *"didn't think it's* [the father's role in breastfeeding and support] *ever been discussed* (in UNICEF UK Baby Friendly course or mandatory training)*."* Such personal research enabled motivated healthcare practitioners to have knowledge of specific resources that could help when providing support to fathers; for instance, Penny was aware of resources such as the Fatherhood Institute and would use this knowledge when providing support:

[8] This examination is the entry point to an internationally recognised qualification and assesses the knowledge and skills required to support breastfeeding mothers and babies. To be eligible to sit the examination every candidate must satisfy the entry criteria of a health sciences and lactation specific education along with a minimum number of lactation specific practice hours determined by the entry pathway followed.

I try and get dads involved in that way and I do point them to the Fatherhood Institute. Some dads like to read stuff like that. (Penny, Health visitor)

Belinda also illustrated how personal interest and motivation aided her education; in her case through "*academic reading"*. She considered this an important facet to her being able to provide the best care for the families in her caseload, and felt that it had increased her confidence in being able to support fathers to provide breastfeeding support to their partner:

As I had nothing from updating sessions on how to provide support to the father, my knowledge about the need to and how to support the father came from my academic reading that I picked up along the way.
(Belinda, Health visitor)

Following the initial UNICEF UK Baby Friendly course, training to update breastfeeding knowledge and skills was provided from within their host organisations via mandatory BFI updating. In the maternity service this involved a one-hour update during the annual in-service training and a further one-day update every second year. Healthcare practitioners appreciated these training opportunities as they helped to increase their knowledge by acting as "*a little bit more of a refresher".* While not all healthcare practitioners attended these training sessions with enthusiasm, they still recognised their worth as identified by Mia:

You go to those (training sessions) *and think, Oh, all-day breastfeeding study day, but you normally always come away with something. You think, Ooh.*
(Mia, Midwife)

Due to the suspension of breastfeeding specific mandatory updating sessions, the health visiting staff had not been able to access up-to-date information through workplace sessions. This suspension was a consequence of the significant workload pressures and shortage of staff experienced by the health visiting service. The combination of the stress of these workload pressures and staff shortages also may have had a negative effect on the attitudes of some of the participants when the updates were running. Nora, a health visitor, noted that colleagues did not have the same degree of enthusiasm for breastfeeding updates as they juggled competing

interests in their limited time: *"I think some people think 'oh here we go again, more breastfeeding training'..."*.

Attendance at training did not automatically generate confidence, it was the acquisition of the knowledge and reflecting on how it could be used and using it that made a difference. The next section focuses on how knowledge generates confidence.

7.3: Knowledge generates confidence

All the participants identified the positive impact of having knowledge about breastfeeding. They identified that having knowledge and the understanding of when and how to use this knowledge was important to practice in an evidenced based manner. This knowledge base also gave the healthcare practitioners the ability and confidence to explain issues and situations to fathers and mothers as described by Chantel:

> *…you need to have the knowledge* [of breastfeeding]*, you need to have the rationale of it to be able to explain and be confident*
> (Chantel, Midwife)

Other healthcare practitioners identified that having knowledge and being able to explain breastfeeding information in a confident manner was an important part of generating confidence in both the father and mother. Many of the healthcare practitioners recognised that some fathers (and their partners) relied on information provided within their family and friends' network. However, as this information was not always up-to-date, or evidence based, it was important that parents received the "*correct information"*'. This meant that the validity of the practitioner's knowledge was important in providing the best care as acknowledged by Kay:

> *I'm confident that the information that I'm offering is valid and that the woman and the father deserve that. You know they have the right to have the correct information rather than like what's been passed down to them… I'm quite confident talking about that now but it's partly experience, but I'd say more the knowledge base… get the confidence in the knowledge means you can deliver it with confidence.* (Kay, Health visitor)

All the healthcare practitioners expressed feeling confident in dealing with aspects of breastfeeding advice and support in the first few weeks after the birth when the issues or problems were those covered by the UNICEF UK Baby Friendly course, such as positioning and attachment issues and frequency of feeds. The healthcare practitioners were also more likely to encounter these issues more regularly and thus were more familiar with them. However, when faced with unfamiliar situations or problems, such as the older breastfeeding baby, some of the healthcare practitioners had limited theoretical knowledge or practical experience, to provide the appropriate care and support. Such limitations of knowledge can be explained by the focus of the UNICEF UK Baby Friendly course on the neonate[9] rather than the older baby (UNICEF UK Baby Friendly Initiative, 2017).

In these situations, the healthcare practitioners often sought help from colleagues as described by Lucy, a recently qualified health visitor:

> *If things are going wrong and there's no obvious cause for that I might feel a bit uncomfortable and ask someone else for support and that's more things that are kind of further down the line of breastfeeding so as baby gets older as opposed to the early days where things tend to be around positioning and attachment. I think I've definitely got a lot of knowledge around that* [positioning and attachment] *but yeah as time goes on and baby's start to do these things that nobody can sort of predict and then it gets a bit more difficult to work out.* (Lucy, Health visitor)

Lucy's example demonstrates the important interplay between knowledge and experience. Those healthcare practitioners who had limited knowledge on how to support certain aspects of breastfeeding that were not regularly seen in practice, were the practitioners who had limited experience, either in terms of number of years or a caseload that did not present breastfeeding issues frequently enough to build / enhance their knowledge base. The issue of experience is presented in the next chapter.

[9] A neonate is a baby in the first 28 days after birth. (Tiran, 2017)

Participants considered that having confidence in the quality of their knowledge base was important, as some of the participants identified that not all fathers reacted positively to the information passed onto them by the healthcare practitioners. The participants considered that fathers may not react positively if the information challenged their beliefs about breastfeeding or knowledge gained from other trusted family and friends. Such *"challenging conversations"* were also often related to the promotion of artificial formula feeding by the father when the mother was not in agreement. This was not an easy situation as described by Kay:

> *I'd say the most challenging is when you get a father or anybody who is important in that woman's life who doesn't really value the breastfeeding and… they're actually talking all about formula feeding, and obviously there is nothing wrong with that if that's what that mother has made the decision to do as well, but normally that decision is influenced heavily by the partner, by the dad, so if he's talking about that and saying "you know, you've not got enough milk, you know, baby should not feed every hour. You need to give them a bottle". Then that's a really challenging thing… I would definitely talk to that father about it but obviously that's more of a courageous conversation than a happy joyous one; it's not this happy proactive father, it's a challenging situation to manage, isn't it?* (Kay, Health visitor)

Kay's sense of confidence appeared to stem from her knowledge of wider infant feeding issues, including the psychosocial context for infant feeding choices, and a confidence to have a *'courageous conversation'* to advocate for the mother and the baby. Kay was just one example of an experienced healthcare practitioner who referred to how knowledge was a critical foundation in having conversations with the father about breastfeeding and how to support the mother and baby. However, what emerged from across the participant's experiences was that it is more than knowledge; it is the healthcare practitioner's willingness, motivation, and belief to have these conversations that provides the framework within which to utilise their knowledge base.

This critical foundation did not just draw on theoretical knowledge to provide breastfeeding support to the father but also knowledge of how and when to use fundamental practical skills. The acquisition of practical skills, along with knowledge, was believed to be needed to have the confidence to provide effective breastfeeding support for the mother and the father. Chantel reflected this view:

> *Skills help you initially but then… it's a mixture of both* [knowledge and skills]. (Chantel, Midwife)

Some of the healthcare practitioners identified how fathers sought solutions to problems and therefore "*a solution-focused* [practical approach]" tended to be well received. Practical breastfeeding skills were generally used in the first few days or weeks after the baby's birth. Such skills focused primarily on positioning and attachment of the baby at the breast. The healthcare practitioners referred to how they would provide the fathers with knowledge and share practical skills that would enable them to become more involved in *"hands-on"* support to the mother and baby; the ultimate aim was to empower them to be more confident in providing effective support and encouragement to the mother. Such an example was given by Nora:

> *If I go and do a breastfeeding support visit and Dad is there it's great because I get Dad looking and helping and looking at the attachment and those sort of things.* (Nora, Health visitor)

As illustrated in Nora's quote above, the use of knowledge of key practical skills in supporting breastfeeding, such as conveying the main aspects to the father was an important part of engaging the father whilst also providing effective care for the mother and baby. In this example, the healthcare practitioner was able to use and relay specific knowledge to the father so that he had the skills to assess the effectiveness of the baby's attachment at the breast.

The healthcare practitioners use of their communication skills were also central to them being able to engage and convey information and skills-based training to the father. Healthcare practitioners referred to how they would observe the non-verbal communication from the father, such as "*their facial expressions", "they may lean forward"* in order to make a judgment as to the willingness of the father to be involved or included. The healthcare practitioners then used these observations to generate physical acts to aid communication and engagement. Examples of engaging the father included physical acts by the healthcare practitioners such as "*turn and face Dad to try and draw him into the conversation"* or inviting him to join the mother and baby through to asking him direct questions such as *"Dad, how's everything for you?" "Do you have any questions?'' "What is it you want to know?"* The use of these communication skills

is presented in further detail in chapter nine with the results of the category 'tuning into the father'.

Some of the healthcare practitioners perceived the interpersonal skills to effectively engage and communicate with the father to be a highly skilled activity, as referred to by Penny:

> *It's quite a skilled engagement, if you like, because I don't want to make them* [the father] *feel uncomfortable but I want them to feel included and so it's finding that right balance.* (Penny, Health visitor).

As referred to earlier in this section (7.3), communication with the father may take courage by the healthcare practitioner. When discussing this issue Kay went onto identify that courage can arise from confidence in both the quality of the knowledge shared and how it needs to be communicated:

> *…I think the more knowledge you gain around breastfeeding… you get more confident that you know the advice that you're offering…I'm not going to cram that down someone's throat… I'd say more the knowledge base, get the confidence in the knowledge means you can deliver it with confidence to the father.* (Kay, Health visitor).

Confidence also appeared to stem from observing how their use of knowledge produced a good or positive effect with the father, as described by Nora:

> *He* [the father] *wasn't in the room at the time and I asked "who is your support?, who do you lean on?" and she* [the mother] *did make a little comment that…dad wasn't overly supportive. So, he came back in with his coffee and just sat down. I …asked mum to show me how she was feeding…and just got dad over and tried to explain to him. I just pulled him into the conversation really, to get him looking and explain to him you know that although we're focused on mum and the issues going on, that actually he could be really involved in this and help out and not feel like he's just at the side and actually he was really good, He was a bit reluctant and he wasn't too keen to start with but I just kind of kept the conversation going and asked him to look at different things and showed him little things like trying to point out the slight drop in the jaw….The next time I*

went things were so much better and he greeted me at the door and he just was a little bit more involved …he was showing an interest and that little family unit was better and I think he'd been up doing a little bit more through the night (Nora, Health visitor).

7.4: Conclusion

Knowledge of breastfeeding was a central foundation in building and having confidence for the healthcare practitioner to provide breastfeeding support to the father. This knowledge for breastfeeding support was aided by the UNICEF UK Baby Friendly course, and the mandatory updating from their organisation. Although there were some healthcare practitioners' who considered that this course did not have the depth or breadth required to meet their needs in practice. In particular, the role of the father and how the father could be provided with knowledge and skill to provide breastfeeding support was not addressed.

The healthcare practitioners who were highly motivated found other ways to gain such knowledge such as through self-directed reading. Their insights also indicated that theoretical knowledge alone was not enough, as there was a need for practical as well as communication skills. The combination of theoretical knowledge and practical skills equipped the healthcare practitioners to develop and have confidence to engage with the father. Confidence grew when the healthcare practitioner was able to use their theoretical and practical knowledge to good effect, thus gaining experience in delivering information and support. This influence of experience on the development of confidence in providing breastfeeding support to the father will be explored in the next chapter.

CHAPTER EIGHT: FINDINGS – 'CONFIDENCE COMES FROM HAVING AND GAINING EXPERIENCE'

8.1: Introduction

As noted in the previous chapter, knowledge was a valued foundation to a healthcare practitioner's confidence and is closely related to the experience of using that knowledge in practice. This chapter will focus on the second category 'Confidence comes from having and gaining experience'. In the context of this chapter, experience is defined as the *"…knowledge of and skill in something gained through being involved in or exposed to it over a period of time"* (Pearson, Field and Jordan, 2007, p.33).

This category was constructed from three focused codes:

- Confidence comes from work experience
- The influence of personal breastfeeding attitude and experience
- Lack of experience with breastfeeding support

Experience will be discussed from several perspectives. The first of these will be the work environment both as a student and then as a practitioner before considering the influence of personal experience. Finally, the lack of breastfeeding support experience will be considered.

8.2: Confidence comes from work experience

The healthcare practitioners in this study viewed gaining experience in their working environment as a natural progression following acquisition of knowledge. They considered that experiential based learning was essential to develop, instil and integrate the theoretical-based knowledge within their practice. Nora highlighted:

> *I think you need the experience to instil the knowledge. So, I think if you've got the knowledge that's underpinning what you do, it's then gaining that experience…* (Nora, Health visitor)

Healthcare practitioners generally gained some of their breastfeeding knowledge whilst a student midwife or student health visitor. Experienced-based learning then continued during the mainstream activities of the role of midwife or health visitor, or within their more specialised role e.g., maternity support worker with a remit of breastfeeding support, or within a specialised practice arena such as Baby Café. These different avenues of acquiring experience will now be discussed.

8.2.1: Gaining experience as a student

In total seven healthcare practitioners had undertaken the two-day UNICEF Baby Friendly Initiative course as part of their pre-registration midwifery or health visiting course, with placement experiences helping to consolidate this knowledge and build experience. Lucy, a health visitor, identified how her confidence was initially acquired through undertaking formal observation of her practice teacher[10] working with and supporting the breastfeeding families:

> *I think it was a matter of… being in practice with my practice teacher and observing my practice teacher and spending time with mums and families where breastfeeding was happening.* (Lucy, Health visitor)

Formal observation opportunities enabled the student healthcare practitioner to be exposed to a breastfeeding environment. Insights from the participants emphasised how this was important for all healthcare practitioners, not just those who did not have personal experience of breastfeeding. Regardless of having breastfed her own children, Chantel, a midwife, emphasised that the experience of working with her mentor[11] gave her a different experience to that of being a mother, and exposed her to the realities that different mothers could have very different experiences:

[10] Practice teachers are experienced health visitors World Health Organization hold a clinical caseload and are responsible for providing clinical practice education for student health visitors. They act as role models and are responsible for the provision and management of a high quality learning environment, the identification of student learning needs, facilitating learning opportunities in practice (Devlin, Adams, Hall & Watts, 2014, p. 28).

[11] An NMC mentor is a registrant who, following successful completion of an NMC approved mentor preparation programme – or comparable preparation that has been accredited by an AEI as meeting the NMC mentor requirements – has achieved the knowledge, skills and competence required to meet the defined outcomes (NMC, 2008, p.23).

> *I exclusively breastfed but it was only when I became a student and went around with my mentor that I learnt everything about breastfeeding. Because I couldn't have, the issues that women were presenting us with, I couldn't have started to have put together a plan when I first started as a student.* (Chantel, Midwife)

These insights highlighted how healthcare practitioners needed exposure to a range of experiences to build their knowledge to prepare them for an effective support role in future practice. Observing the healthcare practitioners led onto being exposed to practice situations when the student had to take the lead. The chance to gain valuable experience without a supervisor was positively received. Nora gave an example:

> *I was asked during my course to go and see this family that was having trouble…mum was at the end of her tether with this baby that just wouldn't settle and he* [the father] *wasn't in the room at the time…she* [the mother] *did make a little comment that he wasn't overly supportive... He came back in with his coffee and just sat down…I just pulled him into the conversation…he was a bit reluctant, and he wasn't too keen to start with…* (Nora, Health visitor)

Nora was able to undertake a follow-up visit with this family and found the father *"to be a little bit more involved."*

As student healthcare practitioners, they were more likely to gain experience with mothers and babies rather than with the father as well. Kay recalled that *"…fathers were not always visible in visits…".* The emphasis on the contact and development of a relationship with the mother was seen to be "*part of the job"* but an equivalent relationship with the father was "*not as common".*

However, despite the requirement to be supervised and supported in their learning, not all healthcare practitioners felt confident on qualification as a midwife or health visitor when providing breastfeeding support to the mother, let alone the father as reported by Beth:

> *If you were trying to involve a dad a bit more, yeah, definitely I feel a lot more confident doing that now than when I was newly qualified.* (Beth, Midwife)

Beth, like other participants highlighted how confidence evolves experientially and that what is available during pre-registration training may be insufficient. This extension of the experience continuum is important as the quality of the exposure to specific experience as a student is not always guaranteed. This is discussed further in the next section.

8.2.2: Gaining experience as a practitioner

Gaining experience of providing breastfeeding support, and to empower fathers to be a breastfeeding supporter was perceived to be important for all the participants involved in this study. This was a unanimous view which reflected an attitude that learning was an on-going process, and that accruing experience led to increasing confidence. Nevertheless, akin to the student experience, gaining experience whilst in the healthcare practitioner role, to build on a knowledge base and increase confidence, could not be guaranteed unless they were in a specifically designated breastfeeding support role. Nora reported:

> *I think you need to really instil that knowledge and get that experience which unfortunately doesn't happen all the time because of the nature of the job, you don't always get breastfeeding, it can be a long time before you get a breastfeeding issue coming in.* (Nora, Health visitor)

Nora was specifically referring to gaining experience of breastfeeding issues with the mother. However, this statement was equally applicable to healthcare practitioner experience with the father, as illustrated by Annie:

> *I'm probably not able to give them* [the fathers] *the right information because I'm not experienced in giving the dad the right information. So, its catch twenty-two. Dads don't want to be involved as much so I don't get the experience of involving them as much.* (Annie, Health visitor)

The participants generally acknowledged that they were confident in terms of knowing how breastfeeding worked, what needed to happen to effectively breastfeed, and to answer general questions to support the parents about breastfeeding. However, some healthcare practitioners were less confident in getting fathers to support mothers with

breastfeeding. This appeared to be the result of their lack of experience or reduced opportunity to work directly with fathers as Annie identified above. This lack of or reduction in direct experience therefore meant that these healthcare professionals felt less confident in their abilities to empower and/or enable the father to provide support to their breastfeeding partner. There were distinct differences between the two services with health visitors more likely to face challenges in gaining experience in supporting fathers than the maternity practitioners. Healthcare practitioners within the maternity services perceived that they had an advantage as they had often met the father at some antenatal appointments and again after birth when many fathers would be on paternity leave. However, some within the maternity service did note that they could not assume that fathers would be present at post birth visits due to the family's financial circumstances as identified by Viv:

> *We are seeing a bit more of, "My partner's self-employed, he's had to go back to work".* (Viv, Maternity support worker)

Work-related issues also influenced the availability of the father at the health visitor visit during pregnancy or at the new birth visit 10 to 14 days after birth. As many health visitors in this study only started their contact with families at 10 to 14 days after birth, and as father's statutory paternity leave is generally no more than two weeks, fathers' absence was a common occurrence as identified by Lucy:

> *…a new birth visit I attended today, dad wasn't there, he was out at work, so we find that quite a lot. So, if we go and it's day 14 a lot of Dads have gone back to work, so they are not actually physically around.* (Lucy, Health visitor)

This issue of being able to meet and engage the father is considered further in chapter nine.

Many of the participants noted that having been a student gave them regular opportunities to gain experience by watching and working alongside other healthcare practitioners, but that this became almost non-existent once they became qualified practitioners. This is because the maternity and health visiting services are generally designed to be delivered by a practitioner working alone; the exception to this may be in safeguarding cases when the practitioners *"double up with another professional*" to ensure staff safety rather than as a forum for gaining knowledge and / or experience from a colleague. One way that the healthcare practitioners appeared to overcome

lone working, and to gain more experiential learning, was to discuss their visits more informally with colleagues. During the group interview, for example, the maternity service practitioners discussed how they informally chatted about families they were visiting, when they met each morning before starting their visits. They identified that these informal and unplanned interactions amongst colleagues enabled passing on *"little tips"* which in turn could make a difference when providing support to another family. However, it is important to note that that the sharing of experiences was inevitably mother rather than father centred. As has been highlighted in section 6.3 the healthcare practitioners frequently referenced their experience of supporting breastfeeding to the mother and baby; this meant that I had to make numerous attempts to refocus them onto their experience, or lack of it, with the father. Sometimes this necessitated redirection by asking them "*Okay but what was your experience in relation to the father?"*

8.2.3: Gaining experience in a specialist role / service provision

For three of the healthcare practitioners in this study a major part of their role specifically focused on providing breastfeeding support. Viv was one example; in her role as a community midwifery support worker the midwives used her to undertake additional postnatal visits to mothers and babies who were experiencing breastfeeding issues. The nature of these visits enabled Viv to accrue a significant amount of experience in supporting mothers and babies in the early days of breastfeeding, and this in turn gave her experience of providing support to the fathers due to their presence whilst on paternity leave. Viv described how her repeated and immersive experiences had enabled her to *"judge the family dynamics within the first few minutes of walking in the door."* She considered how this meant that she had been able to become more attuned to the needs of the mother, father, and baby in the time available to her. Viv's experiences also enabled her to be alert to statements and questions from the father as highlighted below:

> *…you walk in, and the dad says, "I think she* [the mother] *needs to give baby a bottle; it's* [breastfeeding] *making her cry; it's hurting her."* (Viv, Maternity support worker)

Viv went onto describe how she would respond to such paternal concerns whilst also focusing on the mother

> *"Why do you want to do that?"...I have to then have a chat with Mum and say, "And what would you like to do"' … When the Mum says she wants to breastfeed then the dad sometimes backs away a little bit and is not maybe so antsy. I think it's the crying baby and the lack of sleep where they've just thought, 'Okay, let's just get a bottle, that's the answer, isn't it?' When they realise that there's support, just that little bit of reassurance, that there are people about to help them, they tend to then think that they're* [the father] *not on their own.* (Viv, Maternity support worker)

The specialist and focused nature of her role and exposure to father's views and involvement appeared to have provided Viv with a confidence to engage fathers in a more direct way. As reflected in the quote above, these opportunities meant that she was able to recognise the issues and offer appropriate support and reassurance to encourage the father to support the breastfeeding mother, because Viv knew "*what a difference it made to the mother".*

While not all healthcare practitioners had the benefit of a specialist or focused role to build experience, many had the opportunity to work in a specialist practice arena, namely Baby Café[12]. In the geographical area where the health visitor practitioners were located, the health visiting service collaborated with the local City Council to run Baby Café. Kay had worked in Baby Café *"since I qualified"* which was over five years ago. As Baby Café ran in a variety of settings every day of the working week, it offered health visitors such as Kay more regular opportunities to offer support to the fathers. However, Kay did note that the inclusion of the fathers was dependent on the other mothers being *"happy for them* [the fathers] *to be there".* This illustrated a wider societal issue about the acceptance of fathers within the service that society perceived to be for *"mothers and babies".*

[12] Baby Café is a network of breastfeeding drop-ins registered with the National Childbirth Trust. They aim to offer help and support to breastfeeding mothers at any stage in their breastfeeding journey, regardless of the age of the baby or child. Fathers are welcome. Baby Café drop-ins are run by a range of staff including health professionals (midwives, health visitors, or lactation consultants); practitioners such as nursery nurses; or breastfeeding counsellors from the voluntary breastfeeding organisations. Locations vary from church halls and community rooms to children's centres and have facilities for toddlers. (Baby Café, 2020)

In contrast, the midwives and maternity support workers who ran the maternity services breastfeeding support clinic appeared not to be constrained by the same considerations; there appeared to be an expectation that any mother seeking support from the breastfeeding clinic would be accompanied by the father. This could be because the maternity services breastfeeding support clinic was promoted by the postnatal ward staff and community midwifery teams at a time when the father was more likely to be on paternity leave. The clinic also took place within the birthing centre where the healthcare practitioners could see the family in a room which offered both visual and auditory privacy; thus, there was not the same need faced within a Baby Café setting of feeling / having to negotiate the presence of the father with other mothers attending. This afforded the maternity service practitioners an opportunity to gain valuable and direct experience with providing support to the father. These healthcare practitioners did recognise that many fathers attending this breastfeeding support clinic were extremely worried and anxious, recognising that the father often, as reflected by Fay, *"didn't really know what to do but he was there".* This then added an additional need to provide reassurance about the condition of mother and baby before they could start meaningful engagement with the father *"...to begin to figure out what else he* [the father] *might want/need"* (Fay, maternity support worker).

8.2.4: Gaining experience through personal breastfeeding

The previous section considered the influence of experience within the practitioner's role. However, many of the healthcare practitioners who took part in this study were also mothers, who brought with them their own unique personal experiences. I also found that discussions about their own personal breastfeeding experience during the individual interview or group interview emerged without any prompting. Nora, a health visitor, recounted how the memory of her husband's support when she was breastfeeding became a powerful motivator in her practice:

> *I think from personal experience, I had a horrendous time with my first baby… my husband was amazing…so having that at the back of my mind as well, how invaluable that support is keeps me going with these dads.*
> (Nora, Health visitor)

For Nora, the felt value of her husband's support became a personal motivator in her professional role. Alternatively, the following account shows how another participant's

poor experience of support, influenced her desire to provide effective breastfeeding support for mothers and fathers:

> *My experience with breastfeeding is that I breastfed my son until he was about 16 weeks, but I had a very bad experience with my health visitor. She wasn't breastfed trained very well. She made me anxious because of her lack of knowledge and I gave up earlier than I wanted to. Looking back, I would like to have breastfed longer. I feel a real sense of loss about that and a little bit of anger actually. That has influenced my desire to make sure that parents get the right information and support, and they breastfeed for as long as they want to with their babies. I would never like to feel that I've not done that job properly because I know the effects of it when it's not done properly.*
> (Penny, Health visitor)

Penny's account of her personal breastfeeding experience was very moving and powerful. She went onto acknowledge that there is always the potential for healthcare practitioners to bring their personal experiences into their professional practice. She felt it was important that all practitioners should be able to reflect and be aware of *"their own personal experiences",* and then consider how these experiences "*pan out in their professional role".* Penny identified that negative experiences and / or biases could impact the ability to *"follow something up where…a parent needs a bit of support."* Nora and Penny were also typical of many of the other participants who saw that breastfeeding was a family affair that needed a *"team approach".* Thus, the father was perceived as an important *"ally"* but if the healthcare practitioner did not have a personal experience-driven awareness about the value of father support for breastfeeding then they could miss out valuable opportunities to impart appropriate information and support to the whole family.

A further point that emerged was the impact of the participant's previous negative personal breastfeeding experiences. Annie, a health visitor, reflected on how her attitude changed when she realised the potential benefits of their involvement due to new experiences and new knowledge, leading to positive practice outcome in terms of engaging and involving fathers in breastfeeding support:

> *…when I first breastfed my first, I wasn't a health visitor, so I think at that time I probably didn't encourage my husband to come with me* [to the antenatal breastfeeding class] *anyway cause I probably thought, 'well it's my job, you can't do anything, there's no point you coming'. It's only since learning and doing it* [breastfeeding] *and retraining as a health visitor that you realise, they* [the fathers] *are functional, they do have a purpose, they're needed in the process of breastfeeding and if the mum's got that support there, she's probably likely to continue longer than she thought she might. So, I guess my experience has led me to want to involve dads, to encourage them where possible and to let mums know that they're useful as well, they do have their part to play in successful breastfeeding journeys.* (Annie, Health visitor)

Some healthcare practitioners were also able to gain experience through informal support opportunities that evolved as the result of personal experience as a breastfeeding mother. This generally involved being a breastfeeding peer supporter[13] with a clear distinction made between their 'day job' as a healthcare practitioner and being a volunteer peer supporter. However, while a volunteer peer support role helped to develop skills and experience in providing breastfeeding support to mothers, it did not always facilitate a great deal of direct experience with the father as recounted by Annie:

> *Generally, the dads only come with mum in the very early days. So, he's probably acted as the taxi driver to get her there and then often they look like they're just going to leave her at the door, and they are welcomed in and we* (peer supporters) *get them a seat and we sit together, and we make a kind of closed off group so that he's not exposed in the group, cause you have to think about the other mums. And generally, in that situation, 'cause it is early days, the breastfeeding counsellor will deal with that family. So, we don't possibly have very much direct contact with that dad. And we might not see him again.* (Annie, Health visitor)

Annie's reflection on her role as a volunteer peer supporter not achieving a lot of direct contact with the father also resonates Kay's reflection of her role within Baby Café in

[13] A breastfeeding peer supporter is a woman World Health Organization has herself breastfed and has received training to support other breastfeeding mothers (Muller, Newburn, Wise, Dodds and Bhavnani, 2009). They may work in a voluntary capacity or receive basic payment or expenses and provide support in a variety of settings ranging from maternity services, breastfeeding support groups or the mother's home (Jolly et al, 2012).

section 8.2.3. Whilst both situations had the potential to increase contact with the father, in reality there were limitations from the mothers attending, the role that was being undertaken and the delineation of responsibility for providing support. Like their professional role experience, personal breastfeeding experience could be either limiting or generate heightened awareness of opportunities to promote the role of the father and provide support.

8.3: Conclusion

This chapter has presented the findings of how experience gained as a student and/or healthcare practitioner can build confidence especially when providing support to the mother and baby. Both as a student and healthcare practitioner there were limited opportunities to build experience with providing support to the father. This could be related to the family dynamics, caseload demographics or workload. Healthcare practitioners identified that experience that builds on their knowledge base was essential in being able to provide breastfeeding support, firstly to the mother and baby, and then to the father. The next chapter identifies how this combination of knowledge and experience enabled healthcare practitioners to engage with or 'tune into' the father.

CHAPTER NINE: FINDINGS – 'TUNING INTO THE FATHER'

9.1: Introduction

In this chapter I present the category 'tuning into the father'. Tuning in comprised of different cognitive, practical, and psychosocial facets. These facets related to the two focus codes for this category:

- understanding and valuing the father's perspective
- using strategies to engage and encourage the father

The findings presented in this chapter highlight various strategies and actions that healthcare practitioners used to provide breastfeeding support to the father. These insights illuminate how knowledge and experience gave the healthcare practitioners confidence to 'tune into the father'.

9.2: Understanding and valuing the father's perspective

As referred to previously, at the centre of healthcare practitioners' ability to understand the father's perspective was their positive attitude towards fathers and the value they placed on the father's involvement in breastfeeding support. All the healthcare practitioners in this study had a positive attitude towards fathers and their role in parenting, but more specifically for this study, about the role the father could have in relation to breastfeeding support. The way that the healthcare practitioners demonstrated their value of the father was found in statements such as wanting the fathers *'"to feel included".* Most fathers were noted to be *"…very enthusiastic, very supportive of their partners".* The midwives stated that it was the norm within our society for the father to be fully included in the woman's childbearing experience, and that this also included infant feeding. Chantal, a midwife, highlighted that this reflected the message being given by healthcare practitioners:

> *I think in recent years I don't think the fathers have questioned their attendance* [at antenatal and postnatal visits]*. I think it is kind of understood and I think that's just because the message is now out there that it isn't just about women and that men actually are vital in that supportive role.* (Chantel, Midwife)

The healthcare practitioners viewed the father as *"...an equal part of the* [parenting] *journey".* This view was emphasised during the group interview when Mia, a midwife, acknowledged that the woman and her partner *"look at the whole experience more jointly now'".* The healthcare practitioners embraced this joint attitude of the parents to pregnancy and parenting. They extended it to breastfeeding where fathers were included in breastfeeding discussions because Mia *"didn't see it* [breastfeeding] *just as a mother thing*". The healthcare practitioners took a partnership approach to achieve this sense of inclusion and made efforts to "*talk to both of them* [mother and father]". Although, this also made it challenging to filter out the healthcare practitioners' views on their confidence to provide breastfeeding support to the father, rather than to the couple, as previously referred to in sections 6.3 and 8.2.2.

Several of the participants also reported that the initial exploration about the father's views of breastfeeding also enabled them to explore how he viewed his role in supporting breastfeeding. Annie, a health visitor, used an inclusive approach:

> *I just try to include them* [the fathers] *in the conversation. Let them know that it is about them as well as much as it is about the mum. Ask them their views on it* [breastfeeding and breastfeeding support]*, what they think of it…* (Annie, Health visitor).

Penny, another health visitor, used a similar style when she provided opportunity for the father to talk to her:

> *I listen to them* [the fathers] *and I let them talk about how they feel about their partner breastfeeding and their baby being breastfed. I listen to them really, so they lead it. I'll assess which bits I need to come in on but it's a two-way process, but they will lead that.*

The healthcare practitioners used an inclusive approach, seeking to hear the father's views and using communication skills to adeptly ask open questions. Thus, this information was then the starting position from which a sensitive two-way discussion could take place. Such discussions could also be the starting point for identifying the father's *"knowledge level"* in order to *"fill those gaps or give them the correct information about breastfeeding".*

Many of the healthcare practitioners perceived that many fathers did not have a clear idea of the role he can play to support his breastfeeding partner, and thus be struggling with embracing the expectations of a new role and identity. The participants identified that for many fathers breastfeeding was still seen as *"a woman's thing".* The healthcare practitioners referred to how they could see the change of roles, and subsequent lack of direct involvement in feeding their infant created a challenge for many fathers:

> *Those* [fathers] *who are first time parents, who have been busy professionals or in busy stressful jobs, just having to switch off from that world to them being new parents, sometimes some of them struggle. You can see that the dad wants to do something, so he's gone off to clean the car or he's doing the gardening, and that's when you think they need to look at their roles a little better.* (Viv, Maternity support worker)

While this may appear a judgemental viewpoint on gendered roles, this maternity support worker was aware of how short paternity leave is for many fathers and was saddened if he felt it was only *"to do the jobs around the house."* She felt that fathers needed *"a focus"* and that sitting *"next to mum and baby"* was not seen as a legitimate activity or focus. Thus, the father's desire to be actively involved with feeding is understandable. Some of the maternity practitioners also reported seeing more fathers asking the mother to express so they could be actively involved in feeding their baby:

> *Some of the dads are asking the women to pump, so that they can feed the baby. We'll say, 'Why do you want her to do that?' 'So that I can give baby a bottle; so that I can feed baby…' 'Yes, we're getting quite a bit of this at the moment, mixed feeding just seems so trendy at the minute, with them asking us on day two if she can pump so that they can help. That's not the reason why we would suggest that they pump.*
> (Viv, Maternity support worker)

In order to help the father gain an acceptable identify and feel involved, which did not necessarily involve pumping to fulfil their desire to feed their infants, healthcare practitioners suggested alternative ways to the fathers of being involved with their baby. The maternity support worker went onto suggest that once the father was aware of options then *"they sometimes back away from the pumping".* The father's desire to be involved in feeding by encouraging pumping may just reflect the lack of knowledge on the range of options held by men. The strategies used by the participants to help the father is discussed in more depth in section 9.3.

As referred to in section 7.3, the use of effective communication skills was important in understanding the father's perspective, and to engage them in meaningful discussions. The participants identified that they used an array of interpersonal and behavioural techniques to create effective communication. These included asking open questions, exploring issues, listening, and observing the non-verbal signals from both the father and the mother. These methods enabled them to read and assess *each* situation individually and holistically. This assessment enabled the participants to understand the father's perspective, assess the level of engagement by the father and the attitude of the mother towards the father's involvement. Depending on the responses of the father and the mother, the healthcare practitioner could then test the waters and adapt their approach.

Utilising an array of communication skills to understand the father's perspective was only successful if the fathers were visible and / or actively involved. Overall reports about the degree of visibility and involvement of the father were mixed, with midwives reporting a variety of experiences from fathers *"wanting to be involved", "very hands on",* or *"in the other room".* Health visitors also reported a mixed experience of meeting the fathers. Penny noted:

> *the dads will be there for that visit as well because they are motivated, because they want to do the best thing for their baby.*
> (Penny, Health visitor).

In contrast Lucy, a health visitor, recalled that some fathers would "*actually remove themselves from the room altogether".* Many healthcare practitioners however did not automatically assume that the lack of presence or engagement by the father

during their visits was necessarily due to a lack of interest or disengagement. Some participants identified that mothers could dominate a visit and to overcome this, the healthcare participants had to directly ask how the father was doing and if he had any concerns and identify that they were *"happy to chat to Dad".* It also became apparent that some of the healthcare practitioners recognised that some fathers may be shy or lack confidence to approach the healthcare practitioner.

On the occasions where fathers were not engaging, healthcare practitioners referred to how they tried to remain non-judgemental and to demonstrate that the father's involvement would be welcomed and valued. One such way was to show the father that they could trust the healthcare practitioner. Penny, a health visitor, identified how she perceived that she had to overcome a societal perception of being an *"authority figure"* and what she had to convey in order to start building a trusting relationship firstly with the mother and then with the father. She expressed the desire to be regarded as *"genuine"* and *"compassionate".* A few of the healthcare practitioners reflected that their personality was also influential in creating trust through them having a natural and authentic style of engaging with the father, as they perceived themselves to be *"naturally a people's person".* The healthcare practitioners also observed that if they had a confident approach towards the father, it generated trust by the father in the healthcare practitioner and in turn promoted confidence in the father and facilitated a reciprocal relationship that in turn aided understanding the father's perspective.

The ability to create a trusting reciprocal relationship also relied on rapport being established and reciprocated. It appeared that the participants confidence in understanding the father's perspective increased when rapport was established and reciprocated with the father. Some healthcare practitioners considered that the father would be more receptive to the knowledge that they communicated once rapport had been established. To achieve rapport with the father, the healthcare practitioners had to establish a good level of rapport with the mother and for the father to observe the mother healthcare practitioner relationship before he felt comfortable to engage as described by Penny:

> *Dad, or partner, will be listening and then I think when they feel, 'Oh, this person* [health visitor] *is okay. My wife is quite comfortable. She's chatting away' and then they'll watch and wait and… then when they feel ready, they come in. It's not down to me. When they* [the father] *come in, then that's my cue and I'll think, 'Okay, you're happy to…chat now'.*
> (Penny, Health visitor)

Once an effective working relationship was established with the mother, the healthcare practitioner was able to move their focus to the father and using the established rapport was able to gain a better understanding of the father's perspective. This enabled the healthcare practitioner to seek out information about father's previous experiences, as many fathers could be in new relationships, and previous experiences of former partners infant feeding choices may impact their current attitude. As Belinda, a health visitor commented, "*You've got no idea what these men are bringing into the scenario".* Having gained insight and a deeper understanding into the father's perspective, the healthcare practitioners went onto discuss how they engaged with and encouraged the father. These strategies will now be discussed in the next section.

9.3: Using strategies to engage and encourage the father

The healthcare practitioners recognised that any contact was an important opportunity to engage and to start establishing a relationship with the father as well as the mother. Such a relationship enabled the healthcare practitioners to understand the father's perspectives as discussed in section 9.2, but also gave them the opportunity to engage with the father and offer encouragement. Encouragement of the father centred on enabling him to embrace and fulfil the role that was appropriate within his family unit. To achieve this the healthcare practitioners encouraged the father's presence and involvement in visits, provided information about breastfeeding, as well as providing information about how to support a breastfeeding mother physically and emotionally.

9.3.1: Encouraging the father's presence and involvement

Encouragement of the father's presence and involvement in visits necessitated engagement of the father. All the healthcare practitioners acknowledged that trying to understand the father and engage with him was easier when the father was *'engaged'*. The criteria used by the healthcare practitioner to judge whether a father was *'*engaged' included the father "*being there for the visit*", "*showing an interest", "asking questions"* and being "*attentive throughout the visit".* The healthcare practitioners' judgment of the level of engagement of the father also included whether the father's behaviour was active or passive; this in turn appeared to be determined by the level of physical and cognitive involvement of the father in the visit. An example of active behaviour is relayed by Lucy:

> *I've had a couple of dads who were very kind of wanted to be included in the conversation and one dad in particular who actually led the conversation about breastfeeding and he talked about how difficult his partner was finding it and…he talked through the worries that they had as opposed to mum doing it so that was actually unusual from what I've experienced so far.*
> (Lucy, Health visitor)

Lucy also went onto describe how the father's involvement at visits could be physically passive yet cognitively active:

> *I mean again a lot of it has been kind of dad will sit and listen to the conversation that I'm having with mum and you know as much as you try and engage people without contact and things like that, a lot of it does tend to be sort of listening and taking it all in as opposed to doing anything active.*
> (Lucy, Health visitor)

Healthcare practitioners also acknowledged that individual family circumstances led to the father being actively involved in several indirect ways; examples of active but indirect behaviour of the father included "*in the kitchen washing up"*, and "*keeping the other child occupied"*, because these activities contributed to the support of the breastfeeding mother.

The healthcare practitioners found it straightforward to engage with and encourage fathers who demonstrated an engaged attitude. It entailed little effort on the part of the healthcare practitioners to include such fathers in any contact they had with the mother. The majority of contact that healthcare practitioners had with the fathers was face-to-face. Occasionally the healthcare practitioners had received telephone communications, which involved fathers leaving a telephone message seeking help or a direct telephone conversation. Viv, a maternity support worker, was particularly mindful of the need to respond positively to fathers who telephoned as she interpreted this as "*the father's desire to be more actively involved.*"

The strategies to engage and encourage the father spanned both the antenatal and postnatal periods. The first strategy relates to understanding the father's attitude towards breastfeeding, as discussed in the previous section. Continuity of healthcare practitioner was perceived to be particularly important as it helped to facilitate the establishment of a trusting relationship and rapport discussed in the previous section. The quality of the relationship and rapport was particularly evident when breastfeeding problems or differences of approach were encountered, as highlighted by Chantel:

> *It perhaps depends on your relationship that you've had as well. This comes back to continuity of the professional, doesn't it? If you've known them perhaps as a couple and they trust you, you've got some relationship with him almost independently then… you're a little bit more advanced when you get to these difficult conversations because you're there thinking, 'I know what makes you tick a bit more'.* (Chantel, Midwife)

As highlighted earlier, many of the healthcare practitioners perceived that the father did not feel he had a clear role. To help overcome this some of the healthcare practitioners felt they needed to be active in assigning the father a more defined role. Kay, an experienced health visitor, referred to how she aimed to provide fathers with a valued role during pregnancy by making the father the *"information gatherer"*:

> *…if dad's on the antenatal visit as well as the mum I give him the information to read through, you know like when we have leaflets and things then I would make a point of handing that information, I talk about it and hand it to the father, so it really involves them. I guess I'm making them the information gatherer without thinking about it but that's a really important role for them. That's one of the things they can do in breastfeeding is gather that knowledge and then they feel that they can really support the mother that way really.* (Kay, Health visitor)

Continuity throughout the pregnancy and postnatal period was viewed as a key factor to facilitate an effective working relationship. Often the initial meeting gave an opportunity to give a positive response to the father's presence and include him in any conversation before being able to identify those factors that were significant to the father. This is illustrated within the following quote from Penny, a health visitor, about her approach:

> *At the antenatal visit, they* [the father] *will come in and get involved in the discussion…so I talk to both of them, basically about their feelings about breastfeeding, what are the preconceived ideas they've got about breastfeeding.* (Penny, Health visitor)

Both midwifery and health visiting practitioners extended invitations to antenatal breastfeeding workshops to enable the fathers to have more information about breastfeeding in general. Participants provided examples of fathers refusing invitations to attend antenatal breastfeeding workshops. The midwives reported that some fathers' responses were *"Oh well, I don't need to go."* because they did not "*have the boobs"* therefore *"can't do the feeding",* as well as how these attitudes could culminate in a defeated response of feeling that they "*can't help with this* [breastfeeding]*".* Nora, a health visitor, intimated that she observed that the father can feel '*that they miss out if they're not feeding'.* Some participants considered how these attitudes could be influenced by personal, historical, cultural, and social norms of father's roles in childrearing. Annie, a health visitor, offered a wider understanding of the situation when she stated:

> *I think it's intergenerational. They won't have possibly been around a breastfeeding person before and it just goes back to that they can't do anything, so what's the point. They don't understand the wider systems that are involved to support that mum in doing that. They* [the fathers] *have a lack of knowledge, understanding, experience.* (Annie, Health visitor)

However, Belinda, an experienced health visitor, commented that these negative attitudes were to some extent, also influenced by an NHS culture that values women's work and the maternal role:

> *I think it's partly cultural; as in cultural in the NHS culture and that's it's the maternity unit and it's the midwife and it's the mother. It's all m, m, m.* (Belinda, Health visitor)

This view reinforces the interpretation of some of the healthcare practitioners who perceived that many fathers had *"never met anybody that has breastfed before"* and that as such it could reinforce their sense of being "*a bit of an outsider"*. Most of the healthcare practitioners in this study felt that many fathers *"really want to be involved in the newborn care and the feeding",* whilst feeling that fathers were uncertain about how to do so. Participants considered that infant feeding is an essential facet of newborn care therefore fathers whose partners are breastfeeding may feel that they were *"missing out"* if they could not feed the infants directly.

As previously identified, an antenatal visit with the father present was not always guaranteed for the health visitors. In the absence of antenatal contact, at the postnatal visit the healthcare practitioners directly sought the father's views with a more general approach using open-ended questions that could be perceived by the father as generic and non-confrontational such as *"How's it going for you?" "How are you doing?" "How was the baby's birth for you?"*. This general approach then led into a more specific exploration of their views and expectations of breastfeeding. Some healthcare practitioners acknowledged the importance of spending time in sensitively *"unpicking what the barriers are"* before being able to assist the father in *"debriefing on what their issues or concerns are."* These barriers could be social perceptions that breasts are sexual objects, a lack of knowledge of why breastfeeding is important or how breastfeeding works, or a fear of how to deal with

problems if they arise. An example of a subtle approach to explore these issues was provided by Penny:

> *I'd try to get to the root of where those feelings are coming from. Some of it may be a lack of knowledge. It could be any sort of organic reason why he doesn't want his wife to breastfeed. It could be a sexual reason. It's finding out what's at the root of that belief or those feelings and it's trying to unpick that because it could be based on ignorance and, as I say, a lack of knowledge. It could be based on fear. People are complex. It's trying to unpick that in a very gentle, subtle way, I would say. That is, again, a very, very skilled role because you want to meet them halfway, if you like, and reach out. You want them to connect with you, rather than run away. That approach has to be very carefully managed because I want them on board. I can't do this without their support for mum.* (Penny, Health visitor)

Thus, this information was then the starting position from which a sensitive two-way discussion could take place. Such discussions could also be the starting point for identifying the father's *"knowledge level"* in order to *"fill those gaps or give them the correct information about breastfeeding".*

This need to fill these gaps was achieved by providing physical and online information across the antenatal and postnatal periods as well physically highlight and demonstrate the physical signs of successful breastfeeding. Such strategies to convey breastfeeding-related information will be discussed further in the next section.

9.3.2: Providing breastfeeding information to the father

A large part of the role of the healthcare practitioner was to provide information about breastfeeding, as well as providing information about how to support a breastfeeding mother physically and emotionally. This information sharing occurred during antenatal visits and / or antenatal breastfeeding workshops and during postnatal visits and Baby Café. The maternity practitioners made both the woman and the father aware of antenatal breastfeeding workshops and encouraged the

fathers to attend as they believed the fathers *"remember things that the women don't".*

Some of the health visiting practitioners recognised that the antenatal contact was an excellent opportunity to convey information of a factual nature about breastfeeding which they hoped would encourage ongoing engagement of the father. They also referred to how they would look for the aspect of breastfeeding information that the father connected with; for some fathers it was the economic benefits of breastfeeding, such as through Penny noting the father was *"interested in the financial savings of breastfeeding".* For other fathers it was the more scientific approach that engaged and encouraged them. Such technical detail about breastmilk and the anatomy of the breast itself was important to include according to Penny *"because they* [the father] *might not have even looked at the breast like that".* Many of the healthcare practitioners utilised small teaching aids such as the knitted breast to illustrate information, although they recognised that this approach can sometimes be counter-productive when father's respond negatively as illustrated in Annie's example:

> *I've literally got my woolly boob out my bag and had dads go, 'whoa, I'll go and make a drink'." (*Annie, health visitor)

Annie also noted that the fathers who remained during new birth visits could *"go a bit quiet during the breastfeeding chat".* Her approach was to pick up on any topic that could be perceived as less threatening to the father. Annie stated that she often tried to engage the father in conversation with topics such as *"bathing the baby".* This approach appeared to open further opportunities to then offer more breastfeeding specific information to the father. Even information such as the father enjoying time cuddling their baby could become *"a bit awkward"* if Annie encouraged a skin-to-skin technique that involved the father taking his shirt off.

If the father was not present during an antenatal visit, then the healthcare practitioners made an effort to provide information that the mother could then share with the father. Penny illustrated such a strategy:

At the antenatal visit, I will leave the Healthy Start leaflet on breastfeeding. I'll signpost mum to the bits that concerns dads at the back of the leaflet.
(Penny, Health visitor)

As reflected in Penny's quote above, healthcare practitioners would remind both parents of information contained in printed leaflets such as the Healthy Start 'Off to the best start' leaflet. This was important because of the pictorial format of the information made it more accessible to a wider range of people and in stressed situations. Fathers were also directed towards parenting apps available on smartphones and websites of voluntary breastfeeding organisations such as the National Childbirth Trust, La Leché League, Breastfeeding Network and Association of Breastfeeding Mothers as already highlighted in section 1.2.3.2.

9.3.3: Encouraging supportive measures

Healthcare practitioners used opportunities within both antenatal and postnatal visits to engage in a range of supportive activities that could help the mothers breastfeed. They perceived that these were useful aids for fathers who did not know what they could do if the mother was exclusively breastfeeding. The healthcare practitioners such as Viv, a maternity support worker, believed that most fathers felt that they needed to be "*involved in that process of helping and supporting",* prioritising physical support over emotional support. The supportive measures suggested to the fathers encompassed emotional support for the mother and instrumental support to meet her physical needs. It was interesting to note that the fathers were seeking to prioritise physical support suggestions to be seen to be doing something, whilst the healthcare practitioners were promoting emotional support measures as a priority.

Specific information and advice were offered to the father to support the mother to have physical and emotional rest, and usually centred around taking the baby after and between feeds. The healthcare practitioners promoted these opportunities for the father to establish a bond with his baby such as when Lucy suggested activities

of "*cuddling the baby"* rather than placing the baby in a cot, "*having skin-to-skin*[14]", although this was not always positively received as previously identified, "*bathing the baby"*, *"change nappies"*, and "*reading to the baby"*. Other practical suggestions involved just having the baby to "*give the mother some space"* in recognition of the emotional toll early mothering can have.

Emotional support measures centred on the father staying close to the mother and baby providing a physical presence to instil a sense of caring about the mother's experience and consequently the sharing of that experience. The healthcare practitioners recounted how they encouraged the father to "*just be there"* or *"stay close to them while she's feeding".* The sharing of the experience was emphasised by the healthcare practitioners when they referred to the mother and father *"…being one unit…doing it together"*. Parenting activities, including breastfeeding, was perceived by the healthcare practitioners to be a team effort and the father's role was valued.

Whilst the majority of time the focus of engaging with and encouraging the father was to enable the father to provide emotional support to the breastfeeding mother, the healthcare practitioners recognised the need to provide the father with his own emotional support. Viv, a maternity support worker recognised that the father could also experience adverse emotional feelings and felt that part of her role involved "*a little bit of nurturing…I want to support them* [the father]*".* Viv also suggested skin to skin contact with the baby to help the father feel connected:

> *I always say if they're feeling a little bit low and sad then undress baby and put baby under your clothes and have a cuddle. Just explain to them that it's good for dads as well to have some skin-to-skin time and have some nice bonding time with baby…it's really important for…his wellbeing…the oxytocin and that feel good factor.* (Viv, maternity support worker).

[14] Skin-to-skin contact is usually referred to as the practice where a baby is dried and laid directly on their mother's bare chest after birth, both of them covered in a warm blanket and left for at least an hour or until after the first feed. Following this time either the mother or the father can have skin-to-skin contact with their baby. Aside from the ability to initiate breastfeeding, skin-to-skin contact stabilises the physiology of the baby, stimulates the baby's emotional and social development and aids attachment (UNICEF Baby Friendly Initiative, 2019e)

Such emotional support was given when the healthcare practitioner actively observed spontaneous supportive acts from the father and then ensured such acts were recognised. Lucy described:

> *…if dads are doing things that are positive….then reinforcing those positive things that they're doing and…. saying… that's really good that you are supporting your partner in that way, yeah encouraging them to continue.* (Lucy, Health visitor)

Healthcare practitioners would also provide specific examples of how fathers could offer meaningful physical support to the breastfeeding mother. In such cases the healthcare practitioners were more directive and focused on support measures to promote either maternal physical wellbeing such as *"getting drinks and snacks"* or *"get her pillows",* or with suggestions to facilitate baby care such as "*changing nappies*" or *"bathing the baby*". Specific encouragement was given to the father to help with household chores to ensure that the mother could rest whenever there was an opportunity. The importance of the father being able to understand the need for as well as how to support the physical wellbeing of the mother was emphasised by Viv:

> *I think sometimes it's important that they* [the father] *actually understand how demanding breastfeeding can be on the woman, physically as well as mentally. They don't understand sometimes because some of them are sleeping all the way through the night and not realising that mum has been cluster feeding for a long time.* (Viv, Maternity support worker).

Healthcare practitioners also encouraged engagement by making suggestions for supportive activities directly related to the act of breastfeeding. In the early weeks of breastfeeding both maternity and health visiting practitioners identified that specific breastfeeding information for the fathers centred around positioning and attachment of the baby at the breast to facilitate effective feeding. It was important to engage the fathers when the mother was experiencing breastfeeding challenges or problems, as the healthcare practitioners recognised that the father was more likely to retain information than a tired and/or stressed mother so ensured that he was *"a second ear".* This ability of the fathers to be more objective also extended to the father's ability to observe how the baby looked when breastfeeding. The healthcare practitioners emphasised *"looking at the positioning",* and *"making sure*

the chin is really close", and *"tucking baby's bottom in".* Such advice was noted to be more helpful to the father compared to less precise advice such as "*feed a baby when it's hungry"*. The frequency of feeds was also an issue for many fathers and specific information was needed to assure the father that their baby was behaving normally. When the healthcare practitioner's recognised that fathers wanted more precise solutions and answers, the healthcare practitioners had a tendency to offer advice options of *"this is what you should do and this is what you shouldn't do".* The healthcare practitioners appeared to draw on a range of strategies dependent on their assessment of the father at the time of meeting.

9.4: Conclusion

This chapter has presented the findings of how the healthcare practitioners drew on their knowledge and experience to demonstrate role confidence and to 'tune into the father'. This enabled them to engage the father and encourage him in a supportive role appropriate for his family context. The healthcare practitioners identified several challenges in being able to tune into the fathers; these will be developed further in the next chapter.

CHAPTER TEN: FINDINGS – THE CHALLENGES OF PROVIDING BREASTFEEDING SUPPORT TO THE FATHER

10.1: Introduction

Any provision of breastfeeding / breastmilk feeding support to the father by healthcare practitioners was set against a backdrop of challenges. The participants identified a variety of challenges and issues that made engaging with the father more difficult, as well as recommendations to improve service delivery. This final category is entitled the challenges of providing breastfeeding support to the father, and is drawn from four focus codes identified below:

- challenges in the providing a service to fathers
- the lack of a formal breastfeeding support strategy and resources for the father
- recommendations for training
- recommendations for practice

The most significant issues were noted within the health visiting service; thus, these results are presented, and the contrasting maternity service findings are woven in where applicable.

10.2: Challenges in the providing a service to fathers

In attempting to understand the challenge to the participants in providing breastfeeding support to the fathers, it was necessary to consider the service they provided to the mothers and babies in their care, as the support for fathers *was "normally alongside mothers".* All the health visitor practitioners referred to some degree of challenge in providing a service to the mothers and babies in their care. The remit of this study was not to explore service provision per se, but in their interviews many health visitor practitioners identified that the service to mothers and babies had been negatively impacted due to a multiplicity of reasons and this in turn impacted their ability to provide breastfeeding support to the father. The reasons the health visitor practitioners identified included the lack of opportunity to engage

with fathers, workload, staff shortages, financial constraints, and commissioner's targets. These will be presented in the following sub sections.

10.2.1: Workload and related issues

The health visitor practitioners identified that a reduction in staff numbers and the increasing size and complexity of their caseloads and daily workloads was a constraining factor that had influenced the changes in the service provision. An aspect of the health visiting service provision that was affected during the period of data collection was the 28-week antenatal visit not being routinely provided. When asked directly, the health visitor practitioners considered there to be a direct link between the reduction in antenatal visits and the decrease in health visitor numbers. Early interviews, at the beginning of autumn 2017, had references to visiting "*all primips[15] for an antenatal visit"* whilst *"multips[16] are offered an appointment"*, which was reliant on the woman taking up the offer. The later interviews, that took place from December 2017 to May 2018, referred to selective antenatal visits in which "*targeted visits"* were taking place "*if the midwife's got concerns".* These concerns included *"if there's previous anxiety, depression, social care involvement…"*. The health visitor practitioners perceived that the reduction in antenatal provision was a continued reduction in the overall universal quality and quantity of the health visiting service, due to "*cost cutting"*.

Many of the health visitor practitioners expressed their regret at not having had an antenatal contact with the mother and father prior to the new birth visit, as highlighted by Lucy:

> *It's quite hard, knowing the difference it can make when you've been before, and you've got that point of contact, you know each other's faces, you don't have to go through all the history and the kind of clinical stuff. So today, I had a new birth visit this morning, not met her before… So yeah, it's hard without the antenatal; it's hard for them* [the mothers] *as much as it is for us I guess*. (Lucy, Health visitor)

[15] Primip is a shortened version of primigavida which refers to a first-time pregnant woman (The Free Dictionary, 2020a).
[16] Multip is a shortened version of multigravida which refers to a woman who is pregnant for the second or subsequent time (The Free Dictionary, 2020b).

For those health visitors who did undertake antenatal visits, there was no guarantee the father would be present due to his work pressures, as previously discussed in section 8.2.2.

The health visitor practitioners also perceived that the lack of an antenatal contact put more pressure on the new birth visit, as a direct result of losing the opportunity to build a relationship with the parents. When the health visitor practitioners were able to do an antenatal visit but did not meet the father, they relied on the mother to be an active conduit of the information. These participants attempted indirect engagement of fathers by suggesting to the mothers that they could *"talk to dad",* or by signposting *"the bits that concerns dads at the back of the leaflet"* or providing information about the breastfeeding workshops. This lack of opportunity to engage directly with the father antenatally created further challenges as the participants referred to a time limit for the new birth visit. If the mother had not passed on the information given at the antenatal visit, the participants perceived that this could disadvantage the father in being able to provide effective breastfeeding support. Penny, a health visitor, felt that *"Mum's had a bit of a head start, if you like, if she's still breastfeeding*" and that she was "*starting fresh with him* [the father] *really".* If the mother or healthcare practitioner identified issues or problems during the new birth visit, then it further reduced the amount of time available to engage directly with the father, if he was present.

The health visitor practitioners not only recognised the negative impact of the absence of visits on the father but also on themselves. As discussed in section 8.2.2 some of the less experienced health visitor practitioners had identified that they lacked opportunity to gain experience in providing breastfeeding support to the father. These opportunities were limited by the father's absence from visits due to the reasons discussed previously as well as the changes to service provision. In contrast, although the maternity practitioners also identified workload issues, they did not identify an issue with antenatal contact with fathers, as fathers often took time off work to attend maternity antenatal appointments. This perhaps reflects the lack of perceived value in a one-off health visitor antenatal visit and a lack of parental understanding of the importance of such visits on the part of both the father and the mother.

A further impact on the opportunity to gain experience in engaging with the father was linked by the health visitor practitioners to the pressure of reduced staffing exacerbated by the increasing complexity of care provision. Belinda, a health visitor, summarized the situation as "*we're falling down…. because of a lack of funding".* Annie, a health visitor, summed up the consensus over workload and staffing and proffered that she could not see it changing in the foreseeable future:

> *I guess numbers of staff that we've got and what we can physically do in our caseloads…. It's, all about money isn't it, if we had more money to have more health visitors, then we'd bring all that* [universal antenatal visits] *back in, but as it is at the minute it's not going to be happening.* (Annie, Health visitor)

An additional issue that compounded the health visitor practitioners being able to access fathers was their inflexible working hours, with Belinda referring to how they were unable *to 'offer evenings or weekends and things like that'.* The health visitors suggested that their office hours worked for the mothers and babies, as they were available for visits in office hours; however, in some areas it did make it significantly more difficult to engage with fathers who did not have flexible working patterns. While, as referred to earlier, the maternity service practitioners were able to engage with fathers who were on paternity leave, they still described pressures of having to juggle competing demands whilst mindful that they wanted to provide the best care. This was particularly relevant to the community rather than hospital-based staff, as they had to factor in travel time between different locations.

Chantal discussed issues of providing postnatal visits where she had never met the father before and how she had to make the most of the limited time she had:

> *Sometimes it's just your instinct to make that judgement* [about what the father needs]. *It's really difficult, especially, it sounds really bad, but if you've got an afternoon clinic and you've got three visits…and you…go in and you do, you have to think, 'I don't want to rush through this but, at the same time, I am bit pressed for time'. You've just got to absorb everything you can, and that information can help us to go on your instinct really.* (Chantel, Midwife)

Chantel's description highlighted how the healthcare practitioners had to create a solution to ensure that optimal care could be delivered in the face of challenges and constraints. At no point did the healthcare practitioners identify that the constraint of their workload or staff shortages result in substandard care being given; rather they had to be creative in their time allocation by drawing on the depth and breadth of their knowledge and experience to approach the situation in a flexible and relevant manner. One example was provided during the group interview:

> *I think sometimes what we can do as well in those rushed visits, and they're not really rushed, but you get to the bottom of what you need to do quicker. I usually leave them with a plan and say, 'I'll phone you this afternoon and we'll just see what's what then.' What you want to do is give them a little plan and then and then come back to them. I think that helps them* [the mother and father] *to see that, okay, this isn't just about now. This is a journey...* (Cora, Midwife)

This section has highlighted how many of the challenges related to workload, related staffing levels and finance. The participants identified that the basis of these challenges was in turn related to the commissioning of the service. This will now be discussed.

10.2.2: Commissioner's agenda and finances

Many of the health visitor participants felt strongly that the policy laid out in the Healthy Child Programme[17] was being eroded by the agenda of the commissioner of health visiting services. The health visitors considered that how their service had been commissioned was more influential over their practices than government policy. Belinda, a health visitor with over 25 years of experience, was able to reflect the changes which she perceived had occurred:

[17] The Healthy Child Programme is the early intervention and prevention public health programme to provide a universal service for children and families. It offers every family a programme of screening tests, immunisations, developmental reviews, and information and guidance to support parenting and healthy choices – all services that children and families need to receive if they are to achieve their optimum health and wellbeing (Shribman and Billingham, 2009, p.8).

> *We're meant to be the leaders of the Healthy Child Programme, but the commissioners are not commissioning our service as leaders…. In the past, we had total autonomy…You work your caseload. You were…searching for health needs and actually fulfilling those health needs and making relationships with those families, so you knew their health needs…. We are commissioned to have that set script and tick the boxes on that set script. (*Belinda, Health visitor)

The health visitor practitioners perceived that the commissioner's focus and associated targets was now only on *"the mother and the baby",* rather than the family. These targets had a financial association, which in turn restricted the activity of the health visitor as their manager was interested in *"where the money is and meeting targets"* (Penny, health visitor). Consequently, the health visitors as stated by Penny saw themselves being told "*This is what you need to find out when you go and do a new birth visit".* The health visitors identified that due to the commissioning agenda they had *"…more areas to cover within the same timeframe"* (Penny). This caused many practitioners a degree of dissonance in their role. The mother-baby focus rather than a family focus is discussed further in the next section.

10.2.3: Mother-baby focus

As is evident throughout the findings, many of the healthcare practitioners often referred to the focus of the service being on the mother and baby. The health visitors, in particular, identified that they encountered a societal attitude of parenting and breastfeeding being "*still very much mother-centred"* (Kay). Despite perceiving the dominance of this societal view, the participants identified that the majority of fathers wanted to be involved in some way but needed help in ascertaining what would work for them when breastfeeding was seen as an exclusive female activity. Some of the healthcare practitioners considered that this focus was a result of the cultural influence from within their organisation. Whilst reflecting during her interview, Nora, a health visitor, felt that *"there is no emphasis on the father's role at all in anything we do",* and later came to the conclusion that the service was *"really quite poor at supporting the father"*. This seemed to reflect an observation made by Belinda, a health visitor practitioner, who identified the influence of the NHS

maintaining a mother-centred approach (see section 9.2). Due to the organisational focus being on the mother and baby the support was *'directed at the mother'.* This is reflected in Kay's account of her practice:

> *"I'm actively seeking to find out how the mother's getting on with breastfeeding, but I don't think I actively seek to find out if father has any questions about breastfeeding."* (Kay, Health visitor)

As referred to previously, when the father was present, healthcare practitioners expressed frustration at how the mother-baby focus resulted in them having a more limited amount of time to focus on the father:

> *Now it's almost like a smaller part of my role then to get dad in because I've got the other stuff that the Commissioners want doing at that new birth visit and so I have less time to bring dad in on board with the breastfeeding, if he's not already.* (Penny, Health visitor)

Occasionally the challenge to providing a service to the father came from the mother. Some of the participants referred to the mother acting as a gatekeeper and thus restricting access to the father. Equally, some mothers led or dominated the conversations with the healthcare practitioner when fathers were present, which made it challenging for the father to include himself or be included in the discussion. Such restriction was perceived to make it more difficult for them to engage with the father and determine his needs. These lack of opportunities for engagement meant that the participants were unsure whether they were meeting the father's needs when they attempted to provide direct or indirect breastfeeding support.

The healthcare practitioners in this study recognised the issues within their service but did not accept that practice could not change to be more universally inclusive of fathers. There was the desire expressed by Nora but reflected across the participants "*to be better"* at engaging the father and providing the breastfeeding support needed for that particular family. In their desire to discuss how the service could start to be less mother centred, the healthcare practitioners recognised that there was a lack of a formal strategy and resources to provide the father with breastfeeding support. This is discussed in the following section.

10.3: The lack of a formal breastfeeding support strategy and resources for the father.

When the healthcare practitioners engaged with the father to provide breastfeeding support, they were not following a formal strategy, because such a strategy did not exist. They were engaging with the father because they were drawing on their personal beliefs, personal experience and professional experiences that had led them to understand what a difference the father could make to the breastfeeding experience of the mother and baby. In the absence of a specific strategy for providing breastfeeding support for the father, the healthcare practitioners drew on limited resources. In all the interviews the healthcare practitioners from each service identified a national publication that they used because there was nothing else. The health visiting service utilised the Start 4 Life (2015) 'Off to the Best Start' leaflet. The specific information for fathers amounts to three A5 size pages with an emphasis on photographs over informative text. As this is universally available, healthcare practitioners handed it out and in the absence of fathers at antenatal visits, asked the mother to signpost the father to these relevant pages. If the mother did not receive an antenatal visit from the health visitor, then the health visitor was reliant on the maternity service providing this leaflet or equivalent information.

The maternity service also provided the 'Mothers and Others Guide[18]. Within this booklet there is one page dedicated to fathers and breastfeeding. The healthcare practitioners felt that the small amount of information focused on fathers was still insufficient to enable the father to provide breastfeeding support with confidence. Maternity service practitioners were able to identify that even with the provision of these resources, more specific literature for fathers was needed as *"there's not a father's guide to breastfeeding"* (Viv), and that such a guide could also help them feel more confident to provide breastfeeding support to the father.

Despite the constraints and challenges highlighted, the participants were able to suggest several recommendations that were divided into recommendations for practice and recommendations for training. This reflects the positive attitude of the

[18] The 'Mothers and Others Guide' is a concise 32-page booklet for parents to give them all the information they need to make informed choices about feeding and caring for their baby. This ensures they have the required information for compliance with UNICEF UK Baby Friendly Initiative. It is updated annually and purchased by NHS Trusts to give to the parents. (Abbott, 2020)

healthcare practitioners towards the fathers, breastfeeding, and the role of the father in breastfeeding support, as well as the service they are employed within. These recommendations will now be presented.

10.4: Recommendations for training

As referred to in sections 10.3 and 7.2 there was a lack of father-focussed breastfeeding support strategy, resources, and an associated lack of education for the healthcare practitioners. As discussed in chapter seven, initially when asked about training the general response focused on the lack of training and/or updating. I had to ask the healthcare practitioners what specific training they needed to increase and / or support their confidence in providing breastfeeding support to fathers. The response was usually non-specific such as *"there needs to be a little bit more training."* When this response was explored further, a clearer indication emerged focusing on the *'how to' and 'what'* of the provision of support to fathers. This also linked to the nature of the education needed by the fathers which is discussed in section 10.5.

As identified previously the healthcare practitioners in this study all had a positive attitude towards the father and his role in supporting breastfeeding. Some of the participants gave examples of colleagues who they perceived did not have the same attitude and response to fathers. These personal biases were believed to be unhelpful in providing appropriate support to the whole family, creating barriers to families receiving timely care. The healthcare practitioners felt that these individual barriers needed addressing to help them to *"see that the dads need to be more involved".* One potential way to break down these barriers was through the reflection on personal attitudes / beliefs of breastfeeding. It was recognised by Penny as potentially being *"very intrusive"* but also potentially *"healing"* if the healthcare practitioners could resolve personal issues. Penny strongly believed that such reflection should be *"a core component"* in pre-registration training as the work of health visitors was at such an *"intimate level".* She went onto contend that mandatory opportunities to reflect on personal attitudes could help to identify negative biases and gaps in knowledge and experience, and to direct them towards suitable information and support.

10.5: Recommendations for practice

There was the suggestion that specific antenatal education for fathers was needed to enable the father to know *"how to be involved"*. It was suggested that a practical approach could help engage fathers and to reduce any anxieties of not providing suitable support. Specific suggestions concerned an antenatal group for fathers where fathers had the opportunity to learn about and discuss the wider aspects of breastfeeding before having to deal with the reality. These suggestions included knowing what breastfeeding mothers see as support, how to provide practical help, what is normal and when to seek professional help, the importance of just being present. Nora, a health visitor, felt that the absence of women could be liberating for the fathers and would enable the group to be *'dad focused'*:

> *I think that it* [fathers only breastfeeding session] *would be really nice and maybe a little bit less intimidating if there are no wives there, they might feel a bit freer to express concerns and things and it's a really good opportunity to try and unpick some of those barriers to the breastfeeding and what their personal experiences were as children or what they've seen in families.* (Nora, Health visitor)

It was felt that involving other men who have already experienced the transition to fatherhood was a necessity, as it gave a credibility when the father was *"actually hearing it from those that have been there and experienced it.* (Nora)*"*

Another suggestion was to make Baby Café more accessible to the father. Currently the advertisements for Baby Café were, as highlighted earlier, "*'very mum and baby focused"* (Kay). To overcome this, it was suggested that promotional materials should include pictures or *drawings* and text associated with the father. Nora considered how such *"little subtle things"* could make the father *"feel more involved"* thus giving the opportunity for their increased engagement.

The need to make the health visitor antenatal visit invitation inclusive of the father the default position was also highlighted. It was suggested the wording of the letter should be mindful of different circumstances and suggest that *"dads should be there*

too if they can be and that they're welcome" (Annie). To be inclusive the wording may have to reflect the diversity of the family unit within society and include dad or your partner. Equally important within the letter was information about the purpose of the visit.

One health visitor practitioner identified that, whilst undertaking a specialised training course, she had designed a leaflet for fathers. Such local initiatives may be appropriate to fill the void nationally. This health visitor practitioner saw that such a resource could have a dual purpose; firstly, information for the father *"about what support they could offer",* and secondly, the leaflet could act as a tool so that staff would be reminded to reinforce the importance of the father's support role.

10.6: Conclusion

This chapter has presented the final of four categories that related to the challenges for the healthcare practitioners in providing breastfeeding support to fathers. These challenges faced were multi-factorial and not limited to the services the healthcare practitioners worked within. The challenges reflected a wider socio-political attitude towards the family, gender roles and infant feeding. Individually or collectively these challenges / issues all had the potential to limit the opportunity that healthcare practitioners had to build or develop their confidence in providing breastfeeding support to the father.

Overall chapters' seven to ten have presented the four categories that I co-constructed from the data. The next chapter discusses the emergence of the substantive theory and the theoretical lenses I used.

CHAPTER ELEVEN: FURTHER REVIEW OF THE LITERATURE

11.1: Introduction

This chapter presents the rationale and findings from a further scoping review of the literature. First, I provide a rationale for undertaking a further review of the literature in line with a constructivist grounded theory study. Next, I describe the methodology used and the themes identified within the literature, namely:

- The influence of education and training on healthcare practitioner confidence
- The influence of the practice environment and experience on healthcare practitioner confidence
- The influence of competence on healthcare practitioner confidence

11.2: Rationale for the review of the literature

Following the completion of concurrent data collection and analysis, and in line with Charmaz's (2014) constructivist grounded theory approach, I undertook a further review of the literature. The purpose of this review was to help identify any papers that were more generally aligned with my topic area, and that could potentially help me to make sense of, and to develop my emerging grounded theory. As the initial review (detailed previously in chapter three) identified no previous literature in relation to healthcare practitioner confidence in providing breastfeeding support for fathers, I extended this review to explore healthcare practitioner's confidence in general. It was considered that this would help elicit some of the underlying mechanisms and features of confidence in providing healthcare irrespective of the type, and to whom the support was provided.

11.3: Review methodology

Similar to the approach used previously (see section 3.3) Arksey and O'Malley's (2005) framework was selected again to guide this review. I undertook this review from September to October 2019.

11.3.1: Stage 1: Identifying the research question

For this review the question was:

> *'What is known from the existing literature about the confidence of healthcare practitioners?'*

11.3.2: Stage 2: Identifying relevant studies

I used the search terms of confidence and healthcare practitioner along with their synonyms as identified in Table 14; these were the same search terms and synonyms as used in the initial scoping review. I searched four databases - CINAHL, Medline, EMBASE, PsycINFO. I did not restrict the range of years, searching up to 2019, to ensure a broad and comprehensive search. As in the initial scoping review (see section 3.3.2.2) in addition to searching these databases I also searched reference lists and hand-searched the key journals previously identified.

Table 14: Search terms and their synonyms for the further review

Confidence	**Healthcare practitioner**
Assurance	Health professional
Belief	Healthcare professional
Determination	Health practitioner
Self-efficacy	Midwife
Sureness	Health Visitor
	Lactation consultant
	Nurse
	Healthcare provider

11.3.3: Stage 3: Study selection

11.3.3.1: Inclusion / exclusion criteria

As previously discussed in section 3.3.3.1 I applied inclusion and exclusion criteria based on the PEO model. The inclusion / exclusion criteria for this review are identified in Table 15.

Table 15: Inclusion / exclusion criteria for further review

	Inclusion criteria	**Exclusion criteria**
Participant	Healthcare practitioners/ professionals/ workers	Practitioners/professionals/ workers not working in healthcare settings
Exposure	Working in in health care	Not providing any form of health care
Outcome	Confidence	Studies that do not focus on confidence
Type of study	Peer reviewed qualitative, quantitative, and mixed method studies	Grey literature Case studies
Language	English	Non-English

These inclusion /exclusion criteria were applied to the 363 studies identified following a search of the four databases. Following the removal of 15 duplicates, the abstract of 348 papers were then read and 329 were discarded. The reasons for discarding these papers fell into the following reasons that aligned to the exclusion criteria - practitioners/professionals/ workers not working in healthcare settings or providing any form of healthcare, no focus on healthcare practitioner confidence, and studies not published in English. This resulted in a total of 19 papers that informed the review. This process is detailed in the following diagram based on the PRISMA statement (Moher et al, 2009).

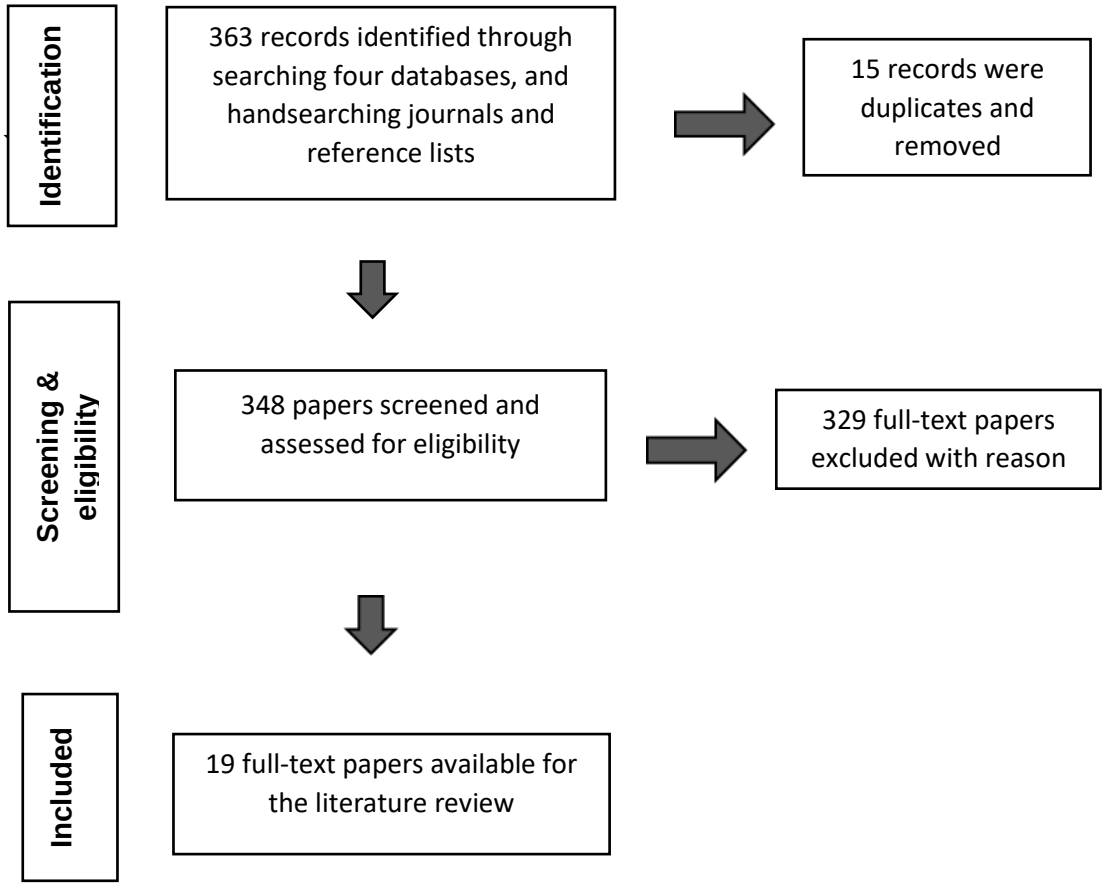

Figure 3: PRISMA flow diagram for the further review

11.3.4: Stage 4: Charting the data

The findings of these relevant papers were extracted, and synthesised. These 19 papers were undertaken in 10 countries with over 1617 healthcare practitioners and other hospital personnel. The range of healthcare practitioners included registered midwives, student midwives, registered nurses, student nurses, obstetricians, anaesthetists, physicians, general practitioners, medical students, operating department assistants, support workers, laboratory scientists, clerks, and allied health professionals. Their work context ranged from universities and associated placements, community, hospitals, maternity hospitals, free-standing birthing units and general practice units. The type of studies varied between qualitative (eight studies), quantitative (eight studies), and mixed methods (three studies).

Table 16 provides summary characteristics for the 19 papers.

Table 16: Summary of papers					
Paper	**Aim**	**Setting**	**Participants**	**Design**	**Findings /conclusions**
Bäck, Hildingsson, Sjöqvist and Karlström (2017)	To describe how midwives reflect on learning and the development of professional competence and confidence.	Central Sweden.	14 midwives from four county hospitals in central Sweden.	Qualitative descriptive. Focus groups (n=4 with 2-6 midwives in each group).	Feeling of professional safety takes time to develop. Confidence and competence are related to personal qualities and capacities. Multiple ways to expand knowledge and competence. Correlation between level of 'hands on' experience and confidence. Confidence described as an internal feeling of self-assurance and comfort. Confidence is related to self-efficacy as experiences could contribute to strengthening the feeling of self-efficacy, which could lead to increased confidence.

Bedwell et al (2015)	To explore factors which may affect midwives′ confidence in their practice.	North West region, England.	12 midwives providing intrapartum care to women.	Hermeneutic phenomenology. Diaries completed for 10 days prior to a semi-structured interview.	Confidence is fragile and easily lost. Other midwifery colleagues were the most influential factor affecting midwives′ confidence. Perception of autonomy appears to enhance confidence. Emotional intelligence used to enhance confidence. Reduction in confidence attributed to workplace culture and conflict.
Brown et al (2003)	To derive a beginning understanding of how nursing students perceive the meaning of professional confidence and to explore those influences that affect the development of professional confidence.	Ontario, Canada	48 student nurses undertaking a 4-year baccalaureate programme.	Qualitative design. Focus groups.	The meaning of professional confidence was described as: feeling, knowing, believing, accepting, doing, looking, becoming, and evolving. Positive and negative influences in developing professional confidence arose from two time periods, prior to entering nursing, and within the nursing program. Prior to entering nursing, the key influences were related to personality and life experiences. The influence within the nursing programme was related to the degree of promoting or impeding development.

Crooks et al (2005)	To explore the components of professional confidence as perceived by diploma-prepared registered nurses enrolled in a two-year student-centred, problem-based baccalaureate degree programme.	Ontario, Canada.	Diploma nurses undertaking a two-year baccalaureate programme.	Qualitative design. Focus groups containing 6-10 students.	Confidence developed in two phases through feeling, knowing, doing, and reflecting. The first phase involved 'becoming informed', and in the second phase the participants 'found their own voice'.
Donovan (2008)	To explore the confidence level of students at the end of an 18-month degree course (for registered nurses), 3-year degree course or the 4-year degree course	North West England.	45 student midwives	Quantitative study. Visual analogue scale to measure confidence in undertaking specific midwifery activities.	Confidence levels varied between the different courses but generally, the most confident students were on the 18-month or the 4-year programme. Relationship between confidence and competence is not equal and linear. Confidence develops due to the quality of the learning experience, the educational programme and personality.

Hayes, Hinshaw, Hogg, and Graham (2019)	To evaluate the impact of a multidisciplinary training project in obstetric emergency skills and drills on the confidence of staff.	Sunderland, England.	69 healthcare practitioners: 17 obstetricians, 14 anaesthetists, 28 midwives, 5 operating department assistants, 5 support workers who worked in obstetrics and were attending emergency skills and drills training with a birthing simulator manikin.	Mixed-methods approach. Pre- and post-test intervention surveys to assess self-reported confidence levels.	A statistically significant increase on the self-perceived confidence levels in the post-test survey. Increase in self-perceived confidence levels greater in those practitioners with low levels of experience than those practitioners with a high level of experience.
Hopstock (2008)	To investigate CPR training, resuscitation experience and self-confidence in skills among hospital personnel outside critical care areas.	Norway	361 staff: 251 nurses, 29 laboratory scientists, 20 clerks, 15 allied health professionals, 13 midwives, 8 doctors, 25 other personnel.	Cross sectional study Pre CPR training session questionnaire.	All hospital staff had moderate self-confidence in their CPR skills. This decreased if it was more than two years since last training episode.
Hunter, Smythe and Spence (2018)	To reveal what enables, safeguards, and sustains midwives to provide labour care in freestanding midwifery-led units.	Auckland region, New Zealand.	7 midwives employed to provide care in freestanding midwifery-led units; 4 case-loading community midwives who cared for women using the midwifery-	Hermeneutic phenomenology. In-depth individual interviews.	Confidence is necessary to provide intrapartum care in freestanding midwifery units. It is nurtured by working in the community or freestanding unit and by the belief that such a unit is an appropriate place for healthy women to labour and

			led units; 3 obstetricians who provide antenatal consultations on site in midwifery-led units.		birth. Experiencing normal labour and birth in freestanding birthing units reinforces midwives' confidence. Maintaining confidence requires trusting relationships in the midwifery team and mutually respectful relationships with obstetricians.
Kaddoura (2010).	To explore the perceptions of new graduate nurses of how clinical simulation developed their critical thinking skills, learning, and confidence throughout their hospital clinical training	America	10 new baccalaureate nursing graduates working in intensive care unit.	Exploratory qualitative descriptive design. Semi-structured interview.	Clinical simulation experience facilitated an increase in confidence in decision-making abilities and dealing with critical situations.
Kaddoura, Vandyke, Smallwood & Mathieu Gonzalez (2016).	To evaluate the effectiveness of clinical simulation for entry-level nursing students by assessing first-degree students' perception of multiple simulated scenarios in their first medical–surgical nursing course.	America	107 nursing students	Exploratory qualitative design. Open-ended survey.	Majority of students stated that high fidelity simulation (HFS) promoted critical thinking, confidence, competence, theory–practice integration, and knowledge deficit identification. HFS enabled prior knowledge to be applied into a clinical setting. A few students found HFS made them feel humiliated, overwhelmed

Klaic, McDermott and Haines (2019)	To explore if there is a relationship between allied health professionals' confidence to perform a range of evidence based practice (EBP) activities and time since graduation from their entry-level degree and the presence of post-graduate qualifications.	Australia	288 allied health professionals: physiotherapy, occupational therapy, speech pathology, social work, dietetics/ nutrition	Cross-sectional survey including 12 questions measuring confidence to conduct a range of EBP activities.	Loss of confidence in their EBP activities within five years of qualifying. More likely to report greater confidence if they had post-graduate qualifications, suggesting that further learning countered the decline in confidence.
Lau, Willetts, Hood and Cross (2015)	To evaluate an aged care program in developing self-efficacy of newly graduated registered nurses	Melbourne, Australia.	24 recently graduated registered nurses enrolled on the12-month aged care graduate nurse programme.	Mixed-methods approach. Pre programme self-efficacy questionnaire. Post self-efficacy questionnaire. Focus group.	An increase in nurses' self-efficacy post-programme. The increased self-efficacy and new knowledge gained enhanced nurses' confidence and enabled them to critically appraise their workplace practices.
Marshall and Sprung (2016)	To understand the experience of a community nurse using the Mental Capacity Act in clinical practice.	North West Region of England.	60 Registered Adult community nurses employed in Band 5-7 posts.	Mixed-methods approach. An electronic questionnaire to collect statistical information regarding community nurse's views, experiences, confidence	The vast majority of participants (86.7%) had received Mental Capacity Act training. However, despite this, 86.7% also felt they would benefit from additional Mental Capacity Act training.

				and knowledge in relation to using the Mental Capacity Act in practice (n=60). Focus group (n=7) and paired interview (n=2).	In a self-appraisal of level of confidence when assessing mental capacity, most respondents gave a neutral response (46.7%). 1.7% of participants felt very confident, 23.3% confident, 25% unconfident and 3.3% very unconfident. Knowledge and confidence of the Mental Capacity Act among community nurses needed to be improved.
Morrell-Scott (2018)	To determine the perceptions of final-year nursing students about the value of simulation.	England	18 final-year Student nurses	Phenomenology. Semi-structured interviews.	Simulation is a useful tool to increase student nurse's confidence as it enables them to link theory and practice.
Sami, Nabeel & Amatullah (2019).	To evaluate the effectiveness of simulation-based training programme on nurse's knowledge and confidence in the management of obstetric emergencies and retention of the acquired competencies.	Saudi Arabia	15 midwives and 15 nurses working in the Labour and delivery unit.	Quasi-experimental design. Pre training administration of NursOB Scale. Post training administration of NursOB Scale. Follow up after 2 months with NursOB Scale.	The acquisition and retention of knowledge and confidence of participants was statistically significant after the simulated training, moving from low to medium confidence pre-training to high post-training. Follow-up at 2 months showed a sustained level of knowledge and confidence.

Selman et al (2016)	To evaluate course participants' self-rated confidence, competence, and knowledge of End of Life Care topics.	England	116 qualified nurses, 38 senior nurses/ managers, 36 general practitioners, 13 health and social care assistants /nursing students, 12 medical training graduates, and 21 other care personnel (eg., allied health professional, medical student).	A before-and-after design using self-completion questionnaires pre-course and post-course. 14 self-assessment questions. examined confidence, understanding and knowledge of End of Life Care topics.	Participants improvements in their self-rated confidence, competence, and knowledge in End of Life Care. All participants identified that the course would positively influence their future delivery of End of Life Care.
Smith and Rushton (2018)	To establish if there was an increase in student nurses' confidence levels after using the Acute Illness Management course structured ABCDE assessment framework for acutely ill patients in a simulated environment.	England	180 final year student nurses.	Quantitative. Pre-course and post-course questionnaires.	Prior to the Acute Illness Management course student nurses did not have confidence recognising and caring for the acutely ill patient. Following the course, the student nurses reported increased included confidence, and the ability to recognise and manage acutely unwell patients, and confidence in using the ABCDE assessment.

Urbutė et al (2017)	To analyze if participants' self-reported knowledge and confidence increased after the Standardized Trainings in Obstetrical Emergencies (STrObE) and whether the impact of the training was sustained.	Lithuania.	Obstetricians and midwives working in obstetric units who participated in STrObE course and completed all the questionnaires.	Prospective longitudinal design. Pre-training online questionnaire (n= 388). Immediately post-training questionnaire (n = 252). 6 weeks post-training questionnaire (n= 160) & 6 months post-training questionnaire (n = 160).	STrObE improved participants' self-reported knowledge and confidence and this was sustained for at least 6 months after the initial training. Those practitioners with lower levels of experience had the greatest increase in knowledge and confidence.
Whelan, McEvoy, Eldin and Kearney (2011)	To assess knowledge, attitudes and self-efficacy in breastfeeding in a group of primary health professionals, and the barriers to providing support.	Dublin, Ireland.	101 general practitioners, 96 public health nurses (PHNs), 59 practice nurses.	Quantitative cross-sectional design. Self-administered questionnaire.	PHN's perceived their role to be one of promoting and supporting breastfeeding as it had inherent benefits. PHN's rated themselves as the most confident of all three professionals as they had the highest self-efficacy scores in specific breastfeeding skills. PHN's and practice nurses had the greatest interest in ongoing training, especially skills-based training. Gaps and inconsistencies in the knowledge and attitudes of different health professional groups in breastfeeding were identified.

11.3.5: Stage 5: Collating, summarizing, and reporting the results

The themes that emerged from the identified papers were:

- The influence of education and training on healthcare practitioner confidence
- The influence of the practice environment and experience on healthcare practitioner confidence
- The influence of competence on healthcare practitioner confidence

These will be discussed in turn.

11.3.5.1: The influence of education and training on healthcare practitioner confidence

Thirteen studies related to the influence of education and training on healthcare practitioner confidence. Four of these studies related specifically to university-based nursing or midwifery pre- or post-registration programmes (Brown et al, 2003; Crooks et al, 2005; Donovan, 2008; Lau et al, 2015). A further three studies focused on simulation training[19] (Kaddoura, 2010; Kaddoura et al, 2016; Morrell-Scott, 2018; Sami et al, 2019) whilst two studies focused on specific obstetric emergency skills training ((Urbutė et al, 2017; Hayes et al, 2019) and one study focusing on cardiopulmonary resuscitation training (Hopstock, 2008). The last three studies focused on specific training courses relating to using the Mental Capacity Act[20] (Marshall and Sprung, 2016), end of life care[21] (Selman et al, 2016), and using the ABCDE framework[22] for acutely ill patients (Smith and Rushton, 2018).

The aim of education and training is to equip healthcare practitioners with the appropriate knowledge and skills to fulfil the requirements of the role as specified by their professional regulating organization (Nursing and Midwifery Council, 2019b). Benner, Sutphen, Leonard and Day (2010) believe that in order to achieve the knowledge and skills to meet role requirements, healthcare education needs to have

[19] Simulation is a generic term that refers to an artificial representation of a real-world process to achieve educational goals through experiential learning. (Al-Elq, 2010, p.35).
[20] The Mental Capacity Act 2005 identifies what health professionals and carers must do when they act or make decisions on behalf of people who cannot act or make those decisions for themselves. (NHS, 2018a)
[21] End of life care is care that covers the last year or months of life for conditions that can no longer be cured and can include palliative care. It also involves psychological, social and spiritual support for the patient, their family or carers (NHS, 2018b).
[22] The Airway, Breathing, Circulation, Disability, Exposure (ABCDE) approach is used to assess and treat all deteriorating or critically ill patients (Resuscitation Council UK, 2015).

an integrated approach that uses contextualised knowledge and situated learning integrated into the classroom and the clinical setting. Studies examining the influence of education and training on healthcare practitioner confidence either assess confidence as a broad concept or self-efficacy in relation to a focused area of knowledge or a specific skill.

A study undertaken by Lau et al (2015) in Australia specifically evaluated the self-efficacy of 24 graduate nurses undertaking a 12-month aged care programme to enable them to provide care in health facilities for older persons. They used a mixed methods approach to measure participants self-efficacy at the start and end of the programme. A follow-up focus group was also undertaken to explore the knowledge they gained as well as their views of course delivery such as the teaching and learning methods and activities. The programme was successful in increasing the self-efficacy of the nurses, but more importantly, the focus group revealed that the nurses believed that they had the confidence to work in an aged care setting. The nurses attributed their increased confidence to their increased knowledge and the skills to critically appraise workplace practices and deal with difficult situations (Lau et al, 2015). Lau et al's (2015) findings of the importance of acquiring knowledge to increase confidence reflected two earlier Canadian studies by Brown et al (2003) and Crooks et al (2005). These Canadian studies set out to explore the significance and increase of professional confidence among 48 nursing students undertaking a four-year baccalaureate programme (Brown et al, 2003) and an imprecisely defined number of diploma nurses on a two-year baccalaureate programme (Crooks et al, 2005). Their results suggest that the students' confidence developed due to becoming informed through both education and experience. The student nurses in Brown et al's study (2003) also acknowledged that in building their professional confidence, prior life experience and using key attributes developed from their childhood was important. These key attributes of a desire to become involved and taking the initiative for their learning enabled the nursing students to acquire knowledge from their lecturers and the registered nurses when on placement. Student nurses also identified that feedback and constructive criticism were important components to developing their knowledge and skills which in turn, built confidence.

A study in the North West of England portrayed a more varied result (Donovan, 2008). Donovan's study was of student midwives from a four-year direct entry[23] pre-registration programme, a three-year direct entry pre-registration programme, and an 18-month midwifery programme for qualified nurses. Confidence levels varied between the different courses but generally, the most confident students were on the 18-month or the four-year programme. Donovan (2008) postulated that those student midwives on the 18-month programme were drawing on their previous pre-registration nursing programme and subsequent experience as a qualified nurse, whilst the four-year students appeared to benefit from the longer duration of their programme that enabled them to have breaks away from the pressures of studying. These breaks enabled the students to reflect on their learning and experience and make sense of it all.

The importance of both knowledge and experience is again echoed in a study that explored how 60 registered community nurses applied the guiding principles of the 'Mental Capacity Act (2007)' in practice (Marshall and Sprung, 2016). Their findings identified the factors that promoted and increased confidence and those that reduced confidence. Confidence increased when the community nurses felt they had good knowledge and understanding due to the specific training and previous experience. Several organisational factors enabled them to use this knowledge and experience, notably adequate time and support from colleagues (Marshall and Sprung, 2016). Confidence reduced when the community nurses reported a lack of knowledge, understanding and/ or experience accompanied by a fear of getting it wrong, and having time constraints in practice. Smith and Rushton (2018) also reported similar influences on confidence levels. In their study, they delivered an Acute Illness Management (AIM) course to final year student nurses and assessed if there was an increase in student nurses' confidence levels after using the structured ABCDE assessment framework for acutely ill patients in a simulated environment. Prior to the course, the student nurses reported a lack of confidence to recognise and care for the acutely ill patient. Following the AIM course, the student nurses reported increased confidence, and the ability to recognise and manage acutely unwell patients.

Smith and Rushton's results (2018) are in accordance with other studies who have assessed if specific training increased confidence levels. Selman et al (2016)

[23] Direct entry courses for midwifery do not require prior qualification as a nurse.

assessed confidence levels in a range of healthcare practitioners involved in providing end of life care in England. Based on a comparison between pre-course and post-course self-ratings of confidence the participants all identified an improvement in their confidence as well as their competence and knowledge. The participants also identified that the course would positively influence their future delivery of end of life care, particularly with confidence to communicate with the patient and their relatives and plan their care. Simulation training is a popular method of increasing knowledge and skills of healthcare practitioners, and in turn, this increase in knowledge and skills results in an increase in healthcare practitioner confidence to use that specific knowledge and skill. Kaddoura's study (2010) explored the perceptions of 10 new baccalaureate nursing graduates working in an intensive care unit in America, of how clinical simulation developed their critical thinking skills, learning, and confidence throughout their hospital clinical post-qualification training. These newly qualified nurses were undertaking a critical care course over six months with a full day of simulation every three weeks. The graduates acknowledged that clinical simulation experience had facilitated an increase in confidence in decision-making abilities and dealing with critical situations. It is not clear if the eight days of simulation alone generated the increase in confidence as Kaddoura (2010) does not state how much clinical exposure working within the intensive care unit the nurses had. Other literature (Morrell-Scott, 2018) suggests that it is a combination of knowledge and experience that increases confidence. In Kaddoura's study (2010) the experience of working within the critical care unit may have augmented the experience received during the simulation days. In Morrell-Scott's study (2018) study, she asked final year student nurses about their perceptions of the value of simulation during their three-year programme. The student nurses believed simulation was a useful tool to increase their confidence as it enabled them to link theory and practice. A further study by Kaddoura et al (2016) examined the impact of repeated exposure to multiple high-fidelity simulation[24] scenarios in one teaching session on the increase in self-confidence. They argued that high-fidelity simulation often only involved one or two scenarios that do not reflect the reality of the workload and complexity of decision-making in clinical practice. Their study participants were 107 nursing students in their third year of study with the previous two years being theory-based. The students had no previous clinical experience or exposure to high-fidelity simulation. The data

[24] High-fidelity simulation uses simulators that '…provide a close-to-reality experience and contain features such as realistic physiological responses, the ability to communicate and interact with the mannequin, and various other feedback mechanisms…(in order to)…present the user with complex and immersive scenarios by providing realistic feedback' (Massoth et al, 2019).

analysis showed that the student nurses had an increase in self-confidence. Importantly for their future practice, the student nurses identified an increase in their competence and the ability to integrate the knowledge from lectures and apply it appropriately. The repeated exposure to high-fidelity simulation also gave the student nurses confidence to communicate, remain calm and practice more flexibly in stressful situations rather than adhere to strict protocols (Kaddoura et al, 2016).

The feature of most studies discussed is that they assess confidence both before and after a training event. In Hopstock's Norwegian study (2008) confidence was only assessed before cardiopulmonary resuscitation (CPR) training. Hopstock was investigating self-confidence amongst a variety of hospital personnel who worked outside critical care areas in regard to their CPR training and resuscitation experience. The findings showed that all hospital personnel surveyed had moderate self-confidence in their CPR skills, but that this confidence decreased if it was more than two years since the last training episode. This highlighted the importance of regular updates to maintain confidence levels in activities that were not used on a regular basis.

In Hayes et al study (2019) they undertook a before and after training survey of 69 practitioners who participated in a training session in interdisciplinary obstetric emergency skills and drills. They demonstrated a significant increase in practitioner confidence immediately after the training. A further study by Sami et al (2019) involving 30 midwives and nurses working in labour ward setting in Saudi Arabia showed that simulation-based training produced an immediate increase in knowledge and confidence. When assessed two months later, this increased level of confidence was maintained. An earlier study by Urbutė et al (2017) in Lithuania also reflected this immediate increase in confidence for obstetricians and midwives after skills training in obstetrical emergencies and similar to Sami et al's study (2019) found confidence was sustained at six months follow-up. Those practitioners who had the least experience saw a greater increase in their confidence compared to colleagues who had the most experience, suggesting that accruing specific skills-based experience, even from simulated scenarios, is an important component for building confidence alongside acquisition of knowledge. Specific training such as using simulation for obstetric emergencies may cause practitioners to perceive greater confidence because they are not actually real, and thus they do not feel a

fear of failing which may be evident in the real practice setting. The influence of the practice environment and experience gained within it is now considered.

11.3.5.2: The influence of the practice environment and experience on healthcare practitioner confidence

Four studies related to the practice environment and experience on healthcare practitioner confidence. Three of the studies focus on midwives and were undertaken in England (Bedwell et al, 2015), Sweden (Bäck et al, 2017), and New Zealand (Hunter et al, 2018). The final study looked at public health nurses[25] (equivalent to health visitors in the UK), general practitioners[26] and practice nurses[27] in Ireland (Whelan et al, 2011).

The practice environment is more than the physical structure; it incorporates other staff, policies and guidelines that can facilitate or inhibit care planning and delivery, and the acquisition of experience. In Bedwell et al's study (2015) midwives were confident in a customary workplace where they were familiar with the layout, policies and guidelines and had previous experience of being a midwife; this generated a confidence in their activities. Within this familiar environment, they had perceived control and autonomy which in turn contributed to their confidence levels, provided that the philosophy of the work environment was congruent with their own personal philosophy. Hunter et al (2018) found that immersion in a practice area developed confidence – thus highlighting the importance of exposure to appropriate and sufficient experience. An Irish study (Whelan et al, 2011) found that public health nurses were confident in providing postnatal breastfeeding support to mothers because it formed a significant part of their role and that they could regularly use their knowledge and skills in practice.

[25] Public health nurses are qualified nurses who provide nursing and midwifery care in the community (Irish Nurses and Midwives Organisation. (2013).
[26] General practitioners are personal/family doctors primarily responsible for the provision of comprehensive and continuing care to individuals in the context of their family, their community, and their culture, always respecting the autonomy of their patients. (The European Society of General Practice/ Family Medicine, 2005).
[27] Practice nurses are qualified nurses who work in General Practitioner surgeries / health centres as part of the primary healthcare team. (NHS Health Education England, no date)

Bäck et al (2017) explored how 14 midwives working on a Labour Ward in four different county hospitals in Sweden developed confidence and competence in a working context. They found that confidence develops over time and there is an association between the amount of hands-on experience and increasing confidence. Hunter et al (2018) also reflect these results in findings from their New Zealand study of midwives. They found that those midwives who are less experienced need 'hands on' care delivery experience and benefit from having an experienced colleague as a presence in the background for reassurance. These findings demonstrate the positive influence colleagues can offer. In their study of midwives' experiences of confidence in the intrapartum setting, Bedwell et al (2015) found that a practitioner's confidence was influenced by their perception of the level of confidence and trust colleagues had of their practice. At times the simple presence of a trusted colleague could increase confidence, whilst conversely negative criticism or questioning of actions could decrease confidence (Bedwell et al, 2015). The level of confidence afforded by colleagues appears to be linked to a judgement of practitioner competence. This association will now be discussed.

11.3.5.3: The influence of competence on healthcare practitioner confidence

Two studies highlighted the influence of competence on healthcare practitioner confidence (Donovan, 2008; Bäck et al, 2017). First, Bäck et al*'s* study (2017) referred to in the previous section links the concepts of confidence and competence. Competence is defined as *"the ability to do something successfully or efficiently"* (Oxford English Dictionary, 2019c, no page). Consideration of competence within a healthcare setting involves the combination of training, skills, experience, and knowledge as well as an ability to use them to accomplish a task (Health and Safety Executive, no date). Confidence is considered an important concept for healthcare practitioners to possess as it is related to competence (Stewart et al*,* 2000), and competence is considered a core component of professional practice that is *"a shifting construction"* (Hodges, 2012, p.41). The World Health Organisation depict competence as an attribute based on skills that reflect knowledge, attitudes, and psychomotor and psychosocial factors (Girardet, 2009). In the UK, healthcare practitioners such as midwives and health visitors are assessed on their competencies before they are able to gain registration; any lapse in maintaining these competencies can result in a Fitness to Practice hearing resulting in a range of sanctions if found to be incompetent (Nursing and Midwifery Council, 2018).

Healthcare practitioners view competence as their ability to carry out their role and fulfil the expectations of other people (Tabari-Khomeiran, Kiger, Parsa-Yekta and Ahmadi, 2007). Importantly competence is regarded as a capability to exhibit the requisite attributes of professional knowledge, skills, values along with personal qualities (Takase and Teraoka, 2011).

Whilst there is a natural tendency to link confidence with competence, they are not synonymous (Bäck et al, 2017). Donovan (2008) found that an increase in confidence was not always proportional to competence, but that decreases in confidence could almost certainly result in diminished skill performance and competence. Donovan's study (2008) demonstrates that the increase of confidence and competence is not equal and linear, and that patient care requiring skilled performance is more likely to be impacted in a negative manner by a decrease in confidence.

11.4: Conclusion

This chapter presented the findings of the further review of the literature undertaken following completion of the data analysis. Focusing on confidence within any aspect of healthcare practitioner work identified three key themes; the influence of knowledge, experience, and competence on the healthcare practitioner's confidence to undertake their role. This further review of the literature revealed aspects that corroborated my empirical work and by identifying key mechanisms that underpinned confidence; these are life experience, personal attributes, and the ability to reflect. How these aspects directed my reading and developed the substantive theory that emerged from the data analysis is described in chapter twelve.

CHAPTER TWELVE: PRESENTING THE SUBSTANTIVE THEORY

12.1: Introduction

This chapter discusses the theoretical explanation of my findings grounded in the empirical data and influenced by the further review of the literature in highlighting two key theoretical concepts which led to the identification of the substantive theory 'developing and engaging practical wisdom through use of self'. This substantive theory is presented to explain healthcare practitioner confidence in providing breastfeeding support to the father. To start, the two theoretical concepts of practical wisdom and 'use of self' will be described, and these will be discussed to highlight their relevance. Finally, there will be a discussion of the theory in relation to my study.

12.2: Developing the theory

In keeping with the principles of constructivist grounded theory (Charmaz, 2014), the substantive theory embodies my co-construction of the data gathered during individual interviews and one group interview with healthcare practitioners working within either maternity or health visiting services. The substantive theory is the stage in the analysis which connects all the previously fragmented codes and threads with the purpose of naming the main concept of the study (Scott, 2004). Chapters seven to ten presented the four categories that emerged from the iterative analysis of the data. It is these four inter-related categories that form the basis of the emerging theory. During the theorising and conceptualising work undertaken, an overarching pattern emerged from the data that appeared to explain healthcare practitioner's confidence in providing breastfeeding support to the father. This became more real as I undertook the further review of the literature described in the previous chapter.

During the process of theorising and conceptualising, I questioned whether I was enabling the core category to emerge or whether I was forcing it from the data. My initial efforts felt forced. As I engaged in the further review of the literature, I was

able to step back and see the four existing categories in a more conceptual light. It was at this point that I made the decision that I had more than one core category. This is a less common approach within grounded theory as it is usual to have one core category (Tie et al, 2019). Hallberg (2006, p.141) believes that grounded theory offers a flexible approach rather than rigid rules as it is *"…a set of guidelines for building conceptual frameworks that specify the relationships among categories."* My review of the literature reinforced that knowledge and experience were critical underpinning and influencing concepts to explain healthcare practitioners' provision of breastfeeding support to the father. My empirical insights and the subsequent review directed me to read around several key concepts more extensively. These concepts included novice to expert (Benner, 1982), competence (Tabari-Khomeiran et al, 2007; Hodges, 2012), and personal attributes such as self-awareness (Jack and Smith, 2007; Rungapadiachy, 2007). It appeared to me that the concepts of wisdom and personal attributes held the best explanation for how and why confidence was displayed by healthcare practitioners. Further reading and exploration led me to a key concept - practical wisdom. When I was exploring the wider literature on practical wisdom, and in particular Schwartz and Sharpe's book (2010) *'Practical wisdom – the right way to do the right thing'*, I realized that in stepping back from the narrower confines of the data and the process of analysis, I had allowed myself to feel and intuit the emerging theory. The literature on practical wisdom also revealed an additional theoretical lens, that of 'use of self' which explained the personal attributes I felt the participants were drawing on. In order to describe how I used these interlinking theoretical lenses to develop my theory, the theoretical basis of practical wisdom will now be presented, followed by 'use of self'.

12.3: The theoretical basis of practical wisdom

The concept of practical wisdom is derived from Aristotle's concept of phronesis – a virtue of practical reasoning. Aristotle (1999, p.89) defines phronesis as *"a state of grasping the truth, involving reason, concerned with action about things that are good or bad for a human being"*. Aristotle (1999) described phronesis as being a different virtue to those of scientific knowledge (episteme) and technical knowledge (techne), existing alongside cleverness, understanding and deliberation. Phronesis is considered a special virtue because it intersects both the intellectual and moral

domains (Sellman, 2009). Aristotle (1999) considered that two abilities were important for phronesis – deliberation of choices and perception of what was morally relevant to the situation. The term phronesis has been interpreted as prudence, practical intelligence as well as practical wisdom (Birmingham, 2004). Practical wisdom is described by Schwartz and Sharpe (2010, p.5) as:

> *The ability to perceive the situation, to have the appropriate feelings or desires about it, to deliberate about what was appropriate in these circumstances, and to act.*

In this study, the interpretation of phronesis as practical wisdom sat comfortably with the actions and processes that the data revealed.

Practical wisdom can be guided by the deliberate use of theory or the knowledge it generates (Birmingham, 2004). Deliberation of the knowledge a person has, can enable the choice of actions that may be possible in the situation under consideration (Birmingham, 2004). Lauder (1994, p.91) suggests that the value in using practical wisdom is that it avoids knowledge-oriented deduction in favour of *"…the actual performing of some action designed to produce good for fellow humans".* Lauder (1994) goes onto suggest that such actions are also the result of deliberation of the most helpful and ethical possibilities. Possessing knowledge is only beneficial if that knowledge can be used in practical ways. Practical wisdom is a process of ensuring that the most appropriate decision is reached; it requires cognitive deliberation of the facts and reflection on previous experience to be able to determine the most appropriate course of action (Ellett, 2012; Kinsella and Pitman, 2012). Possession and use of knowledge does not guarantee a positive outcome; thus in exercising knowledge there is uncertainty and ambiguity (Kemmis, 2012). Therefore, Edmondson and Pearce (2007) argue that possessing practical wisdom also appears to increase the ability to accept and embrace uncertainty or ambiguity.

Schwartz and Sharpe (2010) contend that practical wisdom is not a technical or artistic skill but a moral skill, combining skill with will. They go onto identify that as a skill practical wisdom cannot be learnt through a 'set of techniques', but rather through experience. Using knowledge builds experience, and repeat experiences enables a person to reflect on what they are doing and where improvement can be made. Edmondson (2005) believes that practical wisdom is the result of

deliberation that combines knowledge, experience and reflection with social, ethical, and emotional ability that results in beneficial, apt, and even innovative decisions.

Reflection is at the core of practical wisdom, with cognitive and affective behaviours arising from the reflective process (Ardelt, 2003). Epstein (2008, p.1050) identified that the goals of reflection are *"…insight, wisdom and informed flexibility."* Higgs and Titchen (2001, p.275) consider that this process of reflection involves "*…extensive introspection and critical reflection, and review of practice",* especially when one considers that practical wisdom is not about "*ends in themselves but about the process of wise judgement informing action"* (Connor, 2004, p.56). Such reflection may occur at the time or after an event. Schön (1983) referred to different stages in this reflective process - reflection-in-action and reflection-on-action. There has been some criticism of Schon's reflection-in-action as almost impossible to achieve as reflection is more likely to be *"hot and rapid"* rather than of a *"cool and deliberate"* nature after the event (Eraut, 2006, p.9). Eraut (2006) differentiates between the swift instinctual process that is likely to be occurring in action and one which is more considered and unhurried due to the luxury of time after the event has finished. Reflection is an essential component in practical wisdom because it facilitates the entwining of knowledge and experience (Gade, 2014). Darder, Baltodano and Torres (2003) consider that reflection is part of praxis (practical action) due to its ongoing interaction with action but underpinned by theory to help explain and understand situations. Thus, both the 'hot and rapid' and the 'cool and deliberate' nature of reflection can be used to achieve a more comprehensive insight into the healthcare practitioner's knowledge, actions, perceptions, and judgments. It is equally important to be able to recognise this insight and the actions that ensue. The next section will explore how the use of practical wisdom can be recognised and acknowledged.

12.3.1: Recognising the use of practical wisdom

Schwartz and Sharpe (2010) argue that reflection alone will not aid identification of the generation of or use of practical wisdom. They offer six signs that a person is using practical wisdom. These are:

1. The ability to clearly define the aim for the activity
2. The ability to improvise by balancing differing aims and interpreting the rules in place
3. The use of perception
4. The ability to empathise
5. The use of intuition
6. The use of experience

These six signs from Schwartz and Sharpe (2010) reveal several key qualities that a person with practical wisdom will have. This implies that by seeking to recognise such qualities, it will aid the recognition of practical wisdom. These key qualities can be divided into cognitive and interpersonal qualities. The cognitive qualities include knowledge, capacity for deliberation, judgment, perception, and the ability to learn from experience. The interpersonal qualities include the ability to listen, empathy, courage, mindfulness, and the use of emotion.

In the context of my study, healthcare practitioners needed to draw on both cognitive and interpersonal qualities to provide apt and optimal care and support. Decisions on what is apt and optimal draws on many abilities including self-perception and aided by moral imagination and empathy (Schwartz and Sharpe, 2010). In turn the use of empathy to generate practical wisdom draws on both a cognitive skill (the ability to perceive the situation from another person's perspective) and an emotional skill (the ability to understand feelings of other people) (Schwartz and Sharpe, 2010). These key qualities can be attributed to the individual person as well as the qualities that professional knowledge and experience has enhanced and/or developed. Thus, practical wisdom draws on personal knowledge and experience as well as the knowledge and experience that the person has accrued due to professional activities. These key qualities may be grounded in the 'self' and their use emerges through the 'use of self'. Schwartz and Sharpe (2010) identify that people trust themselves in exercising their practical wisdom for personal reasons, thus there is no reason not to trust the 'self' when working in broader contexts. This concept of 'use of self' will now be discussed.

12.4: The ‘use of self’

The ‘use of self’ concept within a professional patient/client-oriented relationship has long been recognised within areas such as social work (Shaw, 1974), occupational therapy (Solman and Clouston, 2016), and child protection (Munro, 2011). Arnd-Caddigan and Pozzuto (2008) define ‘use of self’ as a thoughtful and intentional drawing on one’s relational ‘self’ within a professional patient / client-oriented relationship. The ‘use of self’ in such therapeutic relationships is drawn from the fields of psychotherapy and counselling (Stickley and Freshwater, 2002). The ‘use of self’ draws on work of psychologists such as Carl Rogers and Abraham Maslow. Rogers (1957, 1961, 1992) focused on the need for the practitioner to be transparent and genuine, using prerequisites that enable the development of helping relationships – empathy, unconditional positive regard, and congruence. This need to be genuine requires the practitioner to draw on their own personality, feelings, and experiences to input into the relationship.

The ‘use of self’ concept entails the need to unpack what is meant by ‘self’. Luckman (1967, pp.48-49) indicates that self combines the *“past, present and future in a socially defined, morally relevant biography”.* Trevithick (2018) suggests that each person has a ‘core self’ that includes a capacity to remember experiences that relate the past and present referred to by Luckman (1967) with future options, assisting the recognition of features and ‘patterns of behaviour’. Swann and Bosson (2008) define ‘self’ as the depiction of oneself, alongside the picture that we have of other people, where we define ourselves in relation to others. Whereas Kaushik (2017) refers to the physical self and the psychological self. The physical self is the bodily image seen by the person and those around them and is usually described in physical terms such as height, weight, appearance. The psychological self is formed from thoughts, feelings, and memories; these contribute to self-image or identity (Kaushik, 2017). However, self-image or self-identity is also influenced by the world a person belongs within; this means that other people are powerful influencers of the ‘self’ (Stryker, 2000).

The physical and psychological ‘self’ contribute to the personal self from which the professional self can be developed and drawn. Ferguson (2018, p.417) considers that a professional ‘self’ exists as *“a core personality and identity that each*

individual has, albeit one that is not fixed but open to change". Ward (2010, p.64) suggests that the professional self is a melding of personal quality and professional skill. This is reflected in a study that asked participants to self-define their 'use of self' in healthcare settings (Dubus, 2016). Participants identified that there are different components to the 'use of self', including using aspects of their personality, being aware of their beliefs, and using relational dynamics in their role. Jamieson, Auron and Shechtman (2010) consider that 'use of self' relates to the invisible, but operable, parts of ourselves and our personalities, such as attitudes, values, motivations, biases, fears, assumptions, anxieties, feelings, habits, self-esteem, and hidden selves. It affects:

- how we appear, talk, and present ourselves (both our physical and personal presence),
- the actions we take, decisions we make, choices we pursue, and styles and preferences we use,
- and the strengths, experience, intelligences, knowledge, and skills we bring to each situation. (Jamieson et al, 2010, p.6)

Jamieson et al (2010) are describing the personal 'use of self'; that which makes each person unique. When taking that personal self into a professional role then there is another 'use of self' to use – that of the professional self. In this setting Dewane (2006, p. 543) considers the 'use of self' to involve:

> *melding the professional self of what one knows (training, knowledge, techniques) with the personal self of who one is (personality traits, belief systems, and life experience).*

In a study by Reupert (2007) social workers described how they brought their personal self into their work to enhance their professional self, using their knowledge, skills, and training. Kaushik (2017) considers that a practitioner needs to use their knowledge, skills, and values of the profession competently and judiciously to augment the well-being of a client. This is partly because use of self can be considered an *"instrument of care"* and patient/client care involves both technical and relational care (Koloroutis, 2014, p.77). Sheafor and Horejsi (2003) also argue that if the 'use of self' is an instrument of care then this implies that the practitioner will be using their self in a positive and directed manner to promote the patient/client's wellbeing rather than their own. Being able to achieve 'use of self' in

patient/client care carries with it accountability and obligation, as using oneself requires abilities such as self-awareness, self-knowledge, self-attunement, self-clarity, self-compassion, empathy, as well as an awareness of their professional boundaries and ethics (Kwiatek, McKenize, & Loads, 2005; Koloroutis, 2014). Thus, 'use of self' is a skill that stands on its own merits (Kaushik, 2017). The ability to build this skill is also influenced by a person's willingness to grow as a person, by understanding their interpersonal skills and limitations using reflection and changing as necessary (Foster, McAllister, & O'Brien, 2006). Trevithick (2018) suggests that practitioners use conscious, non-conscious and unconscious behaviour in their 'use of self'. The conscious behaviour is exhibited as self-awareness whilst non-conscious behaviour is regarded as practice wisdom which is only recalled when asked about its use. Non-conscious behaviour reflects in the use of non-verbal cues (Trevithick, 2018).

By incorporating the 'use of self' into professional practice, it enables practitioners to engage with patients / clients with a sense of authenticity and genuineness (Walters, 2008). Sheafor and Horejsi (2003) also consider that the skill of consciously using 'self' suggests that the person deliberately uses motivation and their communication skills to engage. Such communication skills include active listening with feedback and clarification, open-ended questions, validating, summarizing and silence (McCabe and Timmins, 2006). As a result, the practitioner is more likely to be able to successfully create and build rapport and develop effective interventions (Walters, 2008), that could enable a change to occur (Sheafor and Horejsi, 2003). There is a clear link between 'use of self' and relationship-based practice (Trevithick, 2012) which draws on a variety of personal attributes such as self-awareness, empathy, and communication skills alongside awareness of professional boundaries. Shulman (2008) does warn that 'use of self' in a professional setting necessitates a degree of prudence to ensure that it is guided by a professional role and a clear understanding of the rationale for the contact and intervention. In line with the view that 'use of self' is a skill, Perraud et al (2006) regard that the skilful 'use of self' develops over time with repeated exposure to practice and thus the accumulation of experience, and practical wisdom.

Drawing on the writings of Schwartz and Sharpe (2010) and Edmondson (2005) focused on practical wisdom (referred to in section 12.3) and that of Dewane (2006)

on the ‘use of self’ (referred to in this section) I now go onto consider the substantive theory of ‘developing and engaging practical wisdom through use of self’ to the findings of my study.

12.5: Relating the theory to the findings of the study

The substantive theory of ‘developing and engaging practical wisdom through use of self’ helps to explain the actions and processes that engendered the confidence the participants had to provide breastfeeding support to the father. The concepts of practical wisdom and use of self, provided the theoretical lens to explain how healthcare practitioners make use of their knowledge (chapter seven) and experience (chapter eight) to tune into the father (chapter nine), as well as enabling them to recognise and deal with the challenges they met (chapter ten). This section will be framed using the two theoretical lenses presented in sections 12.3 and 12.4. Schwartz and Sharpe’s (2010) six signs of practical wisdom (see section 12.3.1) enabled me to connect the elements of knowledge and experience that my participants had seen as core to their confidence, as well as personal attributes such as perception, and use of emotion which was previously referred to in section 12.4 as an essential element in the ‘use of self’. Within the crafting of experience other signs of practical wisdom are seen, such as perception. Using perception can help the process of reflection to determine what is a good or poor experience. Exercising such deliberation is also a requisite part of building and maintaining practical wisdom. The crafting of practical wisdom is regarded as a skill (Schwarz and Sharpe (2010). As with the crafting of practical wisdom, the crafting of the ‘use of self’ is also regarded as a skill (Kaushik, 2017), which requires experience and discernment to build.

Schwartz and Sharpe’s (2010) six signs that practical wisdom is being used, is more than a mere list. Deeper exploration reveals that these six signs reflect deeper processes of the attainment and use of knowledge and experience within a framework of reflection and use of an array of personal attributes and interpersonal skills, including those aligned with the ‘use of self’. The participant’s abilities of reflection and deliberation, key features of practical wisdom, enabled them to determine what their existing professional and personal knowledge and experience could contribute to the situation. This therefore substantiates the work of Dewane

(2006) who indicated that in drawing on their knowledge and experience they were using both professional and personal knowledge and experience – thus the 'use of self' became interwoven. As depicted by the work of researchers such as Sheafor and Horejsi (2003), Reupert (2007), and Walters (2008) on healthcare practitioners use of their professional and personal knowledge and experience, the participants in my study drew on both their personal and professional base of knowledge, experiences, and values to aid the deliberations they made. This appeared to be crucial in order for them to discern the options and make beneficial and apt decisions about the strategies they used to understand the father's perspective before being able to engage with the father and then provide breastfeeding support to him. Developing and engaging practical wisdom through 'use of self' was the means they had to do the best job they could in the absence of key frameworks such as a specific training course and a formal support strategy for the father. Their resultant confidence reflects the audacious use of practical wisdom and 'use of self' to create the provision of care and support that aims to meet the needs of each father encountered.

For the following discussion Schwartz and Sharpe's (2010) six signs of practical wisdom have been reduced to four headings due to amalgamation of related signs to aid discussion of these theoretical lenses to the study findings:

1. The ability to clearly define the aim for the activity
2. The ability to improvise
3. Using perception, empathy, and intuition
4. Experience

12.5.1: The ability to clearly define the aim for the activity

Practical wisdom and 'use of self' intersect when considering the aim of the activity to be engaged in. Kaushik (2017) advocates that the 'use of self' involves enhancing the well-being of the client by competently and wisely using one's knowledge, skills, and professional values. Kaushik (2017) also considers that the concept of the client can range from an individual through to the whole of society.

This is an important consideration when healthcare practitioners have a named client but also need to relate to the client's wider support network to realise the full capacity and impact of any care provision activity. The participants in my study frequently verbalised the importance of involving the father. Penny is an example of this belief:

> *I don't see it* [breastfeeding] *just as a mother thing; I see the father as playing a crucial role in breastfeeding actually.* (Penny, health visitor)

The healthcare practitioners in this study had a clear aim of engaging the father to meet his needs to enable him to provide appropriate breastfeeding support to his partner and baby. Kay illustrated this:

> … [you] *observe the whole situation, notice that the father is intrigued or interested, or taking an active part in the visit… wants to understand what's going on and…then obviously I would offer the support there in answering those questions.* (Kay, health visitor).

They acknowledged the value of the involvement of the father in providing breastfeeding support to the mother because they knew what a difference support could make to the mother's breastfeeding journey. This was frequently referred to during the interviews. Nora is one example:

> *I try and just get them involved as much as possible. If I go and do a breastfeeding support visit and Dad is there it's great because I get Dad looking and helping and looking at the attachment and those sort of things and being that second ear so that when Mum's really tired he can be like pull baby in a bit closer, just trying to get them quite involved really as much as they can be because I think their support is invaluable… if they can be onboard with it then the chances of it* [breastfeeding] *being more successful and so just try and gently to encourage them to just be that support.*
> (Nora, health visitor)

The participants saw the evidence of the positive impact of support from the father by seeing it for themselves with greater involvement from the father, hearing it directly from the mothers they cared for or from reading research. The evidence

that the activities the participants were involved in were working often came during follow-up visits as indicated by Nora:

> *She [Mum] did make a little comment that he wasn't, dad wasn't overly supportive so he came back in with his coffee and just sat down. I asked mum to show me how she was feeding her* [the baby] *…and just got dad over and tried to explain to him. I just pulled him into the conversation really, to get him looking and explain to him you know that although we're focused on mum and the issues going on that actually he could be really involved in this and help out and not feel like he's just at the side and actually he was really good, he was a bit reluctant and he wasn't too keen to start with but I just kind of kept the conversation going and asked him to look at different things and showed him little things like trying to point out the slight drop in the jaw when…so I think just feeling a bit more involved and the next time I went things were so much better and he greeted me at the door and he just was a little bit more involved I suppose, I don't think he was perhaps like some of the others but he was showing an interest and that little family unit was better and I think he'd been up doing a little bit more through the night because mum was just exhausted.* (Nora, health visitor)

This example from Nora also reflects the research which has revealed mothers believe that emotional and practical support from the father is essential in enabling them to initiate (Rempel et al, 2017) and continue breastfeeding (Augustin, Donovan, Lozano, Massucci, and Wohlgemuth, 2014; Cisco, 2017).

12.5.2: The ability to improvise

Improvisation is the "*act of making or doing something with whatever is available at the time"* (Cambridge Dictionary, 2020d, no page). Improvisation is an essential component of healthcare (Kneebone, 2018), because taking action reflects the inherent components of practical wisdom, namely deliberation and drawing on the social, ethical and emotional abilities that Edmondson (2005) refers to. This deliberation results in decisions and actions that may be apt and beneficial for the context. Improvisation in turn can promote *"…collaborative and creative*

client-centered practice" (Treiger, 2019, p.139), rather than becoming bogged down in knowledge-oriented deduction (Lauder, 1994) previously referred to in section 12.3. Improvisation does not guarantee success, thus highlighting that practical wisdom is used in situations of uncertainty and ambiguity as previously identified in section 12.3. Working in such circumstances would suggest that practitioners need courage to improvise, with that courage being the result of collectively harnessing multiple personal attributes. These attributes are drawn from the personal and professional 'self' highlighted in section 12.4.

The participants in my study showed how that in the absence of focused training and the lack of a formal breastfeeding support strategy and resources aimed at the father, they used their personal and professional self to draw on their practical wisdom to find innovative and beneficial solutions. The ability to improvise can be viewed as the result of the use of several 'self' based qualities that demonstrate critical thinking (Scheffer and Rubenfeld, 2000). They suggest that these qualities include:

> *confidence, contextual perspective, creativity, flexibility, inquisitiveness, intellectual integrity, intuition, open mindedness, perseverance, and reflection* (Scheffer and Rubenfeld, 2000, p.357).

The participants exercised confidence because they were moving beyond the main remit of the mother-baby dyad focus of care, and thus outside of an area that they had been formally trained for. They demonstrated consideration of the contextual perspective and their open mindedness in how they sought to understand the father's perspective and engage and encourage the father. There were frequent examples given by the participants of how they improvised to engage the father or provide him with support. One such example centred on when the father was not present during a visit, but the participant had an aim of involving him. This is illustrated by Penny:

> *At the Antenatal visit, I will leave the Healthy Start leaflet on breastfeeding. If dad is not there, I'll signpost mum to the bits that concerns dads at the back of the leaflet. At the New Birth visit, I'm hoping that mum has passed on some of that information.* (Penny, health visitor)

There was no certainty that the mother would pass on the information to the father or that he would read it. The decision made by the healthcare practitioner showed that they wished to convey a positive message to the father that his involvement was welcomed. When the father was present during a visit, such improvisation was not necessary as the healthcare practitioner could draw on their perception, empathy, and intuition to engage with and encourage the father. These aspects of practical wisdom are now discussed.

12.5.3: Using perception, empathy, and intuition

Jamieson et al (2010) claim that a person's ability to use knowledge, processes and various concepts is only helpful if they use their perception of the situation, and then have an ability to do something. To read the social context and improvise, healthcare practitioners used their cognitive quality of perception. Perception is defined as *"someone's ability to notice and understand things that are not obvious to other people"* (Cambridge Dictionary, 2020b, no page). The perception of the situation was also grounded in the knowledge of the need for drawing on the 'use of self' to promote relationship-based practice referred to by Trevithick (2012) in section 12.4. The participants use of perception, empathy and intuition also drew on several other personal attributes such as self-awareness and communication skills.

In an effort to create a relationship with the father and provide the most appropriate support to meet his needs, the healthcare practitioners talked about wanting to understand the father's perspective and this was a large part of their ability to tune into the father (see chapter nine). In line with the work of Edmondson (2005), this required them to draw on their social, ethical, and emotional abilities to be able to consider the father's viewpoint from several perspectives. This ability to consider the fathers perspective from different angles is evident in Penny's description of how she tries to discern the father's viewpoint:

> *I'd try to get to the root of where those feelings* [about breastfeeding] *are coming from. Some of it may be a lack of knowledge. It could be any sort of organic reason why he doesn't want his wife to breastfeed. It could be a sexual reason. It's finding out what's at the root of that belief or those*

feelings and it's trying to unpick that because it could be based on ignorance and, as I say, a lack of knowledge. It could be based on fear. People are complex. It's trying to unpick that in a very gentle, subtle way, I would say. That is, again, a very, very skilled role because you want to meet them halfway, if you like, and reach out. You want them to connect with you, rather than run away. (Penny, health visitor)

Some of the healthcare practitioners identified that they faced significant challenges with having time with the father to start to understand their perspective. This led them to draw on their use of self by using assumptions based on a combination of experience and evidence to start taking on the perspective of the father. By valuing the father's perspective, the healthcare practitioners were able to feel empathy for him and in turn, this enabled them to make decisions that aimed to promote the father's needs. Empathy is regarded as *"…ways of knowing what other people are experiencing"* (Meneses & Larkin, 2017, p. 4), and is considered an essential quality for an effective practitioner (Svenaeus, 2014). Empathy enables practitioners to connect with their patients / clients. In my study many participants felt that their ability to connect on a personal and professional level was integral to engaging with the father. This was ably illustrated by Penny when she reflected on her abilities:

I think it's that ability to connect and I don't seem to have an issue with connecting with people… I am naturally a people's person… It's part of who I am. I don't know whether you can teach that or whether it's just something ingrained in that person's persona and personality.
(Penny, health visitor)

Thus, Penny was engaging her 'use of self'. The participants used interpersonal skills of empathy, listening, and emotion to engage with the fathers. Such interpersonal skills as empathy have been shown through the work of Carl Rogers (1957, 1961, 1992) to be a critical component of the ability to engage with another person. Engagement started as soon as the participant arrived for the visit, with them utilising perception and intuition to make rapid judgments from the start of the visit. This is explained by Viv:

> *I have to really try and judge the family scenario and the dynamics within the first few minutes of walking in the door. From the body language and the communication from the dad, you can usually pick up who needs that little bit of extra support or who seems quite clued up.*
> (Viv, maternity support worker)

Healthcare practitioners in my study also demonstrated intuition drawing on both their knowledge and experience to assist them to have increased accuracy in their perception. Increasing their accuracy of perception by using their intuitive knowledge is a skill that Barnfather (2013) associates with the art of caring. Using their knowledge and experience evidences the use of clinical reasoning (Braude, 2009). Nyatanga and de Vocht (2008, p.492) suggest that intuition *"… is knowing without knowing how one knows."*. Holm and Severinsson (2016) would contend that intuition encompasses both the conscious and unconscious mind; the conscious mind knowing the more visible parts of interactions whilst the unconscious mind holds that which is tacit. Holm and Severinsson's (2016) views can be related to Trevithick's (2018) position that people use conscious, non-conscious and unconscious behaviour as referred to in section 12.4. Using Trevithick's definitions, intuition falls into the non-conscious behaviour and thus concurs with Nyatanga and de Vocht's (2008) definition of intuition noted above. Intuition appears to enable healthcare practitioners to deal with unknown or unpredictable circumstances (Standing, 2008), another element of practical wisdom referred to in section 12.3, be more sensitive to their patients /clients and aspire to follow up on cues (Hassani, Abdi, Jalali and Salari, 2016).

The healthcare practitioners in my study exhibited their self-awareness, which Trevithick (2018) believes is an indicator of conscious behaviour. Penny was an example when she revealed:

> *It's* [reflecting] *something I just do routinely every day. Whatever happens in life, on a daily basis, something might just hit home that you reflect on. I just do it naturally. I'm quite in touch with how I feel. I think, 'That made me feel a little bit uncomfortable' or 'I wasn't happy with that' or 'I was happy with that' and I'll think about it and then it's gone. If it's something that's made me feel uncomfortable or I feel I've not done well enough in that, I'll think, 'Why was that?' I'll search myself and identify what that was and why*

it happened and think, 'If that happened again, what would I do? How would I do it differently, so I didn't have that same result?'

Penny is demonstrating that she cognitively deliberates and reflects on her experiences to determine what could be the most appropriate course of action as discussed in section 12.4. She does not articulate the phrases of practical wisdom or 'use of self' but the elements that contribute to both are evident. She is deliberating her knowledge, experience and reflection and drawing on her social, ethical, and emotional ability of practical wisdom described by Edmondson (2005) in section 12.3 along with the elements of 'use of self' identified by Jamieson et al (2010) in section 12.4 such as feelings, attitudes, values, and motivations. This was motivating a desire to make beneficial and apt decisions reflecting Sheafor and Horejsi's (2003) notion that 'use of self' is an instrument of care, with Penny putting the focus on the other person's wellbeing rather than her own. Such self-awareness, along with other attributes, enhanced the perception, empathy and intuition of the participants.

The perception of the healthcare practitioners in this study enabled them to make judgments and test assumptions about what the father wanted or may need. An example of this was given by Lucy who stated:

I think dads sort of, from the ones I've met, they want to have quite a specific kind of specified, this is what you should do and this is what you shouldn't do, so I think if you give information that's a bit more open, then that can be difficult. (Lucy, health visitor)

The combination of perception and intuition enabled the healthcare practitioners to make a judgement as to the level of engagement of the father and thus they were able to plan their strategy to engage with him. In this study, participants frequently referred to cues from the father. Many of the participants identified such as *"if they're* [the father] *present, they are listening"* or *"they* [the father] *may lean forward",* whilst others such as Penny referred to more subtle cues such as *"facial expressions".* Perception also included their awareness of the potential influence they exerted on the father, wanting to be seen by the father as the '*knowledgeable professional'* rather than as *'authority figures'*. Their perception drew on both their

knowledge and experience to determine commonality of need and similarity to other fathers, whilst allowing them to be flexible enough to adjust their interaction and engagement with the father. In turn, the participants also relied on their intuition to gauge how the father was responding to them and their efforts to engage him. This is reflected by Lucy discussing her perceptions:

> *I think if they're in the room then they are interested and they want to hear about their baby and how the baby's doing, I think with anything you sort of judge interest by body language, whether they're getting involved in the conversation…* (Lucy, health visitor)

The healthcare practitioners used their perception and intuition to respond to the uncertainty of situations they found themselves in and drew on a range of cognitive and interpersonal qualities as identified in section 12.4. For example, the perception of the level of interest of the father was open to interpretation. Cora recounted one experience during the group interview:

> *I think it can be difficult, though, because those that disengage, they quite often are the ones that don't come to the antenatal appointments and when you go and see them postnatally they might be in the other room doing the washing up while you're in the lounge with the mum and the baby* (Cora, midwife)

Cora's perception was interpreted by other participants as identifying a disengaged father. Chantel's perception was different. She stated:

> *Actually, I thought you were just about to say that those guys that are in the kitchen washing up and doing everything else are as much supportive as the person that's in the room sitting with the mother.* (Chantel, midwife)

The importance of experience becomes evident within such scenarios.

12.5.4: Experience

In section 12.3 I referred to Edmondson's (2005) view that practical wisdom involves a multiplicity of factors. This was clear in my study as the participants drew on their experience grounded in the foundation of their knowledge, perception, intuition and 'use of self' to discern the needs of the father. Those healthcare practitioners with more experience appeared to use their practical wisdom with greater ease.

However, the participants acknowledged that it took time to gain experience and there was a need to have experience to imbed the knowledge base. Nora reflects this view:

> *I think you need the experience to instil the knowledge so I think if you've got the knowledge that's underpinning what you do it's then gaining that experience and being able to develop in that confidence of how you deliver your information plays a big part as well. I think the more experience you get at delivering it the more natural it all becomes in underpinning that knowledge that you've got.* (Nora, health visitor)

Schwartz and Sharpe (2010) consider that practical wisdom is crafted by having appropriate hands-on experience to nurture it, but do not quantify what is the right or appropriate amount of experience. It was acknowledged that different staff could have variable exposure to experience because of the nature of their caseload, as highlighted by Nora:

> *…because of the nature of the job, you don't always get breastfeeding, it can be a long time before you get a breastfeeding issue coming in.* (Nora, health visitor)

None of the participants identified experience in terms of numbers of months or years but related it to the position that were in at that point compared to when they qualified, such as the example from Beth:

> *The more experience I got watching other people and doing it myself, that all played into it, and I think when you've got that experience, you're a bit more confident about suggesting things to other people, so if you were trying to involve a dad a bit more, yeah, definitely I feel a lot more confident doing that now than when I was newly qualified.* (Beth, midwife)

Annie expanded on this challenge of gaining experience further:

> *I'm probably not able to give them the right information because I'm not experienced in giving the dad the right information, so its catch twenty-two. Dads don't want to be involved as much so I don't get the experience of involving them as much.* (Annie, health visitor)

As identified in section 12.3 Schwarz and Sharpe (2010) practical wisdom is a skill that is crafted. Experience will facilitate this crafting but requires ongoing exposure to build. In the absence of or limitation of direct experience with clients / patients/ other family members, practical wisdom can also be developed through the sharing of experiences by colleagues (Skår, 2010) provided the practice culture enables this to happen. In my study this included vicarious experience through the informal facilitation of the discussion of cases. Such practice enables the sharing of '*tips and tricks'* referred to by some of the participants in this study. This vicarious experience enables the healthcare practitioner to assess and confirm that their practices are aligned to the aim of practice (Skår, 2010).

Schwarz and Sharpe's (2010) six signs of the use of practical wisdom have provided a means of showing how the participants in this study developed and engaged practical wisdom through their use of personal and professional self to be confident to provide breastfeeding support to the father. They drew on many personal and professional attributes such as self-awareness, empathy, and communication skills that are inherent in the 'use of self' to develop and engage their practical wisdom. These theoretical lenses of practical wisdom and 'use of self' were never articulated by name, but through iterative analysis and wide reading, I as the co-constructor saw that these were foundational to how the participants had confidence to provide breastfeeding support to the father.

12.6: Conclusion

This chapter has explored the substantive theory of 'developing and engaging practical wisdom through use of self'. This theory presents the first theoretical understanding of healthcare practitioners' confidence to provide breastfeeding

support to the father; thus, the findings from the theory should be used with care. This theory will now be discussed with reference to the wider literature.

CHAPTER THIRTEEN: DISCUSSION AND CONCLUSION

13.1: Introduction

This chapter commences with a summary of the key findings before moving into a focused discussion of the findings and the substantive theory with reference to the wider literature. This discussion is centred around the influence of three key elements of practical wisdom and 'use of self' on confidence – knowledge in terms of education / training, experience, and reflection. The unique contribution this study has made will be discussed before moving onto the implications for policy, practice, education and training, and research and the associated recommendations. Finally, the strengths and limitations of the study are discussed.

13.2: Summary of the key findings

The aim of this study was to develop a grounded theorising of healthcare practitioners' confidence to provide breastfeeding / breastmilk feeding support to fathers. The key objectives were to identify how and what influences and impacts healthcare practitioners' confidence in practice, to identify the social processes and actions that underpinned healthcare practitioner's confidence in practice, and to identify recommendations for training and practice.

The aim of this study has been realised with the generation of a substantive theory presented in chapter twelve. The first objective of how and what influences and impacts healthcare practitioners' confidence in practice was met. The data revealed that healthcare practitioner's confidence was influenced by their practical wisdom and how they used their professional self, alongside their personal self to engage with the father. The second objective of identifying the social processes and actions that underpinned healthcare practitioner's confidence in practice was met as the data revealed how they used the components of practical wisdom (the combination of knowledge, experience, and reflective ability) by drawing on aspects of their professional and personal self (professional and personal knowledge and experience, personal attributes, and a range of conscious, non-conscious and

unconscious behaviours) to make apt and beneficial decisions and initiate actions. This led the participants to have confidence to 'tune into the father'. The final objective was to identify recommendations for training and practice; the participants were able to start this process and as the co-constructor of the data I have expanded these recommendations to encompass related aspects of policy, practice, education and training and research.

The key findings that emerged from this study identified that the healthcare practitioners lacked specific preparatory training on how to provide breastfeeding support to the father in both the midwifery and health visiting pre-registration courses. This was also evident within the UNICEF UK Baby Friendly training and in the annual employment organisational updates. Experience was used to fill the gap from education and training. Those healthcare practitioners who had worked longer in the role were the most likely to have the greatest experience with fathers, and the greatest opportunity to build experiential knowledge. A key factor in having the confidence to provide breastfeeding support to the father was the way the healthcare practitioners were able to meld their knowledge and experience together to be discerning in how they approached each father. A few of the health visitors identified that they had low expectations of increasing their range of experiences to provide breastfeeding support to the father. They identified several issues and challenges that they perceived was making their role more difficult to achieve this experience. These issues and challenges included workload, staff shortages, commissioner targets and financial constraints, as well as a lack of a specific strategy to provide breastfeeding support to the father. There was the need for a more targeted approach to prepare healthcare practitioners for their role in supporting the father by providing them with education and training that went beyond the mother-baby dyad and included the father as the mother and baby's key supporter.

I now discuss these key findings in relation to the wider literature. As there are no other published studies focusing on healthcare practitioner confidence in providing breastfeeding support to the father, there was no direct alignment of this study's findings with such published studies.

13.3: Framing the findings within the wider context

Due to the absence of other published literature on the focus of this study, the discussion of the findings within the wider literature will be framed around the basis of the healthcare practitioner's confidence – namely practical wisdom and use of self. As discussed in section 1.4, this study focussed on the general trait of confidence rather than the concept of self-efficacy. Whilst accepting Bandura's (1977) idea that confidence reflects a person's self-efficacy, this study only sought to explore the wider belief of confidence rather than self-efficacy's more focused capacity and capability to succeed in a specific situation or task. When contemplating what I wanted to explore about healthcare practitioners providing breastfeeding support to the father, I was not seeking to explore just one specific activity but rather a range of behaviours and beliefs.

In section 11.3, Edmondson's (2005) definition of practical wisdom revealed it to be a combination of knowledge, experience and reflection resulting in beneficial, apt, and even innovative decisions. Within these following sections I discuss the influence of education and training, experience, and reflection on confidence by considering how confidence is created through practical wisdom and use of self.

13.3.1: The influence of education/ training on confidence

The majority of participants in my study had undertaken the two-day UNICEF Baby Friendly course within their pre-registration course; the remainder undertook the course during their employment within a healthcare organisation that was working towards or had achieved accreditation from UNICEF UK Baby Friendly Initiative as they demonstrated meeting the required standards. The healthcare practitioners in my study identified that the UNICEF Baby Friendly course was a good starting point to equip them with knowledge, skills, and confidence to provide breastfeeding support to the mother, but that their confidence to support fathers was limited by the inadequacy of their knowledge base of the 'what' and 'how' to support the father, as this was not included in the course.

The finding that an initial education course for professional registration/qualification may be able to satisfy the registration competencies whilst leaving specific gaps in 'specialist' knowledge and skills is not unique to my study. Such gaps in specialist knowledge and skills are evidenced in studies of professional registration or qualification. Rominov, Giallo, Pilkington and Whelan's (2017) study of Australian midwives' perceptions and experiences of engaging fathers in perinatal services, identified that 83% of the midwives reported no formal training on how to work with the father and identified that they needed both specific education on how to work with fathers and experience with fathers. The inadequacy of pre-registration training to meet the reality of their practice was also demonstrated in Ryan and Smith's study (2016) of Australian pharmacists. They showed that over 80% of pharmacists rated their pre-registration training as inadequate to prepare them to deal with breastfeeding related enquiries (Ryan and Smith, 2016). These pharmacists were willing to deal with breastfeeding related enquiries and they demonstrated a positive attitude towards breastfeeding but had poor confidence in dealing with breastfeeding questions attributable to their lack of knowledge and education (Ryan and Smith, 2016).

The purpose of the UNICEF training is to ensure that practitioners are equipped with the knowledge and skills to meet the Ten Steps to successful breastfeeding by providing mothers and babies the appropriate care and advice that they need. The success of the Baby Friendly Hospital Initiative's Ten Steps to successful breastfeeding is evidenced with systematic reviews such as those undertaken by Beake, Pellowe, Dykes, Schmied and Bick (2012) and Pérez-Escamilla, Martinez and Segura-Pérez (2016). The latter review identified that globally the Baby Friendly Hospital Initiative's Ten Steps to successful breastfeeding has positively impacted breastfeeding outcomes that related to mother and baby, with none of the studies within their review demonstrating a negative impact. Pérez-Escamilla et al's (2016) systematic review identified that the quality of the studies was variable and there were no studies that could compare adherence to all of the Ten steps; however, there has been some positive indication of the benefit of staff training on individual standards (Fallon, Harrold and Chisholm, 2019). The UNICEF training is designed to enable the healthcare practitioners to acquire knowledge and skills to provide appropriate care and support to the breastfeeding mother-baby dyad. None of the Ten Steps specifically refers to the father. Until the UNICEF UK Baby Friendly Initiative addresses the current standards to specifically include the father

and how to focus a part of the course on developing knowledge and skills to provide support to the father, then it will continue to lack this required component.

The increased confidence to support breastfeeding mothers reported by the participants in this study is also reflected in a recently published study that surveyed nurses working either on the postnatal ward or neonatal intensive care unit in a tertiary-level hospital in Singapore after undertaking a 20-hour UNICEF Baby Friendly training course (Fok, Chang, Meng and Ng, 2020). The 148 and 149 nurses in two separate surveys reported an increase in confidence in supporting breastfeeding mothers, teaching, and supporting hand expression of breastmilk, and facilitating attachment of the baby at the breast after undertaking the training course. These specific breastfeeding support skills are related to Standard 5 of the original Ten Steps to successful breastfeeding framework referred to in Pérez-Escamilla et al's systematic review (2016) above. Standard 5 refers to the support of mothers to *"initiate and maintain breastfeeding and manage common difficulties."* (WHO, 2020, no page). In my study the participants identified that having knowledge of the practical breastfeeding skills such as teaching hand expression and teaching and supporting optimal positioning and attachment of the baby at the breast was important to have confidence to provide support directly to the mother. They were then able to transfer this knowledge to their interactions with the father, by being able to direct him to signs to observe during a feed to provide that support to their breastfeeding partner. The participants knowledge came directly from their initial BFI training and was maintained through their organisation-led updates and practical skills reviews[28] which enabled them to stay up to date with new knowledge and refresh their theoretical and practical-skills knowledge base. The participants clearly referred to their confidence in terms of them being knowledgeable about what information to impart about practical breastfeeding skills and how to impart it rather than their self-efficacy in undertaking the skills. The participants were demonstrating their innovative decision-making that comes with practical wisdom to be able to adapt knowledge focused on the mother and use it to benefit the father.

[28] The practical skills review is part of your mandatory infant feeding training. It provides an to practice discussing and demonstrating the practical skills of infant feeding in a safe environment and receive individual feedback. (UNICEF UK Baby Friendly Initiative, 2019f).

The participants also identified that knowledge alone was not sufficient to give them confidence; they required experience to consolidate their knowledge and learn how to deliver the knowledge they had. This chapter now goes onto explore the impact of experience on confidence.

13.3.2: The influence of experience on confidence

Experience was an important component to building confidence. As indicated within the results, the participants in my study equated greater levels of experience with greater confidence. This is supported by other studies. A mixed-methods sequential exploratory study of Irish midwives' confidence in perineal repair (Carroll et al., 2020) indicated that being qualified for 10 or more years was associated with higher levels of confidence in the midwives. This confidence related to making the assessment of the requirement for an episiotomy and the skill of performing the episiotomy, both aspects that require exposure to real-life experience. This finding parallels with my study as the healthcare practitioners who had more experience felt more confident to assess what support was required by the father and then to use their experience to take appropriate action. They were demonstrating their practical wisdom and 'use of self' in drawing on both their knowledge and experience and using their reflective abilities and other personal attributes to generate apt decisions related to the father's situation.

An Australian study of midwives indicated that 'on-the-job' experience was needed and more relevant than pre-registration education for preparing them to support breastfeeding mothers (Cantrill, Creedy and Cooke, 2003). These midwives identified that their confidence was the result of their professional and personal experiences, as well as drawing on colleagues' experience (Cantrill et al, 2003); thus, the concept of the use of personal and professional self is seen as important. Angela, a health visitor in my study, recounted that the training she had received as a nurse emphasised the use of professional experience over that of her personal experience as a peer supporter:

> *Well, we're not supposed to, if it was in my peer support role, I could but as a qualified nurse, you don't bring your own experiences in cause in the end, you're diverting away from them, you're making it about you.*
> (Angela, health visitor)

Angela identified a major difference between health professional training and that for peer supporters. Peer supporters are recruited based on their personal experience to make them credible to the mothers that they will encounter (Muller, Newburn, Wise, Dodds and Bhavnani, 2009). Health professionals are educated to work in a professional manner and their practice is governed by a code of conduct such as that from the NMC (2018). This includes not projecting their views and experience onto the patient / client as The Code is always about prioritising people (Standard 1) and promoting professionalism and trust (Standard 4) (NMC, 2018a). Trust is promoted with the patient/client through judicious 'use of self'. In section 12.5 I made a reference to a study of interpreters by Dubus (2016). Her participants worked hard to gain trust from the client drawing on their personality and using verbal and non-verbal communication to engage with the client. Dubus (2016) emphasised the need to develop trust by being aware of body language, voice, and eye contact. In my study the participants used their 'use to self' to discern the professional and personal experience to use as appropriate with each father.

As stated earlier the more experienced a participant was the more likely they were to be comfortable in engaging with the father. The participants in my study were not dissimilar in reporting that gaining 'on-the-job' experience during pre-registration training, or after qualification, was generally focused on the mother-baby dyad. Their response to a challenging situation involving the mother-baby dyad was to call on their colleagues for either direct help with a breastfeeding mother or indirect help through discussion. This is similar to other studies (Cantrill et al, 2003; Smale, Renfrew, Marshall and Spiby, 2006) where healthcare practitioners recounted that their breastfeeding knowledge had grown due to interaction with colleagues, and using their colleagues experience to 'plug the gap'. The participants in my study did not identify calling on colleagues, either directly or indirectly, if they encountered a challenge with providing support to the father. Gaps in experience may also arise due to organisational issues. The study by Fok et al (2020) referred to in the previous section illustrates that when experience cannot be quickly acquired after a training episode due to service constraints, then the practitioners newly acquired confidence can decline. In their study only 50% of the nurses who reported being confident to use their knowledge and skills were able to do so; the reason was time constraints.

As the healthcare practitioner's knowledge and confidence grew, they were able to use their 'self' in more meaningful ways with the father and demonstrated their practical wisdom as they identified 'teachable moments' to engage and provide strategies and support. Reynolds, Attenborough and Halse (2020, p.26) view a teachable moment as *"brief opportunities for learning".* Whilst Reynolds et al (2020) are writing from the perspective of student nurses as learners, their principles are relevant in the engagement of family members in care delivery and support. These teachable moments arise out of spontaneous opportunities to explore a situation that presents itself. The participants were demonstrating their practical wisdom and 'use of self' as they were flexible and adaptable and made apt and innovative decisions on the 'what' and 'how' to engage the father. They used aspects of 'self' to find the appropriate combination of interpersonal skills to draw the father into their encounter with the mother and baby. Interpersonal skills are at the core of reflective practice. The influence of reflection is now considered.

13.3.3: The influence of reflection on confidence

Healthcare practitioners are encouraged to be reflective and determine if their practice (in terms of decision-making, actions, and outcomes) is good, inadequate, or deficient (Jasper, 2007). It is simply not a means to confirm best practice but facilitates further care delivery and service improvement (Williams, 2020). The fact that healthcare practitioners benefit from being critical reflectors is not a new concept (Boud, Keogh, and Walker, 1985; Johns, 2004). Since the 1980's, reflective practice has been taught within professional education using theoretical approaches such as reflective practice, experiential learning, transformative learning, social cognitive theory, self-directed learning, situated learning, and learning in communities of practice with a variety of outcomes (Palmer, Burns and Bulman, 1994; Johns & Freshwater, 1998; Smith and Trede, 2013; Kauffman and Mann, 2014). Research has shown that students prefer a more ingrained approach in developing their reflective ability by using social and shared opportunities for reflection rather than for example, the 'authoritative' traditional approach of being taught reflective practice (Smith and Trede, 2013). Concerns have also been expressed about the challenge of integrating reflection into curricula that is already saturated with content (Giddens and Brady, 2007; Ndawo, 2015; Feller, 2018). This has led to a 'watering down' of content due to prescriptive instruction,

'recipe-following' and including practice that does not reflect professional codes (Boud and Walker, 1998; Eaton, 2017).

In the UK the importance of the reflective ability of the practitioner is emphasised within the proficiencies for the Future Nurse (NMC, 2018b) and Future Midwife (NMC, 2019c). Reflection is integrated into healthcare practice through forms of clinical supervision (Bifarin and Stonehouse, 2017). However, it has been identified that healthcare practitioners are less enthusiastic to embrace clinical supervision, despite professional requirements to do so due to time constraints and the need to prioritize patient care (Howatson-Jones, 2003; Ducat, Martin, Kumar, Burge, & Abernathy, 2016; Snowdon et al., 2020). It has also been identified that clinical supervision is still not completely embedded into organisational activities. Driscoll, Stacey, Harrison-Dening, Boyd and Shaw (2019) identified challenges to implementation such as high workloads and pressured practitioners; issues that were also reflected by the participants in my study. My study also highlighted organisational constraints such as staff shortages and the influence of external agendas on the workload. Current evidence therefore highlights that there are challenges in terms of how reflective practice is taught within professional education, and how it is integrated into practice.

My study identified that there is a need to ensure that future healthcare practitioners are educated in a way that incorporates reflective practice and how they can use this to enhance their 'use of self' and practical wisdom to be a confident practitioner able to respond to differing needs from their patients/clients and support networks. One such strategy is to encourage activities founded on learning theories such a Mezirow's (2000) transformative learning theory. Kear (2013, p.1086) considers that transformative learning within professions, such as nursing and midwifery, offers a model of interconnectivity. This interconnectivity in Kear's study of student nurses refers to their personal and professional worlds, but this could be re-interpreted as personal and professional self when Mezirow's (2000) personal attributes such as self-awareness and empathy are seen to be requisite parts. Transformative learning expands the consciousness by seeking to critically analyse core assumptions and the unconscious thoughts. It can aid the recognition of conscious behaviours fuelled by self-awareness such as the ability to *"…empathise and attune to others"* (Trevithick, 2018, p.1849). Reflection within transformative learning can illuminate non-conscious behaviour thus enabling a practitioner to

become aware of their practical wisdom (Trevithick, 2018). The benefit of reflecting on knowledge and experience and realising their practical wisdom enables the healthcare practitioner to discover what worked, as well as the possibilities for the future, thus creating the chance for transformative learning. As previously noted in section 12.5, Luckman (1967) considers that the 'use of self' incorporates the past, present and future. Reflection parallels this as it requires knowledge and experience of the past to be used as a benchmark to compare the present, and then either reinforce appropriate practice or illuminate changes for future practice (Koshy, Limb, Gundogan, Whitehurst and Jafree, 2017).

A further strategy to help facilitate implementation of reflective practice is centred on restorative supervision. Restorative supervision was introduced for midwives in 2017 when statutory supervision was removed from the Nursing and Midwifery Order 2001 and replaced by A-EQUIP: an acronym for Advocating for Education and QUality ImProvement (NHS England, 2017). Within the A-EQUIP model there are two particular aspects of interest to this thesis. The first is the formative function of education to increase knowledge and skills development and the second is the restorative function of clinical supervision to enhance health and well-being through support (NHS England, 2017). This restorative function has the potential to address the emotion work of professionals, and in harmony with the other aspects of the A-EQUIP model, enable midwifery practitioners to have a forum to discuss practice issues and their use of personal and professional self, and how this can impact their personal health and well-being. While restorative supervision has started to be introduced in 2021 for nurses following the impact of the Covid-19 pandemic on their health and well-being (Mitchell, 2021), it was already being used within some health visiting teams (Wallbank, 2012; Wallbank and Woods, 2012). A key method to help embed this practice in nursing and midwifery is through the use of professional advocates. Professional Nurse Advocate roles were launched during the COVID-19 pandemic (May, 2021), and along with Professional Midwifery Advocates offer the potential to champion reflection and restorative supervision, to combat the temporal restrictions within practice and promote high-quality care from a well-equipped and healthy workforce. Restorative supervision is also being used within pre-registration programmes for future nurses and midwives (Power and Thomas, 2018; Sheppard, Stacey and Aubeeluck, 2018: Tyler and Lachanudis, 2020). Encouraging the more widespread use of restorative supervision to encourage and enable deep reflection amongst students will create a future workforce that see these aspects as integral to high-quality practice, help address

the emotion work of practitioners and promote patient and cultural safety.

There is work already occurring to secure a future health service workforce with a heightened awareness of their personal attributes. The NHS Ambassadors programme[29] (Health Education England, no date) helps school and college pupils consider how personal attributes and the development of self-awareness is a key attribute to develop before entering a training programme for a health service career. In this way, harnessing pre-programme awareness could accelerate the receptiveness of learning activities (such as reflection) to develop a deeper understanding of the 'use of self' and practical wisdom. The NHS Ambassador programme also aims to ensure the future workforce is representative of the communities it serves; thus, promoting cultural safety.

Myrick, Yonge and Billay (2010) believe that whilst healthcare practitioners aspire to improve the wellbeing of patients / clients they must be aware that their actions are likely to be limited by the context in which they are working. Reflection also has the power to increase awareness of the hindering nature of such organisational structures and procedures (Asselin, Schwartz-Barcott and Osterman, 2013). In my study reflection also aided the participants to identify the organisational constraints that made acquiring experience with the fathers more difficult to achieve. The healthcare practitioners were able to reflect and identify that their pre-registration education and the UNICEF Baby Friendly training was a starting point for their interaction with mother and baby, but that there were deficits in relation to the father. Personal and professional experience and that from colleagues helped to plug this gap; however, many of the participants identified that the range of experience was limited, thus impacting opportunities to reflect on what worked and what did not work. The participants identified several organisational constraints but instead of de-motivating them, they were able to demonstrate some creativity in identifying possible solutions through their recommendations.

[29] The NHS Ambassadors Programme encourages people working or studying in healthcare to volunteer one hour per year to speak in schools and colleges about their roles or participate in careers events and activities. The programme aims to attract the future healthcare workforce by getting young people interested in different roles and professions within the NHS and help to develop the talent pool and ensure a skilled workforce in the future, and ensure the future workforce is representative of the communities it serves (Health Education England, no date).

13.4: Unique contribution to knowledge

This study is unique as it is the first study to provide insight into the confidence of healthcare practitioners to provide breastfeeding support to the father. It has illuminated an aspect of healthcare practitioner support for breastfeeding that had previously not been studied, and thus it contributes to the wider body of knowledge related to the provision of breastfeeding support. It has offered an opportunity for a small number of healthcare practitioners to elucidate their practice in relation to their confidence to provide breastfeeding support to the father. The participants used their general trait of confidence by drawing on practical wisdom and 'use of self'. Their practical wisdom and 'use of self' are founded on personal and professional attributes, knowledge and experience of interacting with people in general life and primarily mothers in professional practice, and how they translate this across to use with the father. The greater their knowledge and experience the more practical wisdom they appeared to have.

As maternity and health visiting practitioners work closely with families, this study can contribute to the wider partnership working that is required to advance the health and wellbeing of all families. This study provides a contribution that could transform how healthcare practitioners think and talk about confidence in undertaking the various components of their role. It adds to knowledge around how confidence can be developed in healthcare practitioners and the challenges that may exist and how more effective partnerships can evolve between parents and healthcare practitioners. This study also contributes to the understanding of some of the current challenges faced by healthcare practitioners working within maternity and health visiting services in the UK, in developing their confidence to provide breastfeeding support to the father. The implications of the findings will now be discussed.

13.5: Implications and recommendations

The key findings provide several opportunities to take a critical look at the practice undertaken by healthcare practitioners and their education / training in preparation to provide breastfeeding support to the father. From the inception of this study, my

primary desire was to make a positive impact on the experience of the father providing breastfeeding support to his partner. As the study progressed, it became clear that the implications extended beyond the practice and education/training of the healthcare practitioners into policy and organisational factors. The policy implications will be discussed first because the implications for practice, and education / training naturally flow out of a policy shift. The implications for research will finish off this section of the thesis. Recommendations are entwinned into each section.

13.5.1: Policy

A major policy shift needs to occur across the UK in how policymakers, commissioners of services and the healthcare practitioners delivering the service see the role of the father. There is evidence available to start this process and change the practice of healthcare practitioners, the nature of the service they deliver, the training required to deliver a re-focused service, and the service that is commissioned. Such evidence is to be found in a report from the Fatherhood Institute *'Who's the bloke in the room?'* (Burgess and Goldman, 2018). Their report highlighted that many fathers felt overlooked and excluded and recommended a shift to put the father at the centre alongside the mother. Their recommendations aimed to strengthen the place of the father, highlighting that it is about:

> *…making fathers welcome throughout pregnancy, birth and early infancy, and valuing the role they play not just as supportive partners but also as independent parents with a unique connection to their baby.*
> (Burgess and Goldman, 2018, p.48).

Recommendations of interest to this thesis included:

1. Invite, enrol, and engage with expectant dads
2. Deliver family-centred services
3. 'Father-proof' maternity staff training
4. 'Father-proof' information for expectant and new parents
   (Burgess and Goldman, 2018, pp.48-49).

Reports like this one from the Fatherhood Institute referred to above, need to inform national and local policy changes to bring the father into focus as a person in their own right, rather than being seen as an appendage to the mother and baby. In the same way that multiple organizations such as the voluntary organisations of NCT, La Leché League and Breastfeeding Network have come together with other organisations such as Lactation Consultants of Great Britain[30], Best Beginnings[31] and The GP Infant Feeding Network (UK)[32] to promote breastfeeding within the UK, their collective influence is needed to create an attitudinal shift about the involvement of fathers in all aspects of the infant's life and development, including breastfeeding. Breastfeeding support is multifaceted and there is a need to enable support to be an everyday entity. The Nigerian proverb *'Oran a azu nwa'* translates into English as *'it takes a community or village to raise a child'* (van der Rheede, 2010, no page). This philosophy needs to be translated into practice so that fathers no longer feel ignored or excluded, and healthcare practitioners feel confident to engage and encourage fathers in providing breastfeeding support.

The healthcare practitioners in this study identified that there was no strategy on the 'how' to support the father and 'what' to include in that support. This requires a strategy to guide best practice in providing breastfeeding support to the father, however this should not be created separate to the strategy to support the mother and baby. To provide appropriate support the father-focused strategy needs to be woven into the strategy to support the mother and baby, as the mother and father are a team working together. To create national consistency, this strategy is best placed within the antenatal and postnatal care guidelines from the National Institute of Health and Care Excellence, as these are the key guidelines used to inform policy and practice within healthcare organizations within the UK.

Breastfeeding support postnatally is influenced by the Postnatal care guideline (NICE, 2021) which replaced the previous guideline published in 2006 (NICE, 2006). In light of the challenges that the UK faces in achieving the WHO (2003) recommendation for a minimum of six months exclusive breastfeeding, there is still

[30] Lactation Consultants of Great Britain is the professional association for International Board Certified Lactation Consultants in the UK (Lactation Consultants of Great Britain, 2020).
[31] Best Beginnings is a child health charity that focuses on giving every child the best start in life from pre-conception (Best Beginnings, no date).
[32] The GP Infant Feeding Network (UK) is a national network of primary care professionals and supportive colleagues advocating for improvements in infant feeding practice (The GP Infant Feeding Network (UK), 2020).

a need to undertake a comprehensive review of the infant feeding component of the Postnatal care guidelines to ensure that the guideline not only reflects the biopsychosocial evidence about the benefits and challenges of breastfeeding but contains key direction on the *how* and *what* of the provision of breastfeeding support for the family unit in the early post weeks and months, ensuring there is a family-centred focus as called for by the Fatherhood Institute and Spencer (2013) in her phenomenological study into women's experiences of breastfeeding. The current guideline focuses on the care surrounding the mother and baby ensuring that it provides a framework for the delivery of safe care. This remit needs to be extended to include key practice points relating to the support of the father in his role transition and monitoring how the father is bonding with his baby, and how the father can be involved in the role of supporting the breastfeeding mother. A father inclusive approach will mirror the practice within the homes of the UK and reflect the client base midwives and health visitors want to engage with.

Father inclusive practice can start at the beginning of pregnancy with a more explicit invitation for the father to attend the antenatal booking visit when breastfeeding will be raised and information about local breastfeeding workshops is given (NICE, 2006; NICE 2021). This is also the opportunity to identify specific information contained within publications recommended to the woman such as the Pregnancy Book[33]. The current edition contains two specific pages for fathers. This could be extended further and have additional links to website pages that enable fathers to gain factual information. The health visitor participants in this study were keen that the invitation letter for the 28-week antenatal visit by the health visitor was reworded to become more father inclusive (as identified in section 10.5) and stress the benefit to both the parents-to-be and the health visitor of meeting together.

In addition to making the antenatal and postnatal visits to the woman / mother and baby more father inclusive, there is a need to establish father friendly and/or father only services. This is in recognition that some men do not feel comfortable to address aspects of childbirth, parenting, and infant feeding in a mixed gender group (Friedewald, Fletcher and Fairbairn, 2005; Shia and Alabi, 2013). Some fathers will be satisfied by a definite father-friendly approach to the provision of antenatal education using male facilitators within classes for both the mother and father. This

[33] The Pregnancy Book is an NHS publication available in electronic form that provides information from the start of pregnancy and into parenthood (NHS, 2019).

approach of using men as a co-facilitator has long been shown to be acceptable to the father (Symon and Lee, 2003). The provision of father-only antenatal classes needs to ensure there is a balance between information-giving and discussion-based strategies. Men may shy away from discussion forums as they need to share their emotions, thus preferring information-giving formats (Nash, 2018).

There is a demand for father-only antenatal classes as evident by the advertisement and uptake of such classes on the internet. Most of the father inclusive services are run by non-NHS organisations such as DaddyNatal (2020) and Pregnancy and Parents Centre (2020) and may incur a fee; this can be a constraint in many families. There is also a need to review the provision for fathers both in antenatal classes and postnatal support classes / groups. These classes / groups could be run jointly by the midwifery and health visiting services in a specified geographical locality to ensure that they are accessible to both the father and staff and are facilitated by local healthcare practitioners and fathers. These need to focus on information giving, sharing tips, and providing a safe space for men to ask questions. Whatever the structure and mix of the classes offered, there needs to be attention to the specific content. The antenatal sessions also need to cover labour and birth, but in relation to this study the focus is on the aspects related to providing breastfeeding support. A recent study in Sweden identified that the fathers wanted information on how to support their breastfeeding partner (Pålsson, Persson, Ekelin, Hallström and Kvist, 2017).

Father-oriented session to focus on breastfeeding could include:

- The importance of their role in supporting breastfeeding
- how they can support mother emotionally
- how they can support mother physically
- how to recognise that breastfeeding is going well
- who to contact for help
- life with a newborn baby – sleeping/waking/feeding patterns, coping with crying
- baby care – nappy changing, bathing, handling, changing clothes

Policy alone will not ensure that healthcare practitioners become confident to provide breastfeeding support to the father; they must be engaged in practice. This is now discussed in the next section.

13.5.2: Practice

The participants in this study clearly identified the value of gaining experience in engaging and providing breastfeeding support to the father. The opportunity to gain experience was constrained by a number of factors such as fathers not seeing they were welcome, fathers being at / returning to work, mothers on their caseload not breastfeeding, changes to work practices such as dropping the antenatal visit by the health visitor, high workloads, and staff shortages. The health visitor practitioners in this study identified that health visiting services were not adequately funded to deliver the universal service mandated in the Health Child Programme. This need has been reflected by the Institute of Health Visiting (2020a) who have joined with the Breastfeeding Network in World Breastfeeding Week in August 2020 to call for several measures including:

> *To ensure that health visiting services are properly funded and the number of health visitors increased to ensure consistent timely nutritional support for all families to support good maternal and infant mental and physical health.*
>
> *To commission and sustainably fund universal, accessible, confidential breastfeeding support delivered by specialist/lead midwives, health visitors and suitably qualified breastfeeding specialists, recognising the role of charitable organisations and community groups and their strong links with communities.* (Institute of Health Visiting (2020a, no page)

Key stakeholders such as the Royal College of Midwives and the Institute of Health Visiting need to continue their lobbying of the government to review the funding of a viable staffing level to meet the caseloads recommended to deliver the highest standard of care to families during their pregnancy and parenting journeys. The Royal College of Midwives (2019) identified that within England there was a shortfall of 2500 full time midwives based on the official birth statistics for 2018, whilst the Institute of Health Visiting's annual report of health visiting in England (2020b) identified that between 2015 and 2019 one in five health visitors were lost from the

workforce; this coincides with the time period when data collection was undertaken for this study. The health visiting report also highlighted the excessive workloads with nearly one-third of the respondents identifying caseloads between 500-1000 children, when the recommended case load by the Institute of Health Visiting (2020b) to facilitate effective working is 250 children. The midwifery caseload is based on the Birthrate Plus calculation that has evolved since its original inception in 1996 (Ball and Washbrook, 1996). Currently midwifery continuity of care teams being rolled out across England arising from the Better Births Initiative[34] (National Maternity Review, 2016) recommend a case load of 35 women per year per full-time midwife.

Despite the focus of the job being on the mother-baby dyad, many of the healthcare practitioners reported in this study that they were not always provided with sufficient time to support breastfeeding. This conflicts with the NICE (2006) Postnatal care guidelines which were current during this study's data collection, which specifically recommend that:

> *1.3.4: Healthcare professionals should have sufficient time, as a priority, to give support to a woman and baby during initiation and continuation of breastfeeding.* (NICE, 2006, no page)

Mothers can expect the midwife and the health visitor in those early weeks to provide the advice and support required to get breastfeeding off to a good start. Not all mothers will require additional and/or specialised support from a midwife or health visitor. There is more scope for healthcare practitioners to be working more closely with voluntary organisations such as National Childbirth Trust, La Leche League, and the Breastfeeding Network. In the past collaboration has been through NHS run breastfeeding support clinics and Baby Café (as previously discussed in section 2.4.1). Breastfeeding mothers have reported that they value support offered by the trained breastfeeding counsellors and peer supporters from the voluntary organisations (Fox et al, 2015). This support may be in person or via telephone helplines.

[34] The Better Births Initiative emerged from the National Maternity Review of maternity services. Their report set out the vision for the planning, design and safe delivery of maternity services; how women, babies and families will be able to get the type of care they want; and how staff will be supported to deliver such care (National Maternity Review, 2016).

There is an opportunity for NHS practitioners to collaborate with the voluntary organisations to widen the in person and telephone helpline support to the father and also to include a wider range of technologies such as online video-calls, and mobile phone Apps with discussion boards. Parents are reliant on Mobile Apps (Mader, 2020), although they identify that many Apps are not specific enough to meet their needs (Mader, 2018). The NHS already uses ChatHealth 0-5 as a way to engage parents in general child health issues through the use of text messaging that is answered within 24 hours by a health visitor (Southern Health NHS Foundation Trust, no date). Mader (2020) identified that whilst there are breastfeeding Apps they are targeted at mothers. There is a need to incorporate the use of breastfeeding specific Apps aimed at fathers, such as the Milk Man App developed in Australia (White, Giglia, White, Dhaliwal, Burns and Scott, 2019). This App was evaluated by fathers as an acceptable source of information. It encouraged conversation between the couple (White et al, 2019) and was particularly successful as it featured a conversation forum (White, Giglia, Scott and Burns, 2018). The recent COVID-19 pandemic has illustrated that more flexible ways of service delivery can be achieved. A recent study by Brown and Shenker (2020) showed that mothers valued the option to receive support via an alternative means such as online or telephone support instead of no support. The use of technology to support healthcare delivery is a global practice (World Health Organization, 2016), with advantages outweighing disadvantages depending on the technology used (Donaghy et al, 2019; Tschamper and Jakobsen, 2019). Drawing on studies in this area it is reasonable to assume that many fathers could welcome such an option compared to no or limited support. In a recent study, Mustafa, Yang, Mortezavi, Vadamalai, and Ramsey (2020) reported on 177 patient satisfaction responses to the use of telemedicine[35]. Of these 177 patients, 40% were new patients whilst the remainder were follow-up appointments and thus already knew the physician. Almost 97% were satisfied with the telemedicine consultation, whilst 77% believed it was equitable to a face-to-face consultation. A significant number (45%) of the participants liked the face-to-face consultations due to the desire for more personal interaction. Mustafa et al (2020) suggested that the future for telemedicine was looking positive due to the potential advantages of saving time and improving access, although access is limited to those members of society who have a mobile phone/ tablet or computer that enables telephone or video

[35] Telemedicine is the delivery of health care services, where distance is a critical factor, by all health care professionals using information and communication technologies for the exchange of valid information for diagnosis, treatment and prevention of disease and injuries, research and evaluation, and for the continuing education of health care providers, all in the interests of advancing the health of individuals and their communities (World Health Organization, 1998).

conference calls. As services emerge from the Covid-19 pandemic there is an opportunity in this 'new normal' to undertake a comprehensive review of how maternity and health visiting services are delivered, and the recommendation would be to continue with a variety of services and match the choice of communication tool to the family and their individual circumstance, thus increasing the possibility of father inclusive practice. The use of technologies that enable visual and auditory connection between healthcare practitioner and father could also be complemented by signposting the father to a range of resources based on the internet or within Mobile phone Apps. Fathers have responded positively to information resources via the internet with discussion board and chat facilities (Nieuwboer, Fukkink, and Hermanns, 2013; Tully et al, 2017), with many fathers finding convenience of access (Metzler, Sanders, Rusby, and Crowley, 2012).

Father inclusive practice needs to be integrated into both antenatal and postnatal service delivery across both the maternity and health visiting services, providing evidence-based information about breastfeeding and the range of support available in their local area. There needs to be more consideration of how healthcare practitioners can begin to engage with the father during pregnancy.

Planning for improvements in father inclusive practices requires fathers to be involved from the beginning to ensure that the services can meet their needs. Within the maternity services a forum called Maternity Voices Partnership[36] already exits to seek the views of women about their local provision. This forum could be expanded to directly access the voices of fathers, rather than rely on anecdotal feedback from women. Accessing fathers through this type of forum would help to ensure a more equitable parent focus, for fathers to feel important and valued in decision making, and for fathers to be involved in the design and development of appropriate and meaningful father-led resources and service provision. This work could involve the results of relevant research, such as the findings and implications identified within my study, to be shared within a father-focused network; to gather their views on the importance and value of this work, and to help inform how these findings could be operationalised in practice. This forum also offers national networking through the lay chairs who meet as National Maternity Voices, thus

[36] A Maternity Voices Partnership (MVP) is a NHS working group: a team of women and their families, commissioners and providers (midwives and doctors) working together to review and contribute to the development of local maternity care.

offering the opportunity to develop a national father-led approach. As the journey to fatherhood involves contact with both the maternity and health visiting services, I would recommend that local collaboration is created to ensure that both services can access the fathers' views to create an integrated approach to promoting and providing father inclusivity.

As identified by the participants in this study there appears to be a greater opportunity for engagement between midwives and the father. Historically community midwives and health visitors have predominately worked office hours and many fathers are unable to have time off work to be present during an antenatal visit, even though they are entitled. To become more father inclusive there is a need to consider the working pattern of both community midwives and health visitors. With the advent of Midwifery Continuity of Care teams (as part of the Better Births initiative) there is an opportunity to re-envisage the working pattern of the midwife to meet the needs of the caseload. This will not be without some opposition. Initially it would be feasible to ensure two antenatal appointments during the second and third trimester of pregnancy[37] are offered at a time that the father could attend; for example by running an antenatal clinic from 5-8pm during the week or on a Saturday morning, or by considering a home visit. Many community midwives are based at doctor's surgeries who already have extended opening times. For those community midwives who are based in County Council Children's Centres[38] or Child and Family Centres (an updated name for Children's Centres to depict the focus on the family), then it would require flexibility to offer home visits due to the limited opening hours of many Children's Centres. Equally there is a need for greater flexibility and understanding from employers to facilitate fathers having more antenatal involvement, but this needs to be matched by healthcare professionals being sensitive to the constraints many fathers may face. There needs to be flexibility from the healthcare professionals to ensure that they offer a range of variable-timed appointments to enable a father to plan around their work commitments and for employers to lose minimal amount of time that their employee is away from the work environment. Such flexibility in appointments could mean having 8am appointments or 6pm appointments from healthcare practitioners with a

[37] A trimester is a defined period of a pregnancy. There are three trimesters in total each lasting approximately three months (Cambridge Dictionary, 2020c)

[38] A children's centre is a place, or group of places, where local families with young children can go to enjoy facilities and receive support that they need, including free parenting support. The facilities and activities provided are designed especially for parents with a child under five years old, or those expecting a baby (Hackney Education, 2020).

flexible approach in their working day either starting earlier or finishing later than colleagues at the same base.

Gaining confidence in providing breastfeeding support in the practice setting could also be achieved by shadowing colleagues in selected visits, breastfeeding support clinics / groups and picking up different ways of interacting with the fathers and learning how to discern their needs. This setting also gives an opportunity to acquire 'on the job' training in an informal manner. 'On the job' training is highly valued by healthcare practitioners. Eraut (2007) identified that learning in the workplace tends to be informal and involve tacit knowledge. Such learning can be the result of working practices or a more recognised learning activity (Eraut, 2007). Creating opportunities for colleagues to work together in specially designed antenatal or postnatal groups for fathers would facilitate the observation of communication skills during healthcare practitioner-father interaction. It would enable the less experienced and/or confident healthcare practitioner to develop confidence in engaging with the father with the reassurance of back-up. In the same way a student would be supported to become increasingly involved, then this could happen for a colleague. The inclusion of a reflective discussion after the event would help to facilitate raised self-awareness of the healthcare practitioner and identification of a SWOT[39] analysis.

It is important that the socio-cultural variation in the geographical area in which the healthcare practitioner works is fully acknowledged. In my study the participants identified that they shared similar characteristics to many, but not all, of the families in their care. At both healthcare practitioner and healthcare organisational levels there is an increasing need to actively engage with the concept of cultural safety to achieve fair and non-discriminatory health care (Curtis et al, 2019). Cultural safety is not a new concept. Papps and Ramsden (1996) refer to cultural safety as the need for careful scrutiny of the power relationships between users and providers of a service and how that affects the quality of the service delivery. More recently cultural safety is being considered within a wider social justice strategy to achieve equity in health and a reduction in discrimination in the provision of healthcare (Lokugamage, Rix, Fleming, Khetan, Meredith and Hastie, 2021). Downing, Kowal and Paradies (2011) suggest that part of the relationship between the healthcare

[39] A SWOT analysis is a planning tool used to understand key factors - strengths, weaknesses, opportunities, and threats - involved in a project or in an organisation (CIPD, 2020).

practitioners and patients/clients also requires the healthcare practitioner being perceptive of their own culture and identity and how this is revealed/expressed in their practice. Ringer (2017) suggests that this is not a 'one-off' activity but rather a continual self-evaluation to be assured that the focus remains on the needs of the patient/client rather than on assumptions and conjectures. Curtis et al (2019) suggest that there is a need for healthcare practitioners to cultivate suitable skills and attitudes and that care provision must recognise and focus on their biases and stereotypes. Such biases and stereotypes can be rooted in both the personal and/or professional self. Reflective discussions could help healthcare practitioners recognise their use of self and practical wisdom (both appropriate and inappropriate), challenge biases, and improve their working relationships with both patients/clients and their support network. It could also enable healthcare practitioners to identify when adaptation would be needed across the various spaces and places where care is delivered, and between various groups and communities across cultures in their locality. To promote and achieve such cultural safety, further education and training may be required. The relationship of practice and education/ training is a close one for healthcare practitioners. There is a mutual dependency with each contributing to the other. The implications for education / training are now discussed.

13.5.3: Education / training

The findings from this study indicated that the healthcare practitioners valued their initial pre-registration courses but had a less positive attitude towards attending organisational-led breastfeeding training perceiving it to be an activity to be tolerated, although acknowledging that they did update their knowledge and/or skills. For some of the participants there had been a suspension of breastfeeding training due to staff shortages and high workloads. This is not an unusual situation as reflected in a UK-wide survey of the Directors and Heads of Midwifery undertaken by the Royal College of Midwives in 2019, to seek evidence to present to the NHS Pay Review Body (Royal College of Midwives, 2019). In the survey 31% of Heads of Midwifery had reduced the level of training provided to staff. There was a greater expectation that training[40] and continuing professional development[41]

[40] Training refers to updating session that occur within the workplace (in-house or in-service training).

[41] Continuing professional development can involve education and training undertaken outside of the employing organization.

was not the remit of paid work time with 85% of Heads of Midwifery reporting that not all continuing professional development was funded during working hours, and 10% stating that they did not pay for any continuing professional development. This reflects some of the participants in this study who financially funded their own professional development in their non-work hours. This sits within the characteristics of engagement with continuing professional development identified by Hearle and Lawson (2019). Their five characteristics included self-initiated, rewarded (either intrinsically or extrinsically), applied in practice, recorded, evaluated, and shared with others, and continues beyond the initial learning activity (Hearle and Lawson, 2019, p.251). Training should achieve organizational goals that include increased staff knowledge, skill, and competency, and improved patient care and satisfaction (Chaghari, Saffari, Ebadi & Ameryoun, 2017).

There appears to be a mismatch between the current provision of breastfeeding education and training to healthcare practitioners and the skills needed by them to provide effective breastfeeding support to the father. The current education / training provision centres on developing knowledge and skills related to breastfeeding for the mother-baby dyad. There have been calls in the past to improve the quality of breastfeeding training. Spencer (2013) in her phenomenological study referred to in the previous section, also stipulated the need for improved staff training with a greater importance given to relationship building, as well as communication skills and techniques. Her recommendations are reiterated in the data from the participants of this study who expressed a desire to know how to engage and encourage fathers.

The UNICEF UK Baby Friendly Initiative training (2019g) has recently been reviewed and refreshed to reflect the latest evidence. It is aimed at any healthcare practitioner working to support mothers and babies. Whilst the promotional information on their website conveys a wider focus there is still no reference to the father. The purpose of the course is to provide:

> *detailed guidance on establishing and continuing breastfeeding and developing close and loving parent-infant relationships, the course takes a holistic view of the family's journey through pregnancy, birth and the important days, weeks and months post-birth which have such a significant impact on future health and wellbeing.* (UNICEF UK Baby Friendly Initiative, 2019g, no page)

A training course already running that focuses on promoting father inclusive practice is from the Fatherhood Institute (2011) who offer a one-day course to healthcare organisations on '*Creating father-inclusive health and social services'.* This training programme was evaluated using views of 134 health visitors and community practitioners from eight NHS Trusts in England who attended the training between 2012 and 2014 (Burgess, Jones, Nolan & Humphries, 2014). The participants indicated that the training programme improved their knowledge, generated more positive attitudes towards the father and increased their intention to engage with the father. Unfortunately, in the financial climate within the NHS running training course from external organizations is expensive and the benefits are not seen as outweighing the cost. The alternative is to develop an additional element to the UNICEF Baby Friendly course that specifically equips staff with knowledge and skills to engage with fathers and has content that is focused on what aspects of breastfeeding knowledge and skills needs to be conveyed to the father to enable him to become an effective supporter.

If a father-specific antenatal class is provided, the facilitators need some antenatal education provision education. An element of this training could be generic but part of it needs to focus on the specific needs of the father; using the framework of the class previously outlined in section 13.7.1. Part of the education / training needs of these facilitators could also involve how to use father-appropriate equipment and resources, to ensure that the father feels that they are the intended target audience for such classes.

Informal discussion of cases in practice already occurs as evidenced in the data from this study. There is a need to harness this naturally occurring activity and enable the time to be made within a working week for healthcare practitioners to regularly present and discuss their cases. This is a common activity within the medical world (Abildsnes, Flottorp and Stensland, 2012), but nurses and midwives have not formally embraced this activity to increase their knowledge and improve patient/client care. Abildsnes et al's (2012) focus group study of 50 general practitioners in Norway shared case stories to explore the interactive processes that resulted. The general practitioners generated discussion on what was best practice for the case and shared useful tips; a feature that the participants in my study reported.

Introducing change can elicit resistance (Amarantou, Kazakopoulou, Chatzoudes and Chatzoglou, 2018). Change management needs to be framed and presented as a positive enhancement to any organisation so that resistance becomes a positive force in terms of posing insightful questions and imaginative alternatives (Todnem, 2020). Healthcare practitioners react positively to change and activities that have a recognisable foundation or framework and are well communicated (Nilsen, Schildmeijer, Ericsson, Seeing and Birken, 2019). Case discussion is an example of a framework. Launer (2016) advocates the use of the 'reflecting team' to help frame the discussion originally promoted by Andersen (1987) in family therapy. Case discussion is a loose framework that enables presentation of a case and then the ability of team members to contribute to ask clarifying questions and consider the case from different perspectives (see Table 17).

Table 17: Conversational rules for case discussion, using a reflecting team (Launer, 2016, p.245)
1. The case presenter first talks without interruption for a couple of minutes (or longer if time permits).
2. Other members of the team then ask questions to clarify the case or its context, but they cannot give advice or make any suggestions (even indirect ones like "have you thought of…?").
3. The case presenter then poses a question or task for the team to consider (for example "is there any aspect of this case I might be missing?" or "what would you do in this situation?").
4. The team responds by discussing this, but without looking at the presenter, or involving him or her in the conversation.
5. Finally, the presenter gives feedback to the team about what was most helpful in the discussion, and what action it will lead to.

In a routine case discussion, it would be easy for a team member to introduce the perspective of the father into the second step as outlined above. Thus, practice can start moving towards being father inclusive without a significant change being perceived by other healthcare practitioners. Such a strategy has the potential to improve practitioner knowledge base, increase collaborative discussion and sharing of expertise, and ultimately has the potential to improve the quality of the care delivery.

13.5.4: Research

This study focussed on an aspect of practice that had not previously been researched. Therefore, recommendations for further research can be made to corroborate my findings and start to extend understanding around healthcare practitioner confidence in providing breastfeeding support to the father.

Further studies are required using larger sample sizes from a more diverse range of geographical settings and including practitioners with a more diverse range of experience in life and work that reflects the personal and professional 'use of self'. Having a larger sample within each professional group could provide a greater understanding of what is known within a professional group and enable more focused recommendations that account for the unique settings each professional group work within. It would be beneficial to study the perceived confidence of the practitioner from both the practitioner's perspective and that of the father as the recipient of the support.

Further work is needed to elicit the views of fathers in terms of how breastfeeding support should be provided. This could (as stated in section 13.5.2) involve sharing the findings of key research with fathers to elicit feedback on whether and how these insights can be implemented in practice. However, it could also involve primary research with fathers, whereby father's voices and views are part of PPI to facilitate the design, conduct, interpretation and dissemination of the research. This is to ensure that the questions that are being asked, how fathers are recruited, and how the data are interpreted and shared are aligned with fathers' values and needs. The PPI group could be drawn from forums such as Maternity Voices Partnership or existing father-focused organisations such as the Fatherhood Institute, to achieve a diversity that reflects the locality.

This type of research could also feed into the training of student midwives and student health visitors to enable them to appreciate the narrative of the professional and the father. Healthcare curriculum in the UK require a clearly visible service-user focus (NMC, 2019c) and using such research could enable the wider development of the focus on the father as a service user rather than the narrower

perspective of the woman / mother-baby dyad. As a midwifery educator it would be interesting to undertake research of student midwives as they progress through the three years of their undergraduate course and then into professional practice to understand more fully how the specific breastfeeding-related education of theoretical and placement-related learning generates practical wisdom and 'use of self' evident as confidence to provide breastfeeding support to the father as well as to the mother.

A further recommendation is to use the findings in conjunction with the work by Bandura (1997) on self-efficacy to develop a tool to help identify /assess confidence and self-efficacy in healthcare practitioners. Dennis and Faux (1999) utilised Bandura's work to produce a breastfeeding self-efficacy scale[42] to assess a mother's confidence to breastfeed her baby. This scale could be adapted to assess healthcare practitioner's confidence and self- efficacy to provide breastfeeding support to the father. It could do this by assessing:

a) Whether a healthcare practitioner chooses to actively engage with the father or not,
b) How much effort the healthcare practitioner will expend to engage with the father,
c) Whether the healthcare practitioner will have self-enhancing or self-defeating thought patterns, and
d) How the healthcare practitioner will emotionally respond to the situations that they meet the fathers in and any challenges encountered.

Using such a scale could help a healthcare practitioner identify their personal and professional 'use of self' strengths and areas for development, as well as their practical wisdom in how they problem solve, create innovative solutions etc. The original work by Dennis and Faux (1999) has been modified and adapted to assess maternal breastfeeding self-efficacy across different age groups, ethnicities, and cultural settings (Dennis, 2003; McCarter-Spaulding and Dennis, 2010: McQueen, Montelpare and Dennis, 2013; Wheeler and Dennis, 2013; Dennis, Brennenstuhl

[42] The breastfeeding self-efficacy scale is used to predict
a) Whether a mother chooses to breastfeed or not,
b) How much effort the mother will expend to achieve breastfeeding,
c) Whether the mother will have self-enhancing or self-defeating thought patterns, and
d) How she will emotionally respond to breastfeeding difficulties (Dennis and Faux, 1999).

and Abbass-Dick, 2018; Amini et al, 2019). It would be valuable to have a complementary healthcare practitioner scale.

13.6: Strengths and limitations of the study

A key strength is that this is the first study to explore healthcare practitioner's confidence in providing breastfeeding support to the father. It has enabled a greater understanding of what is necessary for healthcare practitioners to engage with the father. There were minimal exclusion criteria to ensure that a range of healthcare practitioners could participate; in the end there were eleven professionals and two non-professional participants. I acknowledge that the co-construction of the data is predominately driven by the professionals. I recruited from two different organisations and achieved a relative balance between the two professional groups with six health visitors and five midwives as well as a range of experience in the role. The healthcare practitioners who participated had a desire to share their experiences; it is acknowledged that their willingness to participate may make them different to their colleagues. Perhaps those participants who responded positively to the recruitment already had a degree of confidence, thus are not totally representative of their colleagues.

As a researcher I was lacking in research interviewing experience but had a career spanning over thirty-five years of talking to fellow professionals, women, and their families. My professional roles as a midwife, educator and lactation consultant could be a strength and a possible limitation. Some of the participants revealed that they were more comfortable participating in the study knowing I was 'one of them'. My authenticity was perceived as a positive. My professional knowledge was helpful in trying to understand the structures and processes that the participants identified, but equally I am aware that it could have introduced an unconscious bias in the co-construction of the data and may have influenced the questions and probing I did or did not do within the interviews.

There were challenges in recruitment. One omission of note is that of males in the sample. It was not possible to recruit male health visitors to this study as none were employed in the Trust I was recruiting from. Equally there were no male midwives

in the sample, despite them being employed in the maternity services, as no male midwives were working in the clinical areas accessed for recruitment. A male perspective would enhance the findings as there are some male run services for men in pregnancy and after birth which have received positive feedback (Kuliukas et al, 2019). Issues with recruitment were particularly evident when I undertook theoretical sampling; this may have constrained theoretical saturation by not enabling negative cases to emerge. Another limitation is that the participants came from one area of England.

All the interviews took place in the workplace and whilst this provided the participants with convenience, I was aware of the chance of disruption and distraction. I had to respect the participants' judgement that they were okay to proceed with the planned interview and step away from their work responsibilities. The data collection was restricted to individual interview or group interview format. Whilst this is an appropriate method of data collection for grounded theory, I was aware that it limited the type of data that could be collected. I was reliant on having to interpret the data in relation to the structures and contexts recounted by the participants. If I had used another research design, such as ethnography, I may have collected alternative data and thus produced a differing construction of theory. Whilst I had the primary responsibility for analysing the data, I had the benefit of experienced supervisors who contributed to the discussion over assigning of initial and focus codes, and whose contributions to the discussions of the categories and emerging theory helped to offset my novice researcher status.

13.7: Conclusion

To conclude, this study has explored healthcare practitioners' confidence to provide breastfeeding support to fathers, offering a unique first insight into the general trait of confidence related to healthcare practitioner's interaction with the father rather than the mother-baby dyad. This study has answered the aim of the study and found that in a self-selecting sample of healthcare practitioners from the East of England the basis of their confidence to provide breastfeeding support to the father is a result of them drawing on and engaging their practical wisdom through the 'use of self'.

The healthcare practitioners identified that their pre-registration midwifery and health visiting programmes and the UNICEF UK Baby Friendly Imitative training are a good starting point for the knowledge and skills required to provide care and support to the breastfeeding mother-baby dyad, but neither addressed the 'what' and 'how' to provide breastfeeding support to the father. Exploration of the data has shown how mother-focused the policy, practice, education, and training of healthcare practitioners is in the UK. Motivated healthcare practitioners sought alternative education and training provision to fill the gap; however, even these had their limitations.

In the absence of a clear policy steer to generate a strategy for the provision of breastfeeding support to the father, motivated and confident healthcare practitioners had to fill another gap. To do this, they drew on their personal knowledge of breastfeeding (both positive and negative) and previous professional experience alongside their personal attributes that enabled them to connect with people and engage. This use of self from the personal and professional domain enabled them to draw on their practical wisdom derived from knowledge, experience and reflection. The healthcare practitioners were generally unaware that they were using an interconnected framework of concepts, attributes, and interpersonal skills to create beneficial, apt, and innovative decisions to meet the needs of the father.

Many of the healthcare practitioners identified that they faced many challenges in trying to provide breastfeeding support to the father. They identified what was required to improve their knowledge base, level of experience specifically related to the father but also breastfeeding more generally and made suggestions of how the issues might be resolved. From their insights and a co-construction of the data, the implications and related recommendations have been made. It will take an integrated national, local, and personal approach to effect significant change to the point that the future healthcare practitioner is 'fit for purpose', equipped with knowledge and skills and confidence to be able to adapt to changing demography and needs of the father.

CHAPTER FOURTEEN: THE END OF THE JOURNEY

This final chapter completes this thesis. It presents my reflexive journey as I progressed through my doctoral journey. Reflexive commentary has been embedded throughout the thesis to illuminate the process I experienced.

My journey for this doctoral study started well over six years ago working as a lactation consultant when I questioned why so few fathers accompanied a breastfeeding mother and baby to the breastfeeding clinic. There were many fathers who I built rapport with and who answered my direct questions with honesty. Many mothers were also forthcoming in why their partners were not with them. From a small beginning the idea of undertaking a study grew. Never one to be daunted I had ambitious ideas. Progressing through the study pruned my idealistic views of what I could achieve into a more realistic view. The phrase 'How do you eat an elephant? One bite at a time' became my mantra to quell my overenthusiasm.

Undertaking this doctorate on a part-time basis whilst having a full-time job was a commitment; it meant that I was never fully able to immerse myself in the research world or take on the complete mantle of a researcher. It was a role tagged onto those professional roles of midwife educator, midwifery course leader and lactation consultant that filled my working days. In the early months of this study, I felt like an imposter in the research world as I was not immersed enough to recognise myself as a research student. As the study took shape and started to evolve, I felt less like an imposter. Going from a position of expertise as an educator and lactation consultant to a novice researcher was a humbling experience. It caused me to question everything that I did within the study, but also made me undertake a SWOT (strengths, weaknesses, opportunities, and threats) analysis to help establish new boundaries and new ways of working. Pivotal in also changing how I perceived myself as a researcher were the experiences of presenting aspects of my study either at postgraduate seminars or relevant conferences. The generosity and encouragement of researchers and practitioners who came together from around the world was a wonderful environment to present within. The endorsement from several researchers that my study had never been done confirmed that my literature

searching skills were more than adequate. I came to realise that as a research student I needed the same small encouragements that I gave to my midwifery students.

As a journey it has had the full complement of highs and lows characterised by times of pure joy, exhilaration, and enlightenment as well as moments of despair, frustration, and a fear of failing. These experiences have changed me. I am not the midwife, educator, and lactation consultant I was in January 2016 when I embarked on this study. In so many ways what I have learnt about research and being a researcher has seeped into my other professional worlds. The more I learnt about research, the less I realised I knew. I now have a huge respect for researchers and critique research papers with more compassion as I now understand, in my head and my heart, that there is no perfect research when dealing with people. I was always a good juggler of workload commitments, but undertaking this doctorate meant I became even more skilled at juggling priorities. I was constantly plagued by a feeling that I could do better at being a part-time doctoral student, until it was eased by hearing full-time doctoral students confess to the same concerns. As a professional I had a reputation for 'getting things done'. Along the journey there were many frustrations. A good example was the long wait for ethics and governance approval; this was particularly slow. It is ironic that it took a total of nine months, the equivalence of a woman's pregnancy – an apt analogy for a midwife.

I have learnt first-hand how iterative grounded theory really is. My patience was tested as it was a study that very few parts ever seemed to be finished until the latter months prior to thesis submission. Just when I thought I would have something tied up or tied down, something emerged that caused me to rethink an aspect of this study. I read all about the theory of grounded theory, especially constructivist grounded theory, and felt confident to put this new knowledge into practice. I read published papers to get the feel for the final product. The reality of putting this knowledge into practice was very different. A good example of this was my attempts at coding as discussed in chapter five. When I started to code, I felt I needed to do it 'the correct way' but soon felt like 'a fish out of water' and full of uncertainty. I felt anxious when I realised from supervisor feedback that I had managed to almost miss out the initial coding stage and leap to focus codes. In order not to repeat that mistake I then quickly became overwhelmed with the

number of codes each transcript was generating as I was coding everything in fear of missing something vital. During the months that I was concurrently data collecting and analysing I felt swamped and exhausted as I tried to juggle being a researcher and working at my 'full-time' job. On reflection, I scheduled the early interviews too close together and put unnecessary pressure on myself to transcribe and analyse an interview before moving onto the next interview. I felt grateful that practitioners were responding to the recruitment and just wanted to book them up. In chapter five I was critical of my passivity during the first interview as I was thankful to have commenced data collection within the 70-day deadline set by the Health Research Authority approval. I reflected that this passivity was probably my response to avoid taking over the interview; as a professional I am confident that I can talk to anyone and am naturally chatty. I was extremely humbled watching and listening to participants as they shared their thoughts with me, especially when they became reflective of their own practice, and especially their shortcomings in providing breastfeeding support to the father. My insider knowledge of being a midwife and an IBCLC may have affected how I approached data collection and analysis. At key points I would return and listen to the interview my lead supervisor had undertaken with me to identify my biases and assumptions prior to starting data collection. Listening again helped me to be mindful of those deep-seated assumptions, but also to realise that they were part of me, and I could not ignore them. I wish I had found the constructivist grounded theory workshop run by Kathy Charmaz sooner than I did. Spending two days immersed with like-minded researchers was a turning point for me, a 'eureka' moment that gave me an opportunity to change how I thought about my data. I am now aware that prior to this workshop I had stood on the side-lines looking in on the data and then stepping back from it, almost fearful that I would impose myself too much. From that point I realised I needed to be more intuitive and not worry about emic and etic perspectives but let the data take me where I needed to be, as a true co-constructor. I also grappled with not using all the data because it did not answer my study aim and objectives. It felt like sacrilege after the healthcare practitioners had given up valuable time for me to capture this data. I felt that having the data I had to share it.

I also had the experience of realising, that as I interviewed some of the healthcare practitioners, I was stirring up their working world as they reflected on their practice. At first this worried me but reflecting on my role as an educator I realised that whilst

I was a facilitator of learning I was also a challenger of the status quo. These practitioners were challenging their status quo in their thinking. As a researcher there is always the potential to challenge the status quo. It also made me hopeful that some practical changes may result from this study, because the practitioners had insight.

During the six years I undertook this study I developed a strong working relationship with my supervisory team. I am forever indebted to Gill and Victoria for their knowledge and wisdom. I am thankful that they quickly 'got' how I worked. Their encouragement and challenge have moulded me into a more insightful researcher and helped me think about this study in new ways that helped it to evolve. The conversations and brainstorming with Gill in particular, have helped shape my thinking as I tried to conceptualise and theorise. When I was in grave danger of getting fixated on a theoretical lens and forcing the theory rather than allow it to emerge, her challenge and guidance allowed me to see what had been under my nose all along.

Towards the end of the fifth year on my doctoral journey I had the privilege of being a full-time researcher whilst on sabbatical from my midwifery educator job. It was a luxurious time to completely immerse myself in this study. Whilst it was an isolating experience from my usual norm it enabled me to single-mindedly focus on my study. Just when I felt I was 'starting to see the light' another challenge emerged – that of my health. This interruption caused me to have to extend my doctoral journey into a sixth year. Looking back as I come to the end of that sixth year, I now appreciate that it gave me an opportunity to step back and reflect on my findings and read more extensively. Returning to my doctorate in 2020 I had renewed focus and enthusiasm. I sense that the interruption to my doctoral journey has been a positive one, as it reiterated the true iterative nature of engaging with qualitative research. My deepest hope is that something positive will come from my endeavours and in this last stage of my career I can start the seed of helping healthcare professionals have the confidence, knowledge, and skills to provide the 'what' and 'how to' of breastfeeding support to the father, growing into something bigger and more sustainable.

Do I ever wish I had chosen another study design? Yes. When I was bogged down for weeks trying to analyse data only to find weeks later that it would change again, I yearned for the simplicity of a more contained and prescriptive data collection and data analysis framework. Do I still feel like this as the thesis writing concludes? No. I have learnt that any journey that is worthwhile has a price. On reflection of my substantive theory and the process of theorising I have come to realise that over the course of this study, I have drawn on practical wisdom from my personal and professional selves, acquired research knowledge and experience and both confidence and self-efficacy in research specific skills. This has enabled me to tune into the study with a new confidence and complete the journey that I started, but the road I took has looked different as I have travelled it.

> *Wisdom is mostly the fruit of experience…Let not wisdom be an occasional visitor - let it ever dwell with thee.*
>
> (Counsel, 1892)

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Appendix 1: Reason for discard of paper from CINAHL database search after title and abstract review		
Authors and publication year	**Title of paper**	**Reason for discard**
Ingram, J. & Johnson, D. (2004)	A feasibility study of an intervention to enhance family support for breast feeding in a deprived area in Bristol, UK.	focus on fathers
Sherriff, N., Panton, C. & Hall, V. (2014)	A new model of father support to promote breastfeeding	focus on nature of father support
Hoddinott, P. & Pill, R. (2000)	A qualitative study of women's views about how health professionals communicate about infant feeding.	focus is on mothers
Ingram, J., Johnson, D.& Greenwood, R. (2002)	Breastfeeding in Bristol: teaching good positioning, and support from fathers and families.	focus is on mothers
DiGirolamo, A.M., Grummer-Strawn, L.M. & Fein, S.B. (2003)	Do perceived attitudes of physicians and hospital staff affect breastfeeding decisions?	focus is on mothers
Giugliani, E.R.J., Caiaffa, W.T., Vogelhut, J., Witter, F.R. & Perman, J.A. (1994)	Effect of breastfeeding support from different sources on mothers' decisions to breastfeed	focus is on antenatal intervention
Sherriff, N. & Hall, V. (2011)	Engaging and supporting fathers to promote breastfeeding: a new role for Health Visitors?	focus on fathers' views

Mithani, Y., Kurji, Z., Premani, Z. & Rashid, S. (2015)	Health Care Provider Perception of Father's Role in Breast Feeding Practices.	Focus on perception of father's role
Condon, L. & Ingram, J. (2011)	Increasing support for breastfeeding: what can Children's Centres do?	focussed on breastfeeding promotion & support
Bergman et al (1994)	Involvement of maternity and health care staff in breast-feeding.	focussed on maternity staff practices within hospital
Rêgo, R.M.V., Souza, Â.M.A., da Silva, M.J., Braga, V.A.B., Alves, M.D.S., Leitão, M.V.L. & Cardoso, V.F.L. (2009)	Support and encouragement of the father in breastfeeding: bibliographic study.	this is a review. The main body of text is only available in Portuguese and no translation to English available
Ingram, J. (2008)	The father factor: men can make the difference.	focus on fathers
Datta et al (2012)	The role of fathers in breastfeeding: Decision-making and support.	discard as parental views on fathers
Fenwick, J., Burns, E., Sheehan, A. & Schmied, V. (2013)	We only talk about breast feeding: A discourse analysis of infant feeding messages in antenatal group-based education.	focus on antenatal education content

APPENDIX 2: Invitation letter – Maternity services

School of Health
University of Central Lancashire
Preston
PR1 2HE

March 2017

Dear Practitioner

Study title: Healthcare practitioner confidence and self-efficacy in providing breastfeeding / breast-milk feeding support to fathers: A grounded theory study

Thank you for taking the time to read this invitation. I am inviting you to take part in an interview or focus group as part of the above study. The aim of this project is to explore how confident practitioners working on the postnatal ward, or within community midwifery teams are in providing support to fathers in relation to breastfeeding or breast-milk feeding.

This research project is being undertaken as part of my Professional Doctorate in Health at the University of Central Lancashire. I am being supervised by Dr Gill Thomson and Dr Victoria Hall Moran; their contact details are below.

If you would like to consider taking part in this study, please read the enclosed Participant Information Sheet. You can also contact me on the details provided if you would like any further information.

If after reading this information you would like to take part in the study, please contact me. My details are below.

I look forward to hearing from you.

Yours sincerely
Maxine Wallis-Redworth
Research Student

Email: MCWallis-redworth@uclan.ac.uk
Phone: XXXXXXXXX

Dr Gill Thomson
Senior Research Fellow
School of Health Sciences
University of Central Lancashire
Preston
PR1 2HE
GThomson@uclan.ac.uk
Phone (01772) 894578

Dr Victoria Hall Moran
Reader/Associate Professor
School of Health Sciences
University of Central Lancashire
Preston
PR1 2HE
VLMoran@uclan.ac.uk
Phone (01772) 893830

APPENDIX 3: Invitation letter – Health visiting services

School of Health
University of Central Lancashire
Preston
PR1 2HE

March 2017

Dear Practitioner

Study title: Healthcare practitioner confidence and self-efficacy in providing breastfeeding / breast-milk feeding support to fathers: A grounded theory study

Thank you for taking the time to read this invitation. I am inviting you to take part in an interview or focus group as part of the above study. The aim of this project is to explore how confident practitioners working in health visiting services are in providing support to fathers in relation to breastfeeding or breast-milk feeding.

This research project is being undertaken as part of my Professional Doctorate in Health at the University of Central Lancashire. I am being supervised by Dr Gill Thomson and Dr Victoria Hall Moran; their contact details are below.

If you would like to consider taking part in this study, please read the enclosed Participant Information Sheet. You can also contact me on the details provided if you would like any further information.

If after reading this information you would like to take part in the study, please contact me. My details are below.

I look forward to hearing from you.

Yours sincerely
Maxine Wallis-Redworth
Research Student

Email: MCWallis-redworth@uclan.ac.uk
Phone: XXXXXXXXX

Dr Gill Thomson
Senior Research Fellow
School of Health Sciences
University of Central Lancashire
Preston
PR1 2HE
GThomson@uclan.ac.uk
Phone (01772) 894578

Dr Victoria Hall Moran
Reader/Associate Professor
School of Health Sciences
University of Central Lancashire
Preston
PR1 2HE
VLMoran@uclan.ac.uk
Phone (01772) 893830

APPENDIX 4: Participant information sheet

Healthcare practitioner confidence and self-efficacy in providing breastfeeding and breast-milk feeding support to fathers: A grounded theory study

Participant information sheet – maternity services practitioner

I would like to invite you to take part in my research study that is being undertaken as part of a Professional Doctorate in Health. I am a practising midwife and International Board Certified Lactation Consultant. Before you decide if you would like to take part, I would like you to understand why the research is being done and what it involves. Please take your time to read this information sheet and talk to others if you wish. If you would like to discuss any points or ask any questions please contact me – details are below.

Researcher: Maxine Wallis-Redworth
Email: MCWallis-redworth@uclan.ac.uk
Phone: XXXXXXXXX

Supervisors:

Dr Gill Thomson
Senior Research Fellow
School of Health Sciences
University of Central Lancashire
Preston PR1 2HE
GThomson@uclan.ac.uk
Phone (01772) 894578

Dr Victoria Hall Moran
Reader/Associate Professor
School of Health Sciences
University of Central Lancashire
Preston PR1 2HE
VLMoran@uclan.ac.uk
Phone (01772) 893830

What is the study about?
The aim of this study is to explore how confident staff working on the postnatal ward or in the community are in providing support to fathers in relation to breastfeeding and breast-milk feeding.

Why have I been invited to take part?
You are a member of staff working on the postnatal ward or in the community as part of the midwifery team, and therefore have contact with fathers as part of your role.

What will I have to do?
If you agree to be part of this study, it will involve taking part in either an audio-recorded interview or focus group. You have the choice between an individual interview or taking part in a focus group with a maximum of 8 people. I am aware some people may feel more comfortable in one of these settings rather than the other. The discussion will last approximately one hour. I will be interviewing people over approximately four - five months but please contact me as soon as you can so I can be sure of arranging a time that is most suitable for you.

At the start of the interview/focus group I will ask you to sign a consent form to make sure you understand why you are taking part. As the discussions will be confidential, I will ask you not to disclose any confidential information, and if you are taking part in a focus group to respect the views of others present. I will also be asking you if you would indicate your role (not banding) within the organisation (e.g., midwife, maternity care assistant) and length of experience in that role so that I may see if this has any relation to confidence and self-efficacy. You will have the right to refuse to supply these details.
In the interview/focus group I will ask you about your experience of helping fathers to support their partner with either breastfeeding or breast-milk feeding, and what factors impact on your confidence in providing this support. All interviews/focus groups will be held either in your place of work or a local University facility.
After I have undertaken initial analysis of the findings from both individual interviews and focus groups, I would like to discuss the key themes with a selection of participants to verify if they reflect their experiences. If you agree to take part in this phase of the study, I will re-contact you to confirm if you are still willing to participate. After agreement has been sought and given, a summary of the key themes will be forwarded, and a short telephone interview organised to discuss these further. The interview will be audio-recorded following consent, and data combined for final analysis.
You can also receive a summary of the findings once the study is completed.

What happens with the data?
All data will be anonymised, treated as confidential, and only shared with my supervisors. The consent form will be stored in a locked filing cabinet, and the audio-recordings and transcripts will be stored on the University's password protected/encrypted computer files. All personal contact data will be destroyed at the end of the study. The anonymised data will be kept for five years from the end of the project and then destroyed. The results will be presented within a thesis submitted to the University of Central Lancashire in December 2018. They will also be used for conference presentations and written up for journal paper publications. Please note that whilst I intend to use the information you provide including any anonymised quotes within any research reports, publications or presentations generated by this study, you will not be identified.

Do I have to take part?
It is entirely up to you to decide if you wish to take part or not. You will have the choice to participate in either an individual interview or a focus group. Even if you agree to take part, you are still free to not answer all of the questions, and to end/leave the interview/focus group at any time and without giving a reason.
If you take part in an interview, you may withdraw your data up to two weeks after the interview has been undertaken. Please note if you take part in a focus group, you will not be able to withdraw your data after the session has ended due to the group-based nature of the discussion.

What are the possible benefits of taking part?
There are no direct benefits to you. However, by taking part you will contribute to an understanding of how confident practitioners are in supporting fathers in relation to breastfeeding and breast-milk feeding. This may help in the future to better prepare practitioners for this part of their role, and to inform service delivery. Involvement in the study will give you an opportunity to reflect on your practice. If you are a midwife you may be able to use the experience as part of reflective practice for your portfolio and revalidation.

What are the possible risks of taking part?
It is not envisaged that there are any risks in taking part in this study. However, if you become distressed or feel you need psychological support whilst participating in this study there are a number of support mechanisms to access – your occupational health counselling service, professional organisation counselling service or self-referral to the NHS Psychological Wellbeing Service. Additionally, if poor practice is identified, you will be encouraged to discuss this with your line manager using established processes within your workplace. As a registered practitioner I have a duty of care to report these issues.

Who is organising and funding the research?
I, the researcher, am organising the study as part of my Professional Doctorate in Health at the University of Central Lancashire. I have no commercial funding for this study.

Who has reviewed the study?
This study has been reviewed by the Health Research Authority and the Science, Technology, Engineering, Medicine and Health (STEMH) ethics sub-committee at the University of Central Lancashire (Project No. STEMH649)

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 my supervisors in the first instance. You can also contact the University Officer for Ethics at the University of Central Lancashire at OfficerForEthics@uclan.ac.uk. Please note that the information provided should include the study name, name of researcher and nature of the complaint.

Thank you for reading this information sheet and considering taking part in my study. If you would like to take part please contact me either by email or phone.

APPENDIX 5: Consent form – individual interview

CONSENT FORM

Title of project: Healthcare practitioner confidence and self-efficacy in providing breastfeeding /breast-milk feeding support to fathers: A grounded theory study.

Please read the following statements and initial each box if you agree.

1	I have read and understand the Participant Information Sheet (Version 6 15/05/17) and I have had the opportunity to consider the information and ask questions.	
2	I agree to take part in an individual interview.	
3	I understand that I am free to not answer all of the questions during the interview and may stop/leave interview at any point and without giving a reason.	
4	I agree to the interview being audio recorded and notes being taken.	
5	I understand that if I take part in an interview. I will be able to withdraw my data from the study up to two weeks post-interview.	
6	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.	
7	I agree to anonymised quotes being used within reports, presentations or other publications produced from the study.	
8	I am willing to be contacted to take part in a further interview to discuss the key themes that emerge from analysis of the data.	
9	I understand that if I disclose any incidents of poor practice, the researcher has a duty of care to report this to the appropriate personnel in the Trust.	
10	I agree to take part in this study.	

Name of participant	
Signature of participant	
Date	
Name of researcher taking consent	

Please tick the box below if you wish to receive, by email, a summary of the findings at the end of the study

☐

APPENDIX 6: Consent form – focus group interview

CONSENT FORM

Title of project: Healthcare practitioner confidence and self-efficacy in providing breastfeeding /breast-milk feeding support to fathers: A grounded theory study.

Please read the following statements and initial each box if you agree.

1	I have read and understand the Participant Information Sheet (Version 6 15/05/17) and I have had the opportunity to consider the information and ask questions.	
2	I agree to take part in a focus group.	
3	I understand that I am free to not answer all of the questions during the focus group and may stop/leave the focus group interview at any point and without giving a reason.	
4	I agree to the focus group being audio recorded and notes being taken.	
5	I understand that if I take part in a focus group. I will not be able to withdraw my data due to the group-based nature of the discussion.	
6	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.	
7	I agree to anonymised quotes being used within reports, presentations or other publications produced from the study.	
8	I am willing to be contacted to take part in a further interview to discuss the key themes that emerge from analysis of the data.	
9	I understand that if I disclose any incidents of poor practice, that the researcher has a duty of care to report this to the appropriate personnel in the Trust.	
10	I agree to take part in this study.	

Name of participant	
Signature of participant	
Date	
Name of researcher taking consent	

Please tick the box below if you wish to receive, by email, a summary of the findings at the end of the study

☐

APPENDIX 7: Interview guide

Welcome and settling in

Review of purpose of study and go through consent form

Signing of consent form

Launch question

- What do you think the father's role is in relation to breastfeeding support?

- Tell me about your experience of supporting fathers re breastfeeding / expressing.

Probing questions

What do you do to involve fathers in your visits / information giving? Examples?

What do you discuss with fathers re breastfeeding support?

What information do you give to fathers?

When fathers are not pro breastfeeding how do you change the info given to them?

How do you decide what information to give to fathers?

How do you know what information fathers' want?

Give me an example of how you assess father's knowledge / attitudes?

When you meet a father who has no experience of breastfeeding how do you deal with any barriers they put up?

Tell me about the training you have had on breastfeeding.

What part addressed dealing with fathers?

What training has specifically increased your confidence in addressing breastfeeding? Does this apply to fathers as well as mothers?

How confident are you in interacting with fathers to give them breastfeeding support?

So what makes you confident?

Other practitioners say it is easier to engage fathers if they are confident in their breastfeeding knowledge. How do you feel about this statement?

In what way do you appreciate the support fathers give a breastfeeding mother?

Conclusion

Is there anything else you want to tell me / share with me?

Thank participant.

APPENDIX 8: NHS RHA Approval letter

NHS
Health Research Authority

Mrs Maxine Wallis-Redworth
Cambridge

Email: hra.approval@nhs.net

15 May 2017

Dear Mrs Wallis-Redworth

Letter of HRA Approval

Study title:	**Healthcare practitioner confidence and self-efficacy in providing breastfeeding/breast-milk feeding support to fathers: A grounded theory study.**
IRAS project ID:	**217149**
Sponsor	**University of Central Lancashire**

I am pleased to confirm that **HRA Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications noted in this letter.

Participation of NHS Organisations in England

The sponsor should now provide a copy of this letter to all participating NHS organisations in England.

Appendix B provides important information for sponsors and participating NHS organisations in England for arranging and confirming capacity and capability. **Please read *Appendix B* carefully**, in particular the following sections:

- *Participating NHS organisations in England* – this clarifies the types of participating organisations in the study and whether or not all organisations will be undertaking the same activities
- *Confirmation of capacity and capability* - this confirms whether or not each type of participating NHS organisation in England is expected to give formal confirmation of capacity and capability. Where formal confirmation is not expected, the section also provides details on the time limit given to participating organisations to opt out of the study, or request additional time, before their participation is assumed.
- *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* - this provides detail on the form of agreement

to be used in the study to confirm capacity and capability, where applicable.

Further information on funding, HR processes, and compliance with HRA criteria and standards is also provided.

It is critical that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details and further information about working with the research management function for each organisation can be accessed from www.hra.nhs.uk/hra-approval.

Appendices

The HRA Approval letter contains the following appendices:

- A – List of documents reviewed during HRA assessment
- B – Summary of HRA assessment

After HRA Approval

The attached document *"After HRA Approval – guidance for sponsors and investigators"* gives detailed guidance on reporting expectations for studies with HRA Approval, including:

- Working with organisations hosting the research
- Registration of Research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics and is updated in the light of changes in reporting expectations or procedures.

Scope

HRA Approval provides an approval for research involving patients or staff in NHS organisations in England.

If your study involves NHS organisations in other countries in the UK, please contact the relevant national coordinating functions for support and advice. Further information can be found at http://www.hra.nhs.uk/resources/applying-for-reviews/nhs-hsc-rd-review/.

If there are participating non-NHS organisations, local agreement should be obtained in accordance with the procedures of the local participating non-NHS organisation.

User Feedback

The Health Research Authority is continually striving to provide a high quality

service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/.

HRA Training

We are pleased to welcome researchers and research management staff at our training days – see details at http://www.hra.nhs.uk/hra-training/

Your IRAS project ID is **217149**. Please quote this on all correspondence.

Yours sincerely

Kevin Ahmed

Assessor

Telephone: 0207 104 8171
Email: hra.approval@nhs.net

Copy to: *Mrs Denise Forshaw, Sponsor Contact, University of Central Lancashire*
Mr Stephen Kelleher, R&D Contact, Cambridgeshire & Peterborough NHS Foundation Trust
Dr Gill Thomas, Academic Supervisor, University of Central Lancashire

APPENDIX 9: University of central Lancashire STEMH approval

20 June 2017

Gillian Thomson /
Maxine Wallis-Redworth
School of Community Health
and Midwifery
University of Central
Lancashire

Dear Gillian / Maxine

Re: STEMH Ethics Committee Application
Unique Reference Number: STEMH 649

The STEMH ethics committee has granted approval of your proposal application 'Healthcare practitioner confidence and self-efficacy in providing breastfeeding/breast-milk feeding support to fathers: A grounded theory study'. Approval is granted up to the end of project date*.

It is your responsibility to ensure that

- the project is carried out in line with the information provided in the forms you have submitted
- you regularly re-consider the ethical issues that may be raised in generating and analysing your data
- any proposed amendments/changes to the project are raised with, and approved, by Committee
- you notify roffice@uclan.ac.uk if the end date changes or the project does not start
- serious adverse events that occur from the project are reported to Committee
- a closure report is submitted to complete the ethics governance procedures (Existing paperwork can be used for this purposes e.g. funder's end of grant report; abstract for student award or NRES final report. If none of these are available use e-Ethics Closure Report Proforma).

Additionally, STEMH Ethics Committee has listed the following recommendation(s) which it would prefer to be addressed. Please note, however, that the above decision will not be affected should you decide not to address any of these recommendation(s).

Should you decide to make any of these recommended amendments, please forward the amended documentation to roffice@uclan.ac.uk for its records and indicate, by completing the attached grid, which recommendations you have adopted. Please do not resubmit any documentation which you have **not** amended.

Yours sincerely

Will Goodwin

Deputy Vice Chair

STEMH Ethics Committee

* for research degree students this will be the final lapse date

NB - Ethical approval is contingent on any health and safety checklists having been completed, and necessary approvals as a result of gained.

Response to STEMH
Application Reference No (STEMH 649)
Version No (001)

Recommendation	Applicant Response
In view of the response to question A26 of the IRAS form, relevant UCLan risk assessment forms should be completed / approved (e.g. lone working, etc.)	

APPENDIX 10: Letter of access from the NHS Community Trust for the health visiting service

Cambridgeshire and Peterborough NHS

NHS Foundation Trust

Understanding mental health, understanding people

Research and Development Department
Joint Research Office
Box 277 Addenbrooke's Hospital
Hills Road Cambridge CB2 OQ
Direct Dial: 01223 348438 ext. 58438
E-mail:mary-beth.sherwood@cpft.nhs.uk
www.cpft.nhs.uk

Mrs. Maxine Wallis-Redworth
Faculty of Health, Social Care & Education
Anglia Ruskin University
2nd Floor, Young Street East Road
Cambridge CB1 1PT

23 June 2017

Dear Mrs. Wallis-Redworth

Letter of access for research:

M00802 - Healthcare practitioner confidence and self-efficacy in providing breastfeeding /breast-milk feeding support to fathers: A grounded theory study

This letter confirms your right to conduct research through **Cambridgeshire and Peterborough NHS Foundation Trust (CPFT)** on the terms and conditions set out below. This right of access commences on **28 June 2017** and ends on **31 December 2019** (linked to your substantive contract of employment) unless terminated earlier in accordance with the clauses below.

You have a right of access to conduct such research as referenced above. Please note that you cannot start the research until the Principal Investigator for the research project has received a letter from us giving confirmation from CPFT of their agreement to conduct the research.

For Clinical Trials of Investigational Medicinal Products you should provide the Trust's R&D department with written evidence that you have completed Good Clinical Practice (GCP) training from an EU institution before you start your research. For all other research GCP training is considered 'best practise'. In addition to this the Trust requires you to complete an assigned **CPFT Induction** which can include online and classroom based modules. You are also required to keep this Trust up to date with any Trust specific, professional or NHS Mandatory training on an annual basis, by submitting your certificates, or training reports electronically to this department for our notification and records. An eCademy account will be set up on your behalf. The CPFT Learning and Development Team will email you your

account details. Your category is **D.** Please complete the required modules within your Induction category.

The information supplied about your role in research at CPFT has been reviewed and you do not require an honorary research contract with CPFT. We are satisfied that such pre-engagement checks as we consider necessary have been carried out. Evidence of checks should be available on request to CPFT.

You are considered to be a legal visitor to CPFT premises. You are not entitled to any form of payment or access to other benefits provided by CPFT to employees and this letter does not give rise to any other relationship between you and CPFT, in particular that of an employee.

While undertaking research through CPFT you will remain accountable to your substantive employer/place of study, University of Central Lancashire but you are required to follow the reasonable instructions of your nominated CPFT Manager Kathryn Slater or those instructions given on their behalf in relation to the terms of this right of access.

Where any third party claim is made, whether or not legal proceedings are issued, arising out of or in connection with your right of access, you are required to co-operate fully with any investigation by CPFT in connection with any such claim and to give all such assistance as may reasonably be required regarding the conduct of any legal proceedings.

You must act in accordance with the organisations policies and procedures, which are available to you upon request, and the Research Governance Framework.

You are required to co-operate with CPFT in discharging its/their duties under the Health and Safety at Work Act 1974 and other health and safety legislation and to take reasonable care for the health and safety of yourself and others while on the organisations premises. You must observe the same standards of care and propriety in dealing with patients, staff, visitors, equipment and premises as is expected of any other contract holder and you must act appropriately, responsibly and professionally at all times.

If you have a physical or mental health condition or disability which may affect your research role and which might require special adjustments to your role, if you have not already done so, you must notify your employer and CPFT prior to commencing your research role at CPFT.

You are required to ensure that all information regarding patients or staff remains secure and strictly confidential at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice and the Data Protection Act 1998. Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

You should ensure that, where you are issued with an identity or security card, a bleep number, email or library account, keys or protective clothing, these are returned upon termination of this arrangement. Please also ensure that while on CPFT premises you wear your ID badge at all times, or are able to prove your identity if challenged. Please note that CPFT does not accept responsibility for damage to or loss of personal property.

CPFT may revoke this letter and may terminate your right to attend at any time either by giving seven days' written notice to you or immediately without any notice if you are in breach of any of the terms or conditions described in this letter or if you

commit any act that we reasonably consider to amount to serious misconduct or to be disruptive and/or prejudicial to the interests and/or business of CPFT or if you are convicted of any criminal offence. You must not undertake regulated activity if you are barred from such work. If you are barred from working with adults or children this letter of access is immediately terminated. Your employer will immediately withdraw you from undertaking this or any other regulated activity and you MUST stop undertaking any regulated activity immediately.

Your substantive employer is responsible for your conduct during this research project and may in the circumstances described above instigate disciplinary action against you.

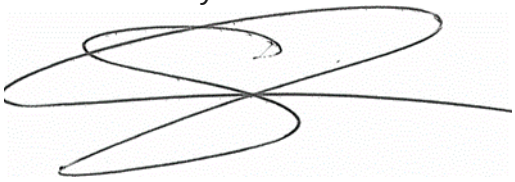
CPFT will not indemnify you against any liability incurred as a result of any breach of confidentiality or breach of the Data Protection Act 1998. Any breach of the Data Protection Act 1998 may result in legal action against you and/or your substantive employer.

If your current role or involvement in research changes, or any of the information provided in your Research Passport changes, you must inform your employer through their normal procedures. You must also inform your nominated manager and the R&D office here in CPFT.

If required contact idcards@cpft.nhs.uk for assistance in accessing an ID badge; this will not include door access.

You can find out more about GCP training on the NIHR website; this is not something we arrange. Please note it is our understanding that there may be a fee involved.

Yours sincerely



Stephen Kelleher

Senior R&D Manager

Cambridgeshire & Peterborough NHS Foundation Trust

Cc

HR/Student Registry Contact

Alison Naylor, Senior Research Officer (aznaylor@uclan.ac.uk)

Nominated CPFT Manager

Kathryn Slater, Health Visitor & Infant Feeding Lead (kathryn.slater@nhs.net)

APPENDIX 11: Letter of access for NHS Hospital Trust for the maternity service

Cambridge University Hospitals NHS Foundation Trust

Research and Development Department
Box 277 Addenbrooke's Hospital
Hills Road Cambridge CB2 0QQ

R&D Manager: Stephen Kelleher stephen.kelleher@addenbrookes.nhs.uk
HR Manager: Nacha Samaila
01223 274660
nacha.samaila@addenbrookes.nhs.uk
HR Advisor: Gayle Lindsay
01223 348496
gayle.lindsay@addenbrookes.nhs.uk

Mrs Maxine Wallis-Redworth
Professional Doctorate in Health Student
University of Central Lancashire
Brook Building Preston PR12HE

3rd August 2017

Dear Maxine

Letter of access for research - A094531 – Healthcare practitioner confidence and self-efficacy in providing breastfeeding

This letter confirms your right of access to conduct research through Cambridge University Hospitals NHS Foundation Trust for the purpose and on the terms and conditions set out below. This right of access commences on 2nd August 2017 and ends on 31st December 2019 unless terminated earlier in accordance with the clauses below.

You have a right of access to conduct such research as confirmed in writing in the letter of permission for research from this NHS organisation. Please note that you cannot start the research until the Principal Investigator for the research project has received a letter from us giving permission to conduct the project and you have provided the Trust's R&D department with written evidence that you have completed GCP training from an EU institution before you start your research.

The information supplied about your role in research at Cambridge University Hospitals NHS Foundation Trust has been reviewed and you do not require an honorary research contract with this

NHS organisation. We are satisfied that such pre-engagement checks as we consider necessary have been carried out.
You are considered to be a legal visitor to Cambridge University Hospitals NHS Foundation Trust premises. You are not entitled to any form of payment or access to other benefits provided by this NHS organisation to employees and this letter does not give rise to any other relationship between you and this NHS organisation, in particular that of an employee.

While undertaking research through Cambridge University Hospitals NHS Foundation Trust, you will remain accountable to your place of work University of Central Lancashire but you are required to follow the reasonable instructions of Lesley Bennett (Midwife) and Jeremy Brockelsby in this NHS organisation or those given on their behalf in relation to the terms of this right of access.

Where any third party claim is made, whether or not legal proceedings are issued, arising out of or in connection with your right of access, you are required to co-operate fully with any investigation by this NHS organisation in connection with any such claim and to give all such assistance as may reasonably be required regarding the conduct of any legal proceedings.

You must act in accordance with Cambridge University Hospitals NHS Foundation Trust policies and procedures, which are available to you upon request, and the Research Governance Framework.

You are required to co-operate with Cambridge University Hospitals NHS Foundation Trust in discharging its duties under the Health and Safety at Work etc Act 1974 and other health and safety legislation and to take reasonable care for the health and safety of yourself and others while on Cambridge University Hospitals NHS Foundation Trust premises. You must observe the same standards of care and propriety in dealing with patients, staff, visitors, equipment and premises as is expected of any other contract holder and you must act appropriately, responsibly and professionally at all times.

If you have a health condition or disability which may affect your research role and which might require reasonable special adjustments to your role, if you have not already done so, you must notify your employer and the Trust's R&D HR Office prior to commencing your research role at the Trust.

You are required to ensure that all information regarding patients or staff remains secure and strictly confidential at all times. Personal identifiable data must be carried securely at all times and mobile devices must be encrypted. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice

(https://www.gov.uk/government/publications/confidentiality-nhs-code-of- practice) and the Data Protection Act 1998. Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution. Data controllers could also be fined for a breach of the Data Protection Act 1998. You must familiarise yourself with the Trust's Information Governance Code of Conduct.

You must keep confidential any information regarding the design, conduct or management or results of any research unless authorised in writing by the Trust to disclose it. You must acknowledge the Trust's contribution in any publication arising out of this Agreement.

Subject to any agreement with your employer to the contrary (e.g. as part of a multi- centre study), any Intellectual Property (IP) resulting from research carried out under this Agreement will be the property of the Trust and you will do all things necessary or desirable to give effect to the assignment of this IP.

You should ensure that, where you are issued with an identity or security card, a bleep number, email or library account, keys or protective clothing, these are returned upon termination of this arrangement. Please also ensure that while on the premises you wear your ID badge at all times, or are able to prove your identity if challenged. Please note that this NHS organisation accepts no responsibility for damage to or loss of personal property.

We may terminate your right to attend at any time either by giving seven days' written notice to you or immediately without any notice if you are in breach of any of the terms or conditions described in this letter or if you commit any act that we reasonably consider to amount to serious misconduct or to be disruptive and/or prejudicial to the interests and/or business of this NHS organisation or if you are convicted of any criminal offence. You must not undertake regulated activity if you are barred from such work. If you are barred from working with adults or children this letter of access is immediately terminated. Your employer will immediately withdraw you from undertaking this or any other regulated activity and you MUST stop undertaking any regulated activity immediately.

Your substantive employer is responsible for your conduct during this research project and may in the circumstances described above instigate disciplinary action against you.

Cambridge University Hospitals NHS Foundation Trust will not indemnify you against any liability incurred as a result of any breach of confidentiality or breach of the Data Protection Act 1998. Any breach of the Data Protection Act 1998 may result in legal action against you and/or your substantive employer.

INDUCTION AND MANDATORY TRAINING
You are responsible for familiarising yourself with the Trust's policies and mandatory training courses such as Moving and

Handling, Health and Safety, Fire Training etc and be aware of the responsibility to maintain a safe environment for patients, staff and visitors.

Your host Manager will ensure that you receive a comprehensive Departmental Induction. She/he will also provide you with details of Corporate Induction, research specific induction and annual Mandatory Refresher Training.

If your letter of access is for more than 3 months, you must attend Corporate Induction. Where your letter of access is for more than 12 months, you must attend annual Mandatory Refresher Training.

If your current role or involvement in research changes, or any of the information provided in your Research Passport changes, you must inform your employer through their normal procedures. You must also inform your nominated manager in this NHS organisation.

Yours sincerely

Stephen Kelleher

Senior R&D Manager

Cambridge University Hospitals NHS Foundation Trust

cc: Lesley Bennett, Infant Feeding Lead, Rosie Hospital
Gill Thomson, Senior Research Fellow, University of Central Lancashire, GThomson@uclan.ac.uk

APPENDIX 12: Transcript of health visitor interview

I: Interview on Tuesday the 14th of November, you've given your consent and you understand what this interview is all about…

P: Yeah I do.

I: So tell me about your experiences of supporting fathers whose partner is breastfeeding their baby.

P: I actually think we're really quite poor at supporting fathers, I think we need to be better at it and there needs to be more out there for dads as well. I often when I do an antenatal visit try and encourage that a dad is there so that we can when we're talking about feeding and those sorts of things that Dad is involved right from the beginning. During my antenatals and new births and those sort of things when I talk about baby café and feeding I always invite dads to come along even if Dad is not at the antenatal I try to say to the mums, dads are welcome, come along and suss it all out prior to having your baby for the support. Apart from that I think we're a bit limited really to what else we offer them. I try and just get them involved as much as possible. If I go and do a breastfeeding support visit and Dad is there it's great because I get Dad looking and helping and looking at the attachment and those sort of things and being that second ear so that when Mum's really tired he can be like pull baby in a bit closer, just trying to get them quite involved really as much as they can be because I think their support is invaluable and I don't think we appreciate that enough really.

I: So you said you see him as a second ear [uh huh] so how do you know what to highlight to a father?

P: I suppose it's I know specifically but I would always get Dad looking at the positioning and taking in those little bits like tucking baby's bottom in and making sure the chin is really close and sometimes it's hard for a mum to look so I always try to get Dad to have a really good look to see what the attachment is looking like and if it's not quite right then him to be the one for those sorts of things and if all's going well being that person that goes and makes her a cup of tea or just makes sure she's comfortable and can sustain her feeding and those sorts of things and support in terms of those sort of things as well.

I: Okay, So, let's go back a stage, when you think about the antenatal visit what specific information do you tend to discuss with a particular emphasis on fathers?

P: Support I think, just explaining to them, I think dads often as well feel that they miss out if they're not feeding so I try and go through different ways of bonding with baby, they can still have the skin to skin and they can bath and they can read and they can take baby off when Mum's having a break, there's lots of other ways of bonding which I try to talk about other than just

feeding because I find lots of them go oh you know but I won't be able to feed my baby so trying to get the point across that actually there's lots more that they can do which is just as great as Mum breastfeeding that gives Mum and baby that time to get the feeding well established and those sort of things and just try to emphasise the level of support and encouragement in supporting Mum to continue breastfeeding if that's what she wishes and those sort of things is invaluable really so if they can be onboard with it then the chances of it being more successful and so just try and gently to encourage them to just be that support.

I: So that's antenatal then you go and do a new birth visit, Dad's there, what do you tend to emphasise with them at that point?

P: Similar things, if feeding is all going well then just encouraging that bonding and that support for Mum especially at night time so you have them do nappies because it is tiring but obviously in the night feeds are really important, I have found some that are struggling and dads are like would it better if we gave the formula so it's just trying to inform them of the benefits to the breastfeeding actually if they're supportive of Mum continuing then actually you can generally get past the issues and sustain the breastfeeding for longer and again just I suppose is also sort of sometimes if mums are struggling I had a dad call me the other day and talk to me, rather than it being through Mum, he was a great support but trying to get so it's not just focused on Mum but actually this is a team, you know they're a family unit, and although mums do the breastfeeding they do play a really big role.

I: So that dad called you, do you specifically make that clear to them that you're not just really focused on the mother and baby but actually they have that ability to call you for advice as well?

P: Yeah I do I think because they're a family unit, I think that's quite important for them to feel that you know yes we do focus on baby and Mum particularly but actually Dad is part of that unit as well so I think it's important for them to feel involved rather than just on the side.

I: Okay what do you do and how do you respond to dads who are obviously not engaging?

P: Tricky because again there's not lots to signpost them to, to get that extra support but I try and encourage them to come along to baby café so they can listen in to other people's experiences and those sorts of things, and just try and explain the benefits of the breastfeeding so that I suppose they can make a bit more of an informed choice rather than seeing it as if I go onto formula baby will sleep more or I can feed, so I think it's just trying to gently open their eyes up a little bit to that it's more than just feeding that comes with breastfeeding and try to explain to them that babies don't just feed for hunger, there are lots of other reasons a breastfed baby will want the breast to be offered so therefore it may feel like they're feeding more

than maybe a formula fed baby and those sort of things, I think it's just trying to educate them a little bit and to get them to understand the benefits really, to encourage them to be able to offer that support to their wife or partner.

I: Um, some people would say actually trying to get to understand why they're taking that stance is important, how do you feel on that?

P: Yeah I think we've lost that art of it being a normal thing to be seen so the chances are that's Dad has never met anybody that has breastfed before or it's not seen as a normal reason so I think unpicking what the barriers are and why they feel is quite important for them to be able to be more open to it, debriefing on what their issues or concerns are and I think it's a massive barrier sometimes especially if they were formula fed or siblings or family members, I think that's never been exposed if it's a fairly new thing I think that's quite a difficult barrier to break down but just try your best to…

I: What gives you confidence then to sort of engage with those dads who are really not pro breastfeeding?

P: My passion to keep Mum breastfeeding and the importance of that. I think from personal experience I had a horrendous time with my first baby with my husband was amazing and never once tried so having that at the back of my mind as well, how invaluable that support is keeps me going with these dads and sometimes you can see it in a mum, Dad's there saying talking about formula feeding, you know Mum doesn't particularly want to give up but then she's feeling a little bit pressured, sometimes we have advocate a little bit for mums when they're not quite feeling able to do that themselves.

I: So you're able to advocate for the mums to the dads but what gives you that confidence that you could be successful?

P: Hopefully by the knowledge that the information that we give them to make them I suppose understand a bit more about breastfeeding and the benefits and those sort of things, I suppose it's just chipping away and trying to make them see that actually this is the normal way to feed a baby, this is what women have done for a long time and I think being confident in how you deliver the information just instils a bit of confidence in the families to trust what you're saying.

I: So your confidence in how you deliver the key information you feel gives the family confidence that perhaps their choices are the right ones…

P: I would hope so.

I: You said knowledge and you said experience, do you think knowledge is more important than experience or experience more important than knowledge to build your confidence?

P: I think you need the experience to instil the knowledge so I think if you've got the knowledge that's underpinning what you do it's then gaining that experience and being able to develop in that confidence of how you deliver your information plays a big part as well. I think the more experience you get at delivering it the more natural it all becomes in underpinning that knowledge that you've got.

I: And what other skills do you use to assess how almost your ability to deliver where the knowledge is going?

P: Listening and getting that feedback from them, almost getting them to repeat what you said so it underpins and get them to almost repeat back what you're saying in a way that you know that they've taken it in rather that just talking to them and listening and them listening to you is just getting that sort of feedback I suppose open questions that almost make them feel a bit like they're making those decisions rather than the decisions being imposed on them, sort of questioning in a way that's a bit more open I suppose.

I: What sort of training have you had and to what extent has that met your needs?

P: I think initially when you do your health visitor training, just do your two days Unicef which is great but I think that's where experience helps to underpin that knowledge because it's just two days and having done the extra what I've done there's a lot more to it than two days of training, I think you need to really instil that knowledge and get that experience which unfortunately doesn't happen all the time because of the nature of the job, you don't always get breastfeeding, it can be a long time before you get a breastfeeding issue coming in and those sorts of things. I don't think we do it in depth enough as a health visitor, my breastfeeding specialist course was amazing, just more about those questioning and answering and how we listen to families and those sorts of things I think gave me a lot more confidence in being able to support mothers with breastfeeding than just the two day UNICEF.

I: And in either the two-day UNICEF or in breastfeeding specialist course what focus was put on helping fathers?

P: I did my two day UNICEF a while ago but I don't remember there being anything about supporting fathers, we did do more about it through my breastfeeding specialist course, there was a day on not just fathers but getting families and things and those sorts of things but again it was in the grand scheme of a year's course was a fairly minimal part though it did come up whereas I don't remember it through the UNICEF at all.

I: So therefore, thinking and reflecting on your experience of training, what suggestions would you make to take forward to better prepare particularly health visitors?

P: I think in updates, we have bite size things once a month during professional development and I think it needs to be put out there really, I don't think people always think about it, I think they focus on the fact that it's a mother and baby dyad really rather than the importance of what father's can bring or partners so I think there needs to be a little bit more training involved and even maybe for one of my homework for my course I designed a leaflet for dads about what support they could offer and it may be that we get something like that for staff to look at as a reminder or something that could be given out during an antenatal contact so that they've got something visual that they can look at and you know take in so I do think there needs to be more done in service about the importance of supporting fathers.

I: When you look at a dad what sort of characteristics are you looking to notice in helping you engage with that father?

P: I would like someone who's attentive throughout the visit, who actually appears to want to be involved, that's questioning, got that little bit, rather than some dads just sit in the corner not taking much notice so they're the trickier ones because then try and direct questions at them to try and bring them involved but the ones that are going to be more receptive are the ones that are showing an interest right from the beginning, that made the effort to be there for the visit and who are showing an interest and asking questions.

I: You picked up the dads that sit in the corner, you said the trickier ones, so tell me about a success in engaging that sort of dad.

P: I actually covered a … it wasn't my family that I seen but I was asked during my course to go and see this family that was having trouble and I got there and mum was at the end of her tether with this baby that just wouldn't settle and he wasn't in the room at the time and I asked who is your support, who do you lean on and she did make a little comment that he wasn't dad wasn't overly supportive so he came back in with his coffee and just sat down so I was kind of asked mum to show me how she was feeding her and those sort of things and just got dad over and tried to explain to him, I just pulled him into the conversation really, to get him looking and explain to him you know that although we're focused on mum and the issues going on that actually he could be really involved in this and help out and not feel like he's just at the side and actually he was really good, he was a bit reluctant and he wasn't too keen to start with but I just kind of kept the conversation going and asked him to look at different things and showed him little things like trying to point out the slight drop in the jaw when…so I think just feeling a bit more involved and the next time I went things were so much better and he greeted me at the door and he just was a little bit more involved I suppose, I don't think he was perhaps like some of the others but he was showing an interest and that little family unit was better and I think he'd been up doing a little bit more through the night because mum was just exhausted.

I: So what makes you think what drives their reluctance to be involved?

P: I think they feel a bit of an outsider feel that sometimes that they don't have a role in this feeding part with mum and baby and generally you're quite focused when you're talking about positioning and attachment and mum's got breast pain or those sort of things, I think they feel a bit like they're a bit helpless and so I think that's a bit of a barrier sometimes they feel there isn't a role for them in that part of the new family so I think it's just trying to make them feel actually yes this is very mother and baby focused but you can be part of that as well by doing other things, not just the feeding.

I: So thinking about the fact that you designed a leaflet for father support, do you think that that may be one of many strategies that may engage fathers more by giving them that sense that someone values their role?

P: I think it's a starting point, yeah I think it's starting at the beginning and the children's centre does a Saturday group for dads but it's not a feeding group, just a play session, and there's nothing else, I think having something where you can go oh this is for you to have a look at rather than just a broader thing for everybody, this is focused on dads that actually there is a bit more value to their role and just highlighting that may just be enough just too make them want to be involved a bit more or understand that there is a bit more of a role for them. I think there is a lot of work today but I think it could be just a bit of a starting block really to give out antenatally because we don't give dads anything, we give a whole pile of stuff but nothing specific for dads.

I: So if you had the opportunity to do some blue sky thinking and start redesigning the service what would be on your wish list for dads?

P: An antenatal group for dads, I think without mum sometimes just so it is dad focused I think that would be really nice and maybe a little bit less intimidating if there are no wives there, they might feel a bit freer to express concerns and things and it's a really good opportunity to try and unpick some of those barriers to the breastfeeding and what their personal experiences were as children or what they've seen in families, I think that would be my first, I would like a dad's antenatal group feeding group to focus on them and I think I would like more emphasis like when you're advertising baby cafés and those sorts of things although it doesn't specifically say mum and baby it is very mum and baby focused whereas I think if we advertised it more as families or there was something in that advertising on those leaflets that said fathers to come and that it's not just mums and babies but bring partners or dads along, just those little subtle things that just make dads feel more involved that we might get a bit more engagement therefore better level of support hopefully, better breastfeeding rates because of it but I just think there is no emphasis on the father's role at all in anything we do and I think even in our training maybe I think to put more of an emphasis on the importance of the support that they can offer overall, not just with feeding yeah absolutely I just don't

think there's enough focus on that and if they've got a good supportive partner or someone that wants to be involved it's invaluable and sometimes I think we need to teach dads a bit more how to be involved rather than expect them just to know what their role should be, I think we need to do a little bit more educating which would be great if we could have a group for dads.

I: Your experience is not unsimilar to mine [really] just to give you a bit of encouragement my focus on dads started because they'd say I'm not staying I'm just the chauffer to this specialist drop in or I was told I wasn't allowed to stay by a health professional, not helpful so it's again trying to get it out but make it from a little seed grow an acorn.

P: Absolutely and even getting dads that have been supportive to deliver some sessions so you're actually hearing it from those that have been there and experienced it, my husband would have loved to do something like that and he's been a bit forced into the breastfeeding role but he would love to teach other dads and tell them there are people out there that would like to do it, if I had that police guy I would get lots of dads involved in talking to other dads, run a support group for them even, something where they can vent and there's lots for mums to go on all these breastfeeding sites and say oh I'm struggling but where is that support for dads and then support his wife or whatever, I think that's we definitely don't do enough.

I: What's your view about dads being able to access an app that's designed specifically for dads?

P: It's probably the way things are going, everybody has got a phone and an app so I think if it was a very good app that's I don't see why, another good starting point with them as well, something that they can tap into.

I: Would you have confidence of using that as part of your support strategies for dads?

P: Yeah I think we use apps, we're talking to parents about different parenting apps and things quite a bit these days and I think if there's one specifically for dads that's quite empowering for them to get on and see if it's for you and support for you I think would be as I say as long as it's very evidence based app and we know we're getting information but yeah I think the way things are going is much more social, they can do it in their own time as well can't they.

I: Apart from things like giving them some practical skills relating to position attachment and some support ideas about things like food and drink for mum, nappy changing for the baby, is there any other specific skills or information that you feel confident in giving dads?

P: Not really because I don't think I've had enough training myself on how to support dads so I suppose as well it's making sure that they've got a source of support, who do they go to to get their support and is that

somebody that's going to be supportive of their views, cause you know not all family members are, we're putting all this support in place for mum but dad also may need some support as well.

I: So what do you think would make you more confident to start tackling wider stuff?

P: It's reasonably more education around it with people that are better placed and have looked into it more about research and what would benefit and those sort of things I think needs to be more widely put out there really so that we're all doing the same sort of thing and offering better service for dads, but it's education I think on how to do that and what sort of information do you give them.

I: Is that because there is a hesitancy that if you don't get it right there may be negative consequences for that dad?

P: Yeah possibly but also I think it's just making sure that what we do for mums is giving good evidence based information and making sure that what you're delivering is going to be of benefit to them and I think what we do, the small amount that we do, we could do more of because I don't think everybody will go into antenatal and try and involve dads or breastfeeding support visit or a new birth or anything and try and think about getting dads more involved, I think sometimes we need to break down the barriers for the health professionals as well and make them see that the dads need to be more involved. I don't know, maybe it's just someone like myself who as infant feeding lead now is knowing how I would deliver some different sort of training to staff to get them to maybe have an education package as such to deliver either alongside a two day UNICEF or just on our updates and those sort of things.

I: So you've talked about some of the barriers, do you think you can identify some of those barriers that may impact confidence, what are those barriers that may impact confidence for your peers?

P: A lack of training I think sometimes, a lack of experience, you know some of our nursery nurses do the two day UNICEF then don't really have much contact with people having breastfeeding issues because we because health visitors will do all the early contact so it's empowering them to instil their knowledge and try and get them a little bit involved as well so that they build that confidence because again it's experience, I think sometimes the barriers are the fact that they're just not using the skills that they've been given enough to become confident in what they're delivering and what they're saying so even like practical skills reviews and those sorts of things maybe adding a little snippet at the end about involving dads but it's keeping that regular and we've had a bit of a fall down in our education unfortunately but it's just trying to get back into it so that everyone feels they've got a role, which I don't think they always do, they feel oh I'm just the nursery nurse but actually they can play a big part in their clinics, they

have a role as well, we all do so I think we just need to push that a little bit more sometimes.

I: So you see that there is a potential for expanding the service within the provision that's already given just by altering their focus perhaps?

P: Yeah I'd like to think so, I think just chip away a little bit so there's been a lack of it just lately and I think people have stepped off the breastfeeding wagon if you like because there's not been much influence and that's not anybody's fault in particular but I think we need to build the confidence of other health visitors up and it isn't just the role of the infant feeding lead, we all have a big role in this, we all have contact with families and mothers and babies and I think we all need to be confident in what we're delivering.

I: So in a way it sounds as though because the focus has gone off breastfeeding you could feel a bit discouraged in a way and do you think that's a barrier to how people might see the role?

P: Yes I do and the training, I think some people think oh here we go again, more breastfeeding training, there's lots of it coming up, cause I need everybody to be back up and feeling that breastfeeding and realising the importance of it and the long term impact that it has, it's not just the early days when you want everyone to breastfeed, it has long term implications for families and things like that so I think if there is a bit of breaking down of barriers to get going again then get people up to not perhaps as passionate as I am but yeah really understanding how they can help and the difference that they potentially can make in that bigger picture.

I: So it sounds like within your added role you feel you have confidence to potentially empower the rest of the workforce?

P: Confidence is growing yeah it's a new role but I'm so passionate about it that I don't want people to see it, I know lots of times [professionals say oh no positioning attachment again but actually we need to be reviewing these simple things that we should be doing day in and day out to make sure that we are confident in what we deliver and I hope that a little bit of my passion will just rub off enough to get people back on board and realise its importance really rather than just seeing it as pushing breastfeeding, but actually breastfeeding is the normal way to feed your baby, that's what the focus needs to be especially some people that have been in the service longer are a bit harder to sort of break down those barriers, I'm hoping that my passion for it will just and trying to mix up how breastfeeding education is delivered as well rather than just being talked out all the time trying to get people a bit more involved and a bit more practical and hands on and I'm trying, I'm working on it, it's very new but I'm determined to give it a good go and try and reinvent the wheel with the breastfeeding in the service a little bit.

I: So role modelling from yourself you see it as a way forward?

P: Yeah I mean I am known for my breastfeeding passion so that's a start and people know that I've done the extra training across the service so hopefully yeah a little bit of that will rub off.

I: Excellent is there anything else you want to add?

P: No I just wish everyone was as supportive of dads and realises that mums, families, staff, health visitors, everybody I think just needs to realise a bit more, have a bit more understanding of dad's role and the importance of that generally I don't think that's enough of that happening so I think it's good to get a bit of research behind it so we can say this is the impact that it has or doesn't have in those sort of things so we can have that little bit of back up saying this is really important.

I: Excellent, thank you.

P: You're welcome.

APPENDIX 13: The relationship of the substantive theory to the categories and focus codes

<table>
<tr><td>Substantive theory</td><td colspan="7">Developing and engaging practical wisdom through the ‘use of self’</td></tr>
<tr><td>Categories</td><td colspan="2">Confidence comes from having and using knowledge</td><td colspan="2">Confidence comes from having and using experience</td><td>Tuning into The father</td><td colspan="2">The challenges of providing breastfeeding support to the father</td></tr>
<tr><td rowspan="2">Focus codes</td><td rowspan="2">Influence of training</td><td rowspan="2">Knowledge generates confidence</td><td>Confidence comes from work experience</td><td rowspan="2">The influence of personal breastfeeding attitude and experience</td><td>Understanding and valuing the father’s perspective</td><td>Challenges in providing a service to fathers</td><td>Lack of formal support strategy and resources for the father</td></tr>
<tr><td>Lack of experience with breastfeeding support</td><td>Using strategies to engage and encourage the father</td><td>Recommendations for training</td><td>Recommendations for practice</td></tr>
</table>