A grounded theory study to elicit the reasons why women who initiate breastfeeding do not access peer support provision.
Situating self in a dichotomised discourse of infant feeding.

by

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ABSTRACT

Breastfeeding is recognised globally as an important health issue. The positive health outcomes for both mothers and babies associated with breastfeeding mean governments are keen to increase rates. One of the ways this has been attempted in the UK is via the establishment of peer support programmes. Uptake of this form of support is problematic however, and the aim of this study has been to construct, with participants, an integrated theory of non-access.

This study has explored the reasons why some women who initiate breastfeeding do not access local peer support provision. A constructionist grounded theory method was adopted and women, health professionals and peer supporters were interviewed in Cornwall, South West England. Thirteen women, fourteen peer supporters and six health professionals participated in twenty four semi-structured interviews. Open coding, constant comparison and focussed coding were used to analyse data and enable the construction of one core category and five main themes to explicate non access of peer support.

Dichotomies in the language pertaining to infant feeding were intertwined throughout the themes, requiring women to place themselves and their experiences within a divided landscape. A background of pressure, moral judgement and a dearth of breastfeeding knowledge form the core category, and the five main themes are situated within this milieu. The first main theme, 'place and space of support', explains how during the early postnatal period the group environment was not considered an appropriate place for support, and some women had stopped breastfeeding before they felt able to access a group environment. The second main theme, 'one way or no way', details the techno-medical rules-based model of breastfeeding adopted by many health professionals. Here breastfeeding is seen as a bodily function divorced from all social, familial and cultural concerns. Women anticipated that peer supporters would adopt the same model and this impacted upon access. The third main theme, 'lack of clarity of aims and ethos', outlines how health professionals and peer supporters lacked a clear sense of both the aims and the ethos of the service, and also of why women might like to access. The fourth main theme, 'not like me', explains how when women struggled to follow 'the rules' they often felt like 'a failure' and simultaneously viewed other women as 'successes', which inhibited access. The final theme, 'practicalities', explains how

practical concerns like group timings and venues were considered to be less important factors in whether or not services are accessed.

Recommendations for practice include re-evaluation by the peer support service of its aims and underpinning values. Revised aims could be embedded and overtly articulated throughout the service. Health professionals could reflect anew upon their own approaches to support. The development of close working partnerships amongst health professionals and peer supporters and a re-consideration of the manner in which peer support is provided is suggested. Future research could include a study focusing on knowledge implementation in this area. An ethnographic study employing discourse analysis could facilitate both a better understanding of women's support needs in the early postnatal period, and also insights into the verbal and non-verbal interactions that create feelings of pressure and judgement.

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1 INTRODUCTION

'Breastfeeding practices within a given culture represent the ways in which women negotiate and incorporate dominant ideologies and institutional and cultural norms with the realities of their embodied experiences, personal circumstances and social support systems' (Dykes, 2005, p.2283).

1.1 Context

This study aims to gain a better understanding of why some women who initiate breastfeeding do not access peer support services. It has involved interviews with women who have initiated breastfeeding but have not accessed peer support, health professionals who signpost to the service, and peer supporters who provide the service. Social constructionism is the epistemology adopted in this study (see Chapter 4). It posits that systems of meaning making in society '*precede*' (Crotty, 1998, p.52) each individual. This means that it is important to adopt an historical perspective in order to adequately study the way people make sense of their world (Crotty, 1998). In this study understanding the historical context of infant feeding can offer insights into how the present study situation has come about.

Crotty (1998) explains how what is known as the enlightenment, or '*the age of reason'* (p.18) heralded the '*assurance of unambiguous and accurate knowledge of the world*'(p.18). This intellectual movement begun in the seventeenth century, stepped away from tradition superstition and received knowledge, and 'gave birth' to the positive scientific method, whereby objective truth about the world could be discovered through the application of this method to observations and measurements of the world. Crotty (1998) explains that, since that time the idea that the world is moving forward on a path of progress has been widely accepted. Scientific discovery and technology developed through the enlightenment movement are the drivers of this progress.

Davis Floyd (1994) suggests that the foundations of enlightenment thought continue to be important in western society today. She explains how a society's core value system can be clearly seen at the time of birth because maintaining a society involves not just the physical reproduction of its members, but also the reproduction of the belief system that enables its

members to make sense of the world. Part of that belief system involves the way members think of themselves in relation to the world and to their own physical reproduction.

Davis-Floyd (1994) identifies the model of reality that forms the central mythology of western culture as technocracy. Technocracy is a *'cohesive and hegemonic mythology which functions as a powerful agent of social control, shaping and channelling individual values, beliefs and behaviours'* (p.1125). Reynolds (1991) suggests that, in a society where this mythology is dominant, knowledge itself is reduced to scientific research and description. Indeed, Reynolds (1991) considers technological progress as a folk term for the replacement of a natural body with a man-made body. He describes this process as the 'one-two punch'. Punch one takes a successful natural process and makes it dysfunctional by the use of technology, while punch two fixes the broken process with technology. Davis-Floyd (1994) uses birth in America as an example of the one-two punch in action, but the story of breastfeeding would do just as well.

While capitalism, science, technology and medicine were in the ascendancy in the west during the twentieth century, breastfeeding rates fell (Dykes, 2002). At the end of the nineteenth century almost every mother breastfed, however over the first half of the twentieth century rates declined dramatically (Flides, 1986). They reached their lowest levels in the UK in the 1960's and 1970's (United Nations International Children's Emergency Fund [UNICEF], 2012a), rose to 66% initiation, and 42% at six weeks by 1995 (Foster, 1997), and then rose further to 81% initiation and 55% at six weeks by 2010 (Infant Feeding Survey, 2010). Many complex factors contributed to the decline in breastfeeding, however Palmer (2009) highlights that before the industrial revolution the home was the *'work production unit'* (p.169), not just for women, but for everyone. Women worked and breastfed their babies at the same time. Once land enclosures and industrialisation took place, self-sufficiency disappeared. People had little choice but to move to towns where work was available, and where childbearing and breastfeeding did not fit well with factory life. In the late nineteenth and early twentieth centuries doctors started making artificial milks that they could sell to middle-class women who accepted them as a *'scientific wonder'* (Palmer, 2009, p.212). Poor urban women forced to leave their babies because of factory work also had to buy artificial milk. This coincided with the rise in hospital births where babies were separated from mothers and strict '*medical rituals'* (Palmer, 2009, p.205) were imposed around breastfeeding. These strict regimes limited suckling time which led to reduced milk production and the necessity for artificial milks (Palmer, 2009).

In 1950's America, a group of women who wanted to breastfeed challenged the artificial feeding culture and formed La Leche League (Palmer, 2009). La Leche League '*played a major part in the rescue of breastfeeding from near extinction in the US'* (p.322), and along with other mother-to-mother support groups around the world that followed its lead, helped to *'bring back the skills that commerce and doctors had almost destroyed'* (Palmer, 2009, p.332). Hence, in the 1970's it was not health workers but mothers who led the way in reviving breastfeeding (Palmer, 2009).

It is important to remember that not all women welcomed a resurgence of breastfeeding. Palmer (2009) explains that some 1970's feminists considered reproduction to be a cause of the oppression of women, and held both birth and breastfeeding in contempt. It is important also to note that many women recognise important benefits associated with artificial feeding, for example in enabling partners to help with feeding more easily (Binns & Scott, 2002), and in enabling greater control of time (Zimmermann & Guttman, 2001).

Although mothers led the way in reviving breastfeeding, Perry (2001) explains how since the widespread artificial feeding of the 1970's, *'it has again become the view of the mainstream obstetric community that breastfeeding should be encouraged'* (p1), indeed recent studies suggest the importance for women of medical discourses around infant feeding today (Burns, Schmied, Sheehan & Fenwick, 2010; Larsen, Hall & Aagaard, 2008; Andrews & Knaak, 2013).

Studies reveal that breastfeeding remains an important issue. In developing countries it is estimated that 1.45 million infant lives are lost each year due to sub-optimal breastfeeding practices (Lauer, Betran, Barros & de Onis, 2006). In the UK it is estimated that assuming moderate increases in breastfeeding, over £17 million could be gained annually via the avoidance of the treatment costs for four acute diseases in infants (UNICEF, 2012). Despite the increases in breastfeeding rates in the UK described above, nine out of ten women who stopped breastfeeding in the first six weeks stopped before they wanted to (Bolling, Grant, Hamlyn & Thornton, 2007), and a lack of support is a common reason given for early cessation (Schmied, Beake, Sheehan, McCourt &Dykes, 2010).

La Leche League (LLL) was the first organisation to develop a formal training course for breastfeeding peer supporters in 1987 (LLL, 2014a). The first UK course ran in 1991 (LLL, 2014b). Peer support has been defined as:

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

Dykes (2005) outlines how other breastfeeding organisations also devised their own peer support schemes, and these began to be delivered by health professionals who trained groups of local women who had breastfed. McInness, Love and Stone (2000) provide an example of the rationale for adopting peer support interventions; they explain that because mainstream health services had not been able to effect significant changes in women's infant feeding practices in a poor area of Glasgow, authorities decided to adopt a different approach and initiate a peer support intervention. Since these early beginnings peer support has been in the ascendancy. It has been advocated by the World Health Organisation [WHO] 2003, the Department of Health [DH]2004, and the National Institute for Health and Clinical Excellence [NICE] 2005 and 2008. Indeed Hoddinott, Lee and Pill (2006a) noted that peer support interventions have become 'fashionable' in the attempt to increase breastfeeding rates.

This history can be seen to feature two opposing forces; enlightenment thought expressed through technocracy, and women's own embodied experiences and knowledge expressed through mother-to-mother support organisations. Because they involve both health professionals and lay women, peer support initiatives form a confluence of these forces. Their advent is significant because it recognises and gives value to women's embodied, experiential knowledge of breastfeeding. Through peer support schemes women and health professionals must form working partnerships and collaborate together. In a personal sense, I too embody these forces; holding a degree in biological sciences, and being a qualified nurse, the mother of three breastfed babies and a peer supporter. This thesis, by way of the examination of issues of access, unpacks this situation and reveals the continued conflict between these two forces.

Peer support in Cornwall has a fifteen year history growing from Sure Start schemes. Peer support training has been devised by the County Infant Feeding Co-ordinators, and is delivered by a home grown mother-to-mother support organisation (which I helped to found). Throughout this time period peer support has taken the form of weekly drop in groups based at Children's Centres. Although group attendance rates are not systematically gathered it is estimated that approximately 30% of those initiating breastfeeding access peer support

groups. From 2010 to 2012, a proactive telephone peer support service (which I set up and established) provided support to one third of the women giving birth in the county.

Gaining a greater understanding of why some women do not use group based peer support is important for several reasons:

There is quantitative evidence of significant non-engagement with peer support that has not been investigated (Dennis, Hodnett, Gallop & Chalmers, 2002a; Di Meglio, McDermott & Klien, 2010; Graffy, Eldridge, Taylor & Williams, 2004; McInnes et al., 2000; Muirhead, Butcher, Rankin & Munley, 2006).

Qualitative studies suggest that those women who do engage with peer support value it highly (Thomson, Crossland & Dykes,2011; Thomson, Dykes, Hurley & Hoddinott, 2012), however no studies of non engaging women have taken place.

Research suggests that good relationships between health professionals and peer supporters are important in regard to enabling access (Dyson et al., 2006; Kaunonen, Hannula & Tarkka, 2012; Meier, Olson, Benton, Eghtedary & Song, 2007), yet the experiences of health professionals and peer supporters regarding access have not been explored.

Quantitative studies suggest that peer support interventions in the UK are not effective in increasing breastfeeding rates at particular time intervals (Hoddinott, 2011; Jolly et al., 2012). As a result it is possible that the whole concept of peer support will be abandoned before important questions about it have been adequately addressed. This would be unfortunate because it would reflect decision making based on insufficient evidence, and it would push to one side and devalue the embodied, experiential knowledge of women.

1.2Overview of the thesis

This study has employed constructionist grounded theory methods to co-construct, with participants, a theoretical understanding of why some women who initiate breastfeeding do not access peer support. An outline of the thesis has been provided as follows:

Chapter 2: Background

This chapter explains the rationale for undertaking this study and examines the concept and aims of peer support. The policy background, as well as the context of the local study area are discussed, along with my personal motivations for undertaking the study.

Chapter 3: Literature review

This chapter outlines the literature review undertaken for this study. The review explores the efficacy of peer support, the evidence for non-access, the qualitative evidence for peer support, and the barriers to and facilitators of peer support.

Chapter 4: Methodology

This chapter details the epistemological and ontological underpinnings of the study and my theoretical perspective. It details the methodology used and the manner in which specific methods were employed in this study.

Chapter 5: Findings

This chapter details the core category of 'a background of pressure, moral judgement and a dearth of breastfeeding knowledge' and goes on to describe five main themes to explain why women do not access peer support. Facilitators of access are also outlined.

Chapter 6: Discussion

This chapter summarises the findings of the study and contextualises them in the light of wider theoretical ideas and literature. The strengths and limitations of the study are considered. The chapter concludes with a personal reflection.

Chapter 7: Conclusion

This chapter draws a conclusion to the thesis.

2 BACKGROUND

This chapter outlines the background rationale for the study and considers the concept of peer support and its aims. It explains why breastfeeding is an issue of importance, outlines the policy base for peer support, and provides details of the local context for the study as well as my motivation for undertaking this project.

2.1. Why is breastfeeding an issue?

Evidence demonstrates that poorer health outcomes are linked to formula feeding when compared to breastfeeding (Horta, Bahl, Martines & Victoria, 2007; Ip et al., 2007). These outcomes affect both mothers and babies. For mothers, breastfeeding is associated with a reduced risk of osteoporosis, ovarian and breast cancer (Ip et al., 2007). For infants, breastfeeding is associated with a reduced likelihood of gastroenteritis and respiratory problems and with longer-term benefits such as a reduced risk of obesity (Horta et al., 2007; Ip et al., 2007). There is a broad body of research evidence surrounding these and other health benefits associated with breastfeeding. The World Health Organisation has developed a Global Strategy for Infant and Young Child Feeding, which recommends that babies should be exclusively breastfed for around the first six months of life, with continued breastfeeding up to 'two years and beyond' (WHO,2003).

The UK has one of the worst breastfeeding rates in Europe (Organisation for Economic Cooperation and Development [OECD], 2009). The National Infant Feeding Survey 2010 reports that although 81% of women in the UK initiated breastfeeding, only 69% were exclusively or partially breastfeeding at one week, reducing to 55% after six weeks (Infant Feeding Survey, 2010). In 2005 a national survey showed that 90% of women who stopped breastfeeding in the first six weeks had planned to breastfeed for longer, and that more than 75% of mothers who ceased breastfeeding within six months stopped before they had intended (Bolling et al., 2007). The community and culture of infant feeding into which a baby is born has been found to have a strong impact upon feeding method. Babies of parents who are younger, from low-income backgrounds, with fewer educational qualifications and who were themselves formula fed, are the least likely to be breastfed (Bolling et al., 2007; National Health Service [NHS] Information Centre, 2011). A lack of support is identified as a key reason for breastfeeding cessation (Schmied et al., 2010). Because of the existence of a large body of research evidence

regarding every aspect of breastfeeding, it is acknowledged that a deep and thorough understanding of this literature lies outside the scope of this study. Therefore I decided that the focus of this study would lie with the evidence around peer support for breastfeeding.

2.2 The policy base for peer support in the UK

Improving breastfeeding rates is a priority within UK health policy (DH, 2004, 2005, 2010a, 2010b; NICE, 2005, 2008). Breastfeeding peer support is advocated by the WHO (2003), DH (2004), and NICE (2005, 2008), as a tool to increase breastfeeding rates. Benefits such as the building of community capacity, increased public awareness of the benefits of breastfeeding and greater choice in service provision are anticipated (NICE, 2008). Additionally it is expected that peer support services might reduce inequalities and improve access to breastfeeding support for women on low incomes, improve the performance and provision of family-centred care, and offer better value for money (NICE, 2008).

2.3 What is peer support?

Peer support for breastfeeding finds its roots in La Leche League (LLL), a mother-to-mother support organisation that first met in America in 1956 (LLL, 2014c). The mission of LLL includes the aim to '*help mothers worldwide to breastfeed through mother-to-mother support, encouragement, information, and education*' (LLL, 2014a). LLL launched its peer supporter programme in 1987 (LLL, 2014a), and the first peer supporters were trained in the UK in 1991 (LLL, 2014b). Since this time other voluntary breastfeeding organisations have also developed their own peer support training programmes, usually involving health professionals training local mothers (Dykes, 2005).

Examination of peer support as a concept is useful as a background to this study. This can be achieved by asking; what is a peer supporter, and what are the aims of peer support interventions?

Close inspection of definitions of a peer supporter within the literature reveal considerable variation in requirements. Three authors define peer supporters as individuals that have two key components; shared experience *and* shared characteristics with the target population (Dennis et al., 2002a; Dennis, 2003; Dyson et al., 2006; Renfrew, McCormick, Wade, Quinn & Dowswell, 2012) (see page 16 for the definition given by Dennis (2003) in her concept analysis).

Other authors provide different definitions that do not contain both components (Jolly et al., 2012; Mickens, Modeste, Montgomery & Taylor, 2009). In their systematic review of peer support for breastfeeding continuation, Jolly et al. (2012) undertook a meta-regression analysis of the effect of setting, intensity and timing of the interventions considered. In their study peer support was defined as:

> '*Support offered by women who have received appropriate training and either have themselves breast fed or have the same socioeconomic background, ethnicity, or locality as the women they are supporting. Peer supporters may be voluntary or receive basic remuneration or expenses'* (p.1).

Two authors do not mention shared characteristics or experience in their definitions (Smith, 2007; The Joanna Briggs Institute, 2012). When considered together, all these definitions of peer supporters demonstrate limited consensus around characteristics of a peer supporter.

Broad and varied definitions of a peer supporter would not be problematic if each study demonstrated that the characteristics they used to recruit peer supporters, made them 'true' peers from the point of view of the target women. By 'true', I mean that the target women identified the characteristics they considered to be important in a peer, and that this directed the recruitment of the peer supporters. The key problem is not with the varied definitions used, but with the fact that the target women have not been considered in the process. For example, in the peer support interventions by Arlotti, Cotterell, Lee and Curtin (1998); Dennis et al. (2002 a); Graffy et al.(2004); Ingram, Rosser & Jackson (2005);Martens (2002);Meier, Olson, Benton, Eghtedary and Song(2007);Muirhead,Butcher, Rankin and Munley (2006); Nankunda,Tumwine, Nankabirwa and Tylleskar (2010); and Rossman et al. (2011) the parameters of 'peerness' with target women before recruitment of peer supporters are not established.

Jolly et al. (2012)'s meta-analysis, which uses the definition of peer support described above, serves to highlight the importance of the definition of peer support and its effect on the interpretation of research evidence. By defining a peer as someone who has had the same experience as the target population, *or* shares the same socio economic background *or* shares the same ethnicity *or* lives in the same locality as the target women, equal importance is

placed on all of these factors. Only one of these factors would be needed for the researchers to consider any intervention a 'peer support intervention'. It is interesting that the authors did not consider 'characteristics' as a basis of interpretation alongside other design and context-based features such as the setting, intensity and timing of the intervention. Jolly et al. (2012)'s analysis concluded that peer support is not effective in higher resource settings. Jolly et al. (2012)'s paper includes the study by Graffy et al. (2004) in which peer supporters shared only one characteristic with the target women (namely that they too had breastfed their babies). A significant proportion of the women did not access peer support, but were not asked why. The authors concluded that the lack of uptake may be due to the support not being offered proactively, or because women did not share many characteristics with the peer supporters (Graffy et al., 2004). Whilst this was deemed to be a high methodological study (Jolly et al., 2012), it appears hard to classify this as a 'peer' support intervention.

2.4 What is peer support supposed to do?

NHS commissioning guidelines for breastfeeding peer support (NICE, 2008) explain that a peer support programme should engage with local communities, train and supervise peer supporters appropriately, and provide a high quality service. Peer supporters should contact new mothers within 48hrs of their transfer home from hospital (or within 48hrs of a home birth), and provide ongoing support according to individual need. The guidelines note the potential benefits of commissioning such a service. Some of the benefits are associated with increased breastfeeding and exclusive breastfeeding rates, others relate to increased awareness of the benefits of breastfeeding and impacts on capacity-building in the whole community.

Literature around peer support for breastfeeding reveals that there are many aims and objectives that peer support programmes have been expected to realise. These can be grouped broadly into three areas and are discussed in turn below:

- Individual behaviour change.
- Building a culture of breastfeeding as experienced by women engaging with the interventions.
- Changing the way communities react to, and collectively feel about breastfeeding.

Individual Behaviour Change:

Randomised controlled trials are designed to assess the efficacy of peer support interventions on individual behaviour change (i.e. breastfeeding initiation, exclusive breastfeeding and breastfeeding continuation rates) (Britton, McCormick, Renfrew, Wade & King, 2007; Chung, Raman, Trikalinos, Lau & Ip,2008; Dyson et al., 2006; Fairbank et al., 2000; Renfrew et al., 2009; Renfrew et al., 2012). A systematic review undertaken by Renfrew et al. (2012) found that all forms of additional support, whether from lay people or professionals, had a positive effect on breastfeeding outcomes.

In their qualitative study of a peer support intervention, Thomson et al. (2011) provide insights into the mechanisms by which behaviour change can occur by drawing on the 'hope' frameworks developed by Morse and Doberneck (1995) and Snyder (2002). Women explained how shared experiences fostered a trusting relationship with peer supporters. They told how peer supporters made realistic evaluations of the situations at hand, helped them to consider alternative approaches and to set goals, mobilised resources to help them reach their goals, provided ongoing evaluation of progress towards goals, and enabled them (by means of praise and reassurance), to continue to breastfeed.

Building a culture of breastfeeding:

When studying peer support delivered in a group setting, some researchers specifically aim to create a culture of breastfeeding for attending women (Ingram et al., 2005; Raine, 2003). There is evidence that such cultures do develop, and that women find them invaluable (Hoddinott, Chalmers & Pill, 2006b; Ingram et al., 2005; Raine, 2003; Thomson et al., 2011). The literature highlights two key ways in which these emerging breastfeeding cultures might impact on the wider community. Hoddinott et al. (2006b) found that 'informal networking' outside the group occurred more than they had anticipated, and Brown and Lee (2011) reported how peer support groups created networking opportunities. Rossman et al. (2011) identified that many women emulated their peer supporter, either informally by talking about helping other mums or family members with breastfeeding, or more formally through wanting to become a peer supporter themselves. Other researchers also found similar responses (Aiken & Thomson, 2013; Battersby & Sabin, 2002; Britten, Hoddinott & McInnes, 2006; Scott & Mostyn, 2003).

It may be that networking and emulation are mechanisms by which peer support might affect community attitudes, although this idea is not clearly identified in the literature. For example Raine (2003) reports how her study *'aimed to encourage and promote breast-feeding in the community by rebuilding and revitalising support networks for mothers, utilising the skills of local volunteer peer supporters'* (Raine, 2003, p.464).

Many studies identify the importance of the relationship between health professionals and peer supporters (Battersby & Sabin, 2002;Dyson et al., 2006; Kaunonen et al.,2012; Meier et al., 2007), and the fact that good relationships enabled more women to access peer support (Bronner, Barber, Vogelhut & Resnik, 2001), whereas poor relationships could hamper access (Muirhead et al., 2006). Despite the importance of this relationship, it appears that health professionals and peer supporters have not been asked about their experiences of enabling access to peer support interventions.

Community impact:

The third area related to the aims of breastfeeding peer support identified in the literature concerns changing the way communities react to, and collectively feel about breastfeeding. Raine (2003) states that '*the challenge is to find strategies to overcome the barriers to breast-feeding, while acknowledging and strengthening the positive elements already in place. One such strategy is to use peer counsellors'* (p.465). Raine clearly indicates that part of the role of the peer support group is to change social attitudes towards breastfeeding. Quintero Romero, Bernal, Barbiero, Passamonte and Cattaneo (2006) anticipate that peer support schemes will change social prejudice. Ingram et al. (2005) suggest looking at strategies to break down community barriers to breastfeeding, including peer support schemes. It is unclear from reading these studies exactly how peer support schemes will do this. It might be that, as discussed above, the very act of creating a group will impact on the community, or it may be that more direct action is expected. The only example of direct action is the mention of peer supporters actively engaging with local businesses and signing them up to a breastfeeding friendly scheme (Raine, 2003).

2.5The local context of the study.

Cornwall has a population of 532,300 (Cornwall Council, 2011a), and ranks 110th out of 326 local authorities in terms of overall deprivation. Eight Cornish Lower Super Output Areas (LSOAs) rank in the 10% most deprived in the country, whilst twenty five LSOAs rank in the

20% most deprived in the country (Cornwall Council, 2011b). Nineteen percent of Cornish children under sixteen are living in poverty (Cornwall Council, 2013).

Whilst breastfeeding initiation in Cornwall in 2013-2014 was 81% which is above the national average for England, continuation rates were lower than the national average with 54.6% of women exclusively or partially breastfeeding at ten to fourteen days, and 40.9% of women exclusively or partially breastfeeding at six to eight weeks (personal communication from Infant Feeding Co-ordinator).

Voluntary peer support groups have a fifteen year history in Cornwall. Growing out of Sure Start schemes, 33 breastfeeding groups (most of which meet weekly) are run and 'owned' by approximately 150 peer supporters. Peer support training, developed by the County Infant Feeding Co-ordinators, is delivered by Real Baby Milk[1]. In 2009 Department of Health (DH) money became available to provide a pilot project whereby proactive peer support was offered to one third of mothers giving birth in the county. I set up and established this project which ran from 2010-2012[2].The results revealed that in some areas breastfeeding rates increased by 4% at ten to fourteen days, and by 1-2% at six to eight weeks. Funding for this pilot has now been withdrawn.

A pilot project began in May 2013 whereby peer supporters support women on the postnatal ward at the Royal Cornwall (Treliske) Hospital in Truro, and provide information on the local breastfeeding groups. This scheme delivers peer support to around 15% of women delivering at Treliske. This is currently the only formal breastfeeding support available to women apart from standard care[3]. Although attendance data for all the peer support groups across the

[1]Real Baby Milk is a Cornwall based not for profit social enterprise which I helped to establish in 2006, and worked for from 2006-2011. Initially my work aimed to link all the breastfeeding groups in the County together. I visited the groups listening to the peer supporter's ideas. Through this process a standard was agreed that would be common to all groups. This included all groups using the same resources, having common policies about confidentiality and the role of the peer supporter, and also built a network whereby support could be rendered and ideas exchanged. Part of this process was the incorporation of UNICEF baby friendly standards into the peer support training outcomes.

[2]The pilot areas for this service were chosen because they had low breastfeeding rates and/or because they were in geographical areas served by midwives managed by, or mainly dealing with out of county deliveries (it was anticipated that this service would become universal and it was important to identify issues likely to occur in all geographical areas). There was variability in the impact of this service.

[3]Standard postnatal care for primaparous women comprises a phone call from a midwife on day one. During this call the contact venue for face to face care is discussed and agreed. On days five and ten a face to face contact takes place, usually in a clinic environment. Some areas have maternity support

county has not been systematically gathered, it suggests that approximately 30% of women who initiate breastfeeding access peer support groups.

In September 2012, Cornwall attained full UNICEF Baby Friendly status for the Hospital, Community Services and Children's Centres (UNICEF Baby Friendly, 2012b). Peer supporters had consistently been included in training programmes in the years leading up to full accreditation, and many undertook interviews for Stage Two accreditation of the Children's Centres.

I have a nursing background, and have been a peer supporter in Cornwall since 2004. I currently work voluntarily, and have previously worked in paid employment, to develop peer support in Cornwall. I was the first of my friends to have a baby. None of the new friends I met through becoming a mother breastfed. I had a straightforward birth and breastfeeding experience and a supportive family, although my son did not sleep very much and I felt overwhelmed by how much he needed me. Despite having lots of friends, I did not have anybody who was experiencing the same issues. During this time I would have valued peer support enormously, and after my second baby was born I signed up for Sure Start peer support training which was new to my area. In 2005, whilst pregnant with my third baby, I applied for and gained a grant to enable the start of a breastfeeding group in my home town of Launceston. I have worked with others to raise money for at least one cohort of local mums to be trained as peer supporters in the town every year since then. I realised the importance of working with health professionals, mothers and other stakeholders in a continual cycle of refection about the group and whether it was 'working' in their eyes or not. For example when the group opened it was called 'Launceston Breastfeeding Support'. This name was quickly rejected and changed to 'Up Front Launceston' because health professionals identified that women felt the word 'support' in the title made it sound like the kind of group where an attendee may have to sit in a circle and tell everyone else all about their problems. In reality the group is informal and gives women the opportunity to socialise with other breastfeeding mums. Over the years, and in concert with gathering group attendance figures, this cycle of reflection has continued, focussing on how to enable initiating women to attend the group. Over many cycles of 'action' it became clear that, although the percentage of initiating women that attended the group had increased markedly from the time the group was launched, efforts to further increase this percentage were proving ineffectual. I also suspected that this

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assistants who may visit the home on day one (personal communication from Infant Feeding Co-ordinator).

local picture was repeated across the county. The desire to find out about the reasons why this was happening was the key motivation for my undertaking this study. My purpose in exploring this area is to strive towards meeting women's support needs, whilst respecting and maintaining other positive impacts of peer support interventions. It is not dogmatic pursuance of a specific model of peer support.

2.6 Study rationale

The rationale for this study comes from two sources; firstly one of personal experience of its relevance, and secondly from reading available literature about peer support. These sources suggest that:

- Published quantitative studies indicate that peer support interventions in UK settings are ineffective in relation to their aim of increasing breastfeeding rates at specific time intervals (Hoddinott, 2011; Jolly et al., 2012). Consequently, there is a real likelihood that the whole concept may be jettisoned before some fundamental questions about it are properly addressed. This would preclude improving the efficacy of current services and gaining valuable knowledge about the current situation that could be used to inform future initiatives. It could also be seen to devalue women's embodied experiential knowledge of breastfeeding.

- There is quantitative evidence of significant non-engagement with peer support that has not been explored (Dennis et al., 2002a;Di Meglio et al., 2010;Graffy et al., 2004;McInnes et al., 2000; Muirhead et al., 2006). This is borne out in the local context by the group attendance rate of approximately 30 % of initiators.

- There is qualitative evidence that women who do engage with peer support value it highly (Thomson et al., 2012; Thomson et al., 2011), but that there have been no primary studies that focus on why women do not engage.

- Although there has been no direct study of women who do not access peer support, literature suggests the existence of social and cultural barriers that may be affecting

non-engaging women (Hoddinott et al., 2006b; Ingram et al., 2005; Meier et al., 2007), but these women have not been asked about their experiences.

- Target women have not been asked about how they would define a peer supporter. This could be impacting on access.

- Research evidence suggests that good relationships between health professionals and peer supporters are important in enabling women to access peer support (Dyson et al., 2006; Kaunonen et al., 2012; Meier et al., 2007), but the experiences of health professionals and peer supporters around access have not been explored.

- Nine out of ten women who stop breastfeeding in the first six weeks would have liked to have breastfed for longer (Bolling et al., 2007), and a lack of support is identified as a key reason why many discontinue (Schmied et al., 2010). Peer support is recognised in policy terms as an important tool to increase breastfeeding rates (DH, 2004; NICE, 2005, 2008; WHO, 2003). Due to low continuation rates in Cornwall it is important to investigate why around 70% of women who initiate breastfeeding do not access breastfeeding peer support.

The primary gap in knowledge that this study aims to address is why some women who initiate breastfeeding do not access peer support services. I aim to construct, together with participants, an integrated theory of non-access.

3 LITERATURE REVIEW

3.1 Aims of the review

The literature review was undertaken with the aim of reviewing all literature discussing the reasons why women do not access breastfeeding peer support services. When the literature was examined, it was discovered that whilst a small number of studies discuss non-access, there had been no primary studies designed to explore this issue in-depth. A decision was therefore made to explore and present the evidence-base of peer support, as well as the barriers to and facilitators of this form of support. In this chapter I present the search strategy undertaken for the review, the evidence for the efficacy of peer support, the evidence of non-access to peer support interventions, the qualitative evidence for peer support, and the facilitators of and barriers to peer support.

3.2 Undertaking the review

Literature review question.

What are the barriers to, and facilitators of breastfeeding peer support?

Databases searched:

EBSCO host EJS, CINAHL plus full text, E Journals, ERIC, Medline, Medline full text, psycARTICLES, psycINFO, social science abstracts and socINDEX were searched.

Search terms used:

Breastfeeding, breast feeding, breast-feeding, peer support, lay support, non professional, woman, mother and maternal were the search terms used.

Terms that incorporate barriers and facilitators were; access, location, financial, culture, language, social, psychological, geographic, information, communication and attitudes.

Figure 1 Inclusion/exclusion criteria

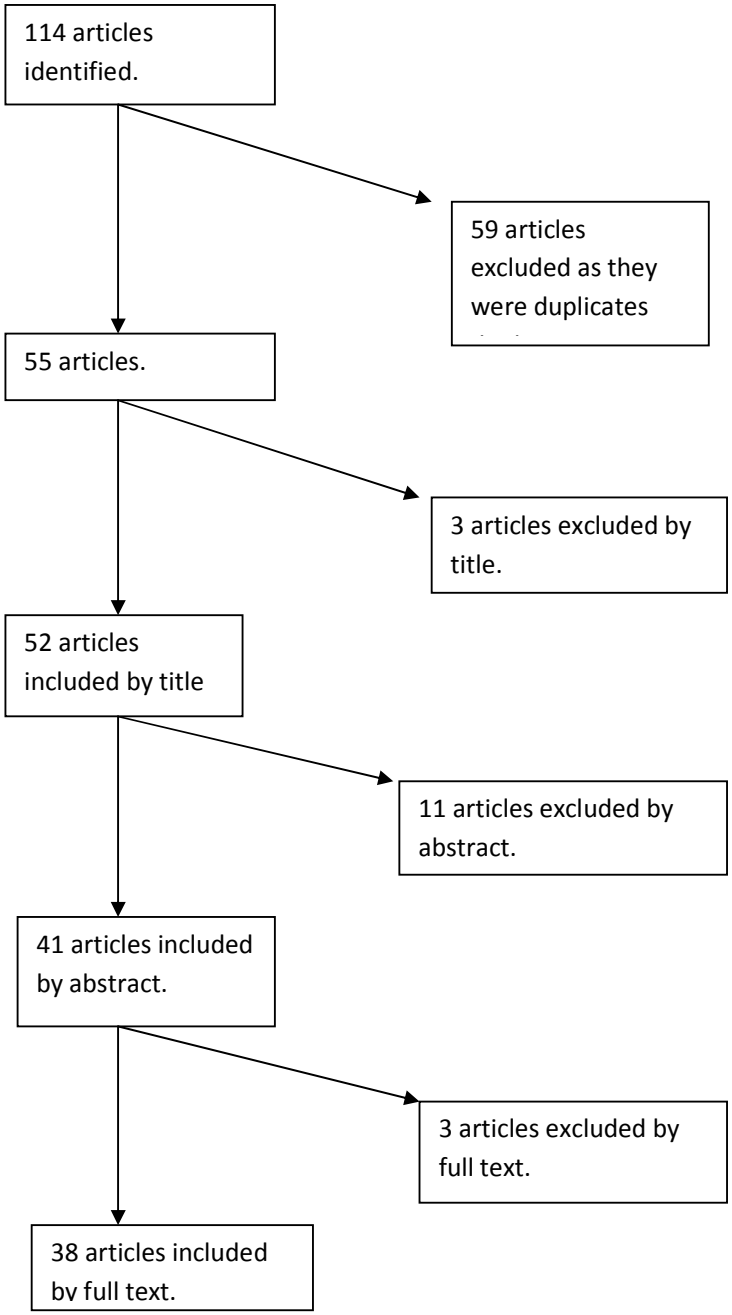
	Inclusion criteria	**Exclusion criteria**
Participants	Pregnant or breastfeeding women.	Non pregnant, or non breastfeeding women.
Support offered	Peer support/lay support. Support offered by a non health professional.	Support offered by a health professional.
Study type	Published in peer reviewed journals.	Non peer reviewed publications
Language	English language.	Other languages.

The search was undertaken on Friday 23rd November 2012.

Explanation of search method:

EBSCO host EJS was used, with all the databases selected as detailed above.

Figure 2 Results of search strategy for literature review



All 38 articles were read and re-read several times. Bates (1989) explains the approach of 'berry picking', whereby rather than relying wholly on the traditional method of literature searching, several different search strategies are used to pursue the search. I used these ideas to guide my approach to analysing the literature in this review. This seemed particularly relevant because many of the articles included discussion of the barriers to and facilitators of peer support, but these were not necessarily their main focus. I used the footnote chasing approach suggested by Bates; any references found in an article that seemed pertinent and interesting were followed up, and the original article found and read. References within this article that were important were also sought out and read, and this continued as each article was considered. In this way a further 46 referenced articles were identified and read. In addition, two articles were sent to me by my supervisory team.

Quality assurance

The lack of literature focussing on non-access to peer support necessitated a broad narrative approach to reviewing the literature. In the light of this, a quality assurance process was not considered necessary.

Combining the literature

Different methods of presenting the literature were considered, for example presenting the articles chronologically. Ultimately however, I felt that a thematic presentation would be the most helpful method. Thematic analysis was undertaken using the approach suggested by Braun and Clarke (2006). Four themes were identified and are explained below.

3.3Theme one: Evidence for the efficacy of peer support

Several reviews of interventions to increase breastfeeding duration and exclusivity have found increased support from lay persons/peers and professionals to be effective (Britton et al., 2007; Chung et al., 2008; Renfrew et al., 2012). Renfrew et al. (2012) summarise their review of the effectiveness of support for breastfeeding mothers by stating that '*support by both lay supporters and professionals had a positive impact on breastfeeding outcomes'* (p.2). However, evidence for the efficacy of peer support interventions in the UK has been questioned. In her narrative review Hoddinott (2011) highlights the under powering of UK

trials, the reductionist approach of many UK interventions, and issues around how interventions interact with health services, which may in part explain why UK interventions have not shown significant results. In their systematic review and metaregression analysis of peer support interventions in low, middle and high income countries including the UK, Jolly et al. (2012) also found that UK trials were ineffective. In short Hoddinott (2011) and Jolly et al. (2012) concur with Renfrew et al. (2007), that there is a current lack of good quality UK research evidence with which to inform policy in this area. Four problems with the evidence have been identified and are outlined below.

3.3-1The evidence does not consider women's views

In their critique of the evidence base of interventions to promote and support breastfeeding, Renfrew et al. (2007) considered it 'notable' that women's and families' views were not well represented, particularly when family and societal influences are known to be so important.

3.3-2There is a narrow focus on individual behavior change

Trials evidence focuses narrowly on breastfeeding rates at particular time points, and does not consider outcomes that are embedded in the cultural and social background of women's lives. For example, if a woman were to breastfeed for five days, this may be a large departure from the cultural norm of her social background, and may have impacted upon the attitudes and experience both of the woman, and others around her. Hoddinott (2011) suggests that a shift towards structural change (rather than personal behaviour change) is needed in the UK. She explains how current interventions tend to narrowly address individual behaviour, sometimes in short, single-dose interventions, which do not reflect the socio-cultural complexities of infant feeding practices. Hoddinott (2011) sees the interplay between the trial and the wider healthcare system as important, as well as the impact of trials on the socio-cultural ecology of the intended recipients and their communities.

Bonell, Hargraves, Strange, Pronyk and Porter (2006) provide several interpretations of structural definitions in their discussion of the use of randomised controlled trials (RCTs): '*Broad-school definitions encompass interventions aiming to foster 'macro-social' changes[ ] as well as those addressing 'meso-social' change (e.g. social networks, community norms and local health systems)*'(p.1136). Some peer support interventions have clearly stated aims to influence these 'meso-social' environments (Ingram et al., 2005; Raine, 2003), however there has been no investigation into whether peer support interventions have affected social

networks or community norms. A key way in which this could be addressed is through the experiences of women who have not engaged with these interventions.

Bonell et al. (2006) suggest RCTs of structural interventions can be prone to type 2 error (the failure to reject a false null hypothesis). This is possible when considering peer support interventions. Bunton, Murphy and Bennett (1991) discuss areas of health promotion theory that have generally been overlooked in the field of peer support. Bunton et al. (1991) view interventions as being embedded in society and culture rather than from the narrower standpoint of their impact on the individual. If Bunton et al. (1991)'s standpoint is adopted, one can see that by not attending to the way in which infant feeding practices are culturally transmitted, and by assuming that health service initiated interventions are the only and most significant factors in cultural change, early cultural changes could be missed. For example, many trials included in Renfrew et al.'s (2012) Cochrane Review measured breastfeeding rates at four to six weeks. This timeframe has little to do with detecting cultural changes in feeding practices, rather it is a pragmatic time point linking with medical assessment. Additionally it may be that evaluations of interventions are not using an appropriate timeframe facilitating measurement of effects. These possibilities are not discussed in the literature.

3.3-3The explanations given for lack of efficacy are not well underpinned

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

3.3-4The UK evidence points to access as being problematic

Jolly et al. (2012) admit that the evidence used in their review did not allow them to distinguish between trials being ineffectual per se, and women not engaging with the interventions. This is an important admission that has not been investigated.

Renfrew et al. (2012) define proactive support as that which is *'offered proactively by contacting women directly'* (p4), they note that five out of the six UK trials included in their Cochrane review did not provide proactive support, and that no trials offering non-proactive support worldwide have proved effective. In the only proactive peer support trial in the UK, peer supporters were not informed of delivery in a timely manner, so many women had stopped breastfeeding before support could be given (Muirhead et al., 2006).

3.4 Theme two: Evidence of non access

There are many examples in the literature that reveal access to peer support as being problematic. McInness et al. (2000) found in their cluster trial of a community-based peer support intervention in Scotland that only 70% of women in the intervention group received an antenatal visit, and of those who initiated breastfeeding only 76% received at least one postnatal visit from their helper. Likewise, a review of Scottish peer support programmes also identified that uptake was problematic (Britten et al., 2006).

The trial undertaken by Graffy et al. (2004) (outlined in Chapter 2), noted significant non-engagement that was not investigated. Furthermore, a trial of peer support for young mothers undertaken in the US by Di Meglio et al. (2010), found that half of the intervention group might not have actually received any peer support.

In their RCT of peer support for primaparous women in Canada, Dennis et al. (2002a) found that 28% of those eligible for peer support did not want it, with 48.5% of these women reporting '*sufficient support from their current support network* '(p.24) as the reason for declining peer provision. No qualitative investigation was undertaken to explore this further. The same trial also found that those women who did sign up to take part sometimes did not fully engage. In her report of maternal and volunteer perceptions of the RCT study, Dennis (2002b) suggests that this could be because the women did not connect with their peer supporter. Women and peer supporters in her study both cited *'inability to make a connection'* (p.174), as a barrier to peer support.

3.5 Theme three: Qualitative evidence reveals that peer support is important to women

Qualitative evidence gathered from women who have engaged with peer support interventions reveals that they have found them valuable. The key areas of benefit are detailed as follows:

3.5-1Peer support has enabled women to sustain breastfeeding

Studies have identified how peer supporters can help women overcome their breastfeeding problems and facilitate breastfeeding continuation. Nankunda et al., (2010); Rossman et al. (2011); Scott and Mostyn (2003); Thomson et al., (2011) and Thomson et al. (2012) all provide qualitative evidence that peer supporters enable women to sustain breastfeeding where they would otherwise have stopped. The women in these studies continued to breastfeed for longer than they would have done without peer support, however these increases may not coincide with routinely collected data on breastfeeding continuation gathered as part of trials.

3.5-2 The type of support women want and need

Dykes and Williams (1999) found in their phenomenological exploration of perceived breast milk inadequacy, that women want practical support, empathy and approval. This finding is mirrored by those of other researchers. Hoddinott and Pill (1999) interviewed pregnant mothers in the East End of London. They found that women expressed a desire for support from an experienced mother who would increase their confidence and who would spend time with them. Meier et al. (2007) in their qualitative evaluation of a peer support programme, and Graffy and Taylor (2005) in their qualitative analysis of women's needs around breastfeeding, both found that women wanted practical support with breastfeeding. The following sections explain how peer support can offer this.

3.5-3Peer supporters provided empathy and approval support

Thomson et al. (2011) found that peer supporters provided the appraisal support women needed. They praised the women, recognised their breastfeeding success, reaffirmed their expectations, reassured them, and instilled calm. '*This positive affirmation enhanced women's self esteem and self-efficacy to continue* '(p.11). Rossman et al. (2011) found that the emotional support peer supporters provided to the women was *'like mothering the mother' (*p.20). They were found to do this in a caring, nurturing and non-judgemental way. Rossman et al. (2011) also identify providing encouragement to be key. This was because their encouragement enabled mothers to persevere when challenges arose. Other authors, such as

Meier et al. (2007), and Thomson et al. (2012), also found the provision of encouragement to be important.

3.5-4Peer support fosters belonging

Dykes and Williams (1999) identify part of appraisal support as 'belonging'. A study by Ingram et al. (2005) identified how the peer support group developed a sense of community for attending women; how it gave them a sense of belonging, and served to normalise breastfeeding. Hoddinott et al. (2006b) and Thomson et al. (2011) also identify social aspects of peer support as being important. Raine (2003) explains how utilising women's shared skills and experience via peer support underpinned the aim of normalising breastfeeding (by valuing the skills and experiences of normal women). Furthermore, Hoddinott et al. (2006b) found that *'many women gained bodily, emotional, and performing confidence through exposure to breastfeeding in the group, having a safe place to practice their skills and talk openly about their own and other people's embarrassment'*(p.142).

3.5-5Peer supporters preserved and encouraged women's confidence

Hoddinott et al. (2006b) found that the communication style used between peers at groups acted to preserve personal confidence. Peers at groups were most likely to offer *'tips'* that implied a '*good bet'*, were spoken from personal experience, and acknowledged that risk was attached (p.142-3). Peers were not telling other mothers what to do from the position of an 'expert', but were sharing 'tips' whilst acknowledging that they may not 'work' in another mother's situation. This enabled mothers to preserve their own personal confidence. Women in Hoddinott et al.'s (2006b) study valued having access to differing breastfeeding experiences and approaches from the other women at the group. Unpredicted role models and examples of mutual empowerment were found. Hoddinott et al. (2006b) conclude: '*Our findings suggest that groups may facilitate women's own decision-making, and enable a more woman-centred approach to feeding decisions, than women report in one-to-one relationships with either health professionals or peer supporters'*(p.145). Similar findings were also identified by Kruske, Schmied, Sutton and O'Hare (2004).

3.5-6 Availability of time

Qualitative studies identify that time was important to help women sustain breastfeeding. Nankunda et al. (2010) in their study of peer support in rural East Africa, and Thomson et al.

(2011) found that women valued highly the fact that their peer supporters could spend as much time as they needed with them. Women in Battersby and Sabin's (2002) study of a peer support intervention in England, knew the peer supporters were there just to support breastfeeding and this made it easier for them to contact them or to accept their proactive support.

3.5-7The impact of recruitment practices on available qualitative evidence

Thomson et al. (2012) identify limitations of recruitment practices on the qualitative evidence. Women who fully engage in peer support interventions have been more likely to be interviewed than those who minimally engage, and no interviews have taken place with women who do not engage. This may indicate that qualitative evidence of times when peer support has not met women's needs has not been reported. Other qualitative authors do not discuss the impact of their recruitment practices on the evidence base.

3.6 Theme four: Facilitators of and barriers to peer support

The literature reveals several facilitators of and barriers to peer support provision. Although physical barriers such as lack of transport (Meier et al., 2007), and inappropriate venues (Hoddinott et al., 2009) were referred to in the literature, their mention was minimal. The main barriers to and facilitators of peer support found in the literature could be regarded as cultural and or societal.

However, it is important to emphasise that the studies discussed only involve women who engaged with such interventions, and therefore it is unknown whether non-engaging women experience the same factors.

3.6-1 Relationships with health professionals

Health professionals were identified in several studies to facilitate access to peer support, for example Anderson and Grant (2001); Hoddinott et al. (2006b); Raine (2003); and Shaffer, Vogel, Viegas and Hausafus (1998). In these studies it emerged that in order for the peer support intervention to be successful, it required the health professionals to signpost women to it, or to accompany them to groups. Hoddinott et al. (2006b) found that facilitating access via health professionals was vital, and one of the first things that required action. Bronner et al. (2001) found that the relationship between health professionals and peer supporters directly facilitates effective peer support. In areas where the relationships between peer

supporters and health professionals were good, the peer counsellors found it easier to recruit women. Other studies, for example Ahmed et al. (2006), Battersby and Sabin (2002), Kaunonen et al. (2010) and Meier et al. (2007), also note the importance of the relationship between peer supporters and health professionals with regard to reducing barriers to peer support. They suggest that this relationship requires ongoing work and investment.

The literature also provides examples of times when health professionals do not facilitate access to peer support interventions. For example Raine (2003) describes how although some health professionals referred all women, some referred only some, and still others none at all. Peer supporters in the study were aware of this and felt that as the intervention became embedded and time passed, health professionals would get used to talking to mothers about peer support. Muirhead et al. (2006) found that co-operation with health professionals was essential, and that some health professionals did not want lay people involved in the care of women. Hoddinott et al. (2009) explain how health professionals may be less committed to peer support because in areas of high social deprivation attending a group was not good use of their time. These areas have not been explored in the literature.

Thomson et al. (2012) found that issuing gifts to women enabled the peer supporters to gain increased access. In turn this enabled more trusting relationships to be built, and resulted in closer partnership working between peer supporters and health professionals. Dennis (2002 b) also found that 9.3% of the interactions between peer supporters and women resulted in referral to a health professional.

3.6-2The connection via shared experiences and characteristics

Many authors emphasise the central importance of the relationship between the peer supporter and the woman receiving support when discussing how peer support works. There is evidence that shared experience is important. Rossman et al. (2011) state that '*The effectiveness of the breastfeeding peer counsellor role is thought to be embedded in the relationship between new and experienced mothers'* (p.14). They found this shared experience powerfully motivated women to induce lactation. In her concept analysis, Dennis (2003) states that learning '*occurs more effectively when presented by peers with whom individuals identify, and share common experiences'* (p.326).

Furthermore, Thomson et al. (2011) found that women appreciated that their peer supporter had breastfed as it enabled trust in the relationship, and that this '*definitely made a difference'*(p.6). It was the knowledge that their peer supporter had herself been in their situation that made the mothers trust the information the peer supporters gave them.

Many studies including those by Arlotti et al. (1998); Kistin, Abramson and Dublin (1994); and Long et al. (1995), base their choice of peer supporters on the shared characteristics of race, income and living in the same area as the target women. Hoddinott et al. (2006b) notice that these are assumptions made by the researchers about the importance of these characteristics to the target women. It is assumed that if women are supported by other women similar to them in these ways, a connection will be made between them.

3.6-3The first contact or visit

A barrier to peer support is anxiety around the first visit or contact between women and peer supporters. For example Dennis (2002b) found that peer counsellors experienced anxiety on making the initial phone call to a woman, and Hoddinott et al. (2006b) found that women were worried about not knowing what a group would be like. The barrier of the first visit can be seen as comprising of two elements, firstly a lack of confidence, and secondly not knowing what a group might be like. Kruske et al. (2004) interviewed women who had not taken up group-based support, and preferred to attend one-to-one appointments with a nurse. When looking back on their early weeks of parenting, some of those women who had not attended groups felt their low confidence had stopped them from leaving the house. The idea of attending a group had been too much for them to consider. Ingram et al. (2005) found the idea of breastfeeding in front of other people to be a barrier for women. This could reflect a lack of confidence. Hoddinott et al. (2006b) explain how women were worried about group etiquette and who else may, or may not be there. They also explain that women were facilitated in making their first visit by meeting a health professional outside the venue, encouraging them to bring friends and companions with them, or to arrive together.

3.6-4Perceived lack of similarity between peer supporters and target women

In Hoddinott et al.'s (2006b) study, they found that when given a choice, group-based peer support was much more popular than one-to-one peer support. Women explained that having just one person would emphasise that person's experience, which might not be like their own, whereas the group gave access to diverse experiences. Women wanted to be able to *'pick a*

person I trusted' (p.144). Hoddinott et al. (2006b) interpreted that one-to-one peer support formed more of a risk to confidence and empowerment than group-based peer support. In their narrative review considering 'who supports breastfeeding', Clifford and MacIntyre (2008) interpret Hoddinott et al. (2006b)'s findings positively. They see group-based delivery of peer support as a facilitator to support because women can choose their peer supporter. However, if the target women perceive the peer supporters to be dissimilar to them, this could deter them from access. As Hoddinott et al.(2006b) did not include non-engagers in their study, we do not know whether this perception was a reason for non-attendance. Despite this, there is evidence of this idea in the perceptions of attending women, in that one mum says she was surprised that the others at the group weren't all *'hippy types'* (p.141). Also some women expected the peer coaches to be *'snooty'* and '*older'* (p.144). A perception of 'mismatch' in values could therefore inhibit women's access to both one-to-one and group-based peer support.

3.6-5 Lack of proactive support

It has been suggested earlier that a lack of proactive support could be a barrier to access to peer support interventions. When Hoddinott and Pill (1999) interviewed deprived mothers in London they found that women had difficulty in articulating why they had not sought breastfeeding support. They reported how women experienced embarrassment and a sense of failure, that they wanted to protect themselves from a further reduction in their self-confidence, and they anticipated 'being told' what to do. A decision not to access support was therefore related to these women wanting to find their own solutions. There was only one mother in this study who talked about why she had not contacted a breastfeeding counsellor. She anticipated that the telephone support would not meet her needs. In a study by Hegney, Fallon and O'Brien (2008) of women who continued breastfeeding whilst encountering extraordinary challenges, and women who did not continue, it was found that women who discontinued breastfeeding felt embarrassment about asking for help, and preferred to 'do it themselves'. Likewise, Dennis (2002b); Graffy and Taylor (2005); and Hoddinott et al. (2006b) also found that women often did not ask for help. The mention in many of these studies (Hegney et al., 2008; Hoddinott & Pill 1999; Hoddinott et al. 2006b) of women wanting to find their own solutions seems to suggest that women's sense of agency, confidence and control would all be put at risk by asking for help.

3.6-6 Women's social needs

Women's social needs can be seen as a barrier to delivering peer support. Meier et al. (2007) describe how peer counsellors had to help women with their social situations around housing, food insecurity and relationship problems before they could begin to support them with breastfeeding. Similarly in Kistin et al.'s (1994) study, it was the difficult social situations of the peer supporters that often affected how the study ran.

3.7 Rationale and conclusion

Reviews of the efficacy of peer support interventions in developed countries and in the UK (Hoddinott, 2011; Jolly et al., 2012), have found them to be ineffective. This contrasts with qualitative evidence revealing how peer support has met women's support needs and enabled them to maintain breastfeeding when they would otherwise have stopped (Thomson et al., 2011; Thomson et al., 2012; Scott & Mostyn, 2003). McCormack et al. (2013) suggest that one problem with the evaluation of many interventions is the insufficiently detailed contextual information. This causes difficulty in assessing the relative importance of various aspects of the intervention, which can mean the intervention is disregarded. Thomson and Trickey (2013) call for a realist review of the evidence for peer support interventions. Currently there is not enough evidence to demonstrate whether peer support is effective in terms of increasing breastfeeding rates at specific time intervals in the UK. The evidence base is weak, and there is a need for well designed trials that recognise breastfeeding as a socio-cultural practice embedded in society (Hoddinott, 2011). One important aspect of the evidence base is the finding common to many trials, that access to peer support is problematic. Although researchers such as McInness et al. (2000) have highlighted this as an area for future research, no studies have investigated non-access. Furthermore, qualitative evidence has not sought the views of women who have not engaged with interventions. Likewise, when the barriers to and facilitators of peer support are considered, the views of non-engaging women have not been studied. The barriers and facilitators identified in the literature gathered from the views of women who did engage, concern cultural and societal factors which may not be the same for women who do not engage. Whilst the potential relevance of outcomes from other fields of research are acknowledged, for example studies of non-engagement with other forms of peer support or with other aspects of Sure Start programmes, this study will make a first step towards addressing these gaps with regard to peer support for breastfeeding.

4 METHODOLOGY

4.1 Introduction

This chapter explains the methodology and methods used in this study, and the rationale for the approach that has been utilised. The chapter firstly considers epistemology and ontology by way of reflection upon my epistemological position when first setting out, and its subsequent development. Following this, my theoretical perspective, the methodology I have used, and the methods I have employed will be discussed.

4.2 Epistemology and ontology

Crotty (1998) explains that epistemology pertains to the nature of knowledge, to what it is grounded upon, whereas ontology concerns the nature of being, the '*what is*' the nature of existence (Crotty, 1998, p.10). Through reflection upon my initial approach to this study I realise that I had not truly considered the nature of the knowledge and understanding I was hoping to develop, nor the nature of the 'what is' that was to be studied. Consideration of these issues enabled me to reflect that at the beginning I held positivist views. I was expecting to 'discover' the 'real' reason why some women do not access peer support services. I certainly had not considered that I myself would have an impact on the outcomes of the study. As I have read, considered and attempted to comprehend the epistemological and ontological perspectives that have been expounded by others, my standpoint has changed. I now reject the objectivism elucidated by Crotty (1998),that considers meaning and reality as facts existing whether or not there is anyone who is consciously aware of them, purports that there is one true reality, and suggests that truth about the world can be described and 'discovered'. Likewise, I also reject subjectivism whereby meanings are made, or created in the minds of people without reference to things in the world, and then applied to objects in the world (Crotty, 1998). The approach I now adopt is the epistemology and ontology bound up in social constructionism.

Humphrey (1993) explains that the meanings we assign to objects, events and 'things' that we encounter in our life-world are generated from our conscious awareness. He argues that before humans were in the world, 'things' (objects, events, etc) existed, but that these 'things'

held no meaning until there was a mind to represent them. It is not that the 'things' in the world do not matter, but that their meaning is not inherent (Humphrey, 1993). At the same time, neither are meanings created totally within the mind, divorced from the things in the world and applied 'readymade' onto them. Instead it is argued that meanings are constructed out of the interaction between our minds (our conscious awareness) and the things in the world (Crotty, 1998). In constructionism meaning is a *'construction and interpretation of the world as experienced by participants in as much as it is possible to understand another person's lived experience'* (Crotty, 1998, p.42). In this way *'Constructionism brings objectivity and subjectivity together, and holds them there'* (Crotty, 1998, p.44).

Social constructionism builds on and develops these ideas further. From this perspective, the mind does not act independently of other minds, as if it were the first mind ever to interact with the object in question (Fish, 1980). Rather Fish (1980) explains how 'things' (objects, events, experiences) are constructed by the interpretive procedures we use to make sense of them, and these interpretive procedures or strategies are already embedded in us (or we in them). Helman (2001) explains how culture can be seen as *'an inherited 'lens' through which an individual perceives and understands the world'* (p.2), but also that culture must be placed in its own context which '*is made up of historical, economic, social, political and geographical elements'* (p.4). Social constructionism holds that we are totally absorbed, or encultured into social institutions and conventions, and it is through only these conventions that we are able to access *'a publicly available system of intelligibility'* (Fish, 1980, p.332). Geertz (1973) discusses how our interpretive systems, or meaning-making systems, have been at play throughout the vast majority of human evolution. To 'be' human these systems interact with our biology and the world. Indeed without these systems we could not make meaning, or interpret our life-worlds. However, Spradley (1980) argues against cultural determinism, suggesting that enculturation does not mean people are only ever able to act in one particular way, but rather there is a balance between individual agency and the extent to which culture is binding.

4.3 Theoretical perspective

Interpretivism

Crotty (1998) explains that a theoretical perspective is the philosophy that informs a methodology, the assumptions that philosophy holds, its logic and criteria. Therefore a given

epistemology informs the theoretical perspective adopted. As I have adopted the epistemological and ontological approach of social constructionism, my theoretical perspective for this study is interpretive. Given that I myself have been enculturated into a system of meaning-making, as have participants in this study, it would be impossible to take the positivist approach in which allegedly 'value-free' methods are used to test hypotheses about the social world and look for laws and ways of predicting outcomes (Crotty, 1998). Interpretivism *'looks for culturally derived and historically situated interpretations of the social lifeworld'* (Crotty, 1998, p.67), thus my interpretive approach aims to construct interpretations of the social world that are helpful and recognised as being culturally embedded and situated (Crotty, 1998).

Symbolic interactionism

Symbolic interactionism is a perspective that is firmly embedded in ideas of social constructionism. Crotty (1998) discusses how symbolic interactionism considers every person as a thoroughly social construction whereby the influence of society permeates every aspect of human life. Central to this perspective is the notion of the self being constructed by means of interaction with the generalised 'other', and the importance of seeing the world from the perspective of the 'other'. Indeed, by taking the role of the other, interaction must take place. This interaction involves significant symbols, which could be gestures or words, in order for one person to start to understand the other's way of making sense of the world (Crotty, 1998). This theoretical perspective is in accordance with the aims of my study in terms of trying to gain some understanding about why some women do not access peer support services. Therefore, the view-point of the 'other' is of primary concern.

An inherent problem in trying to take the view of the 'other' is that what we see and pay attention to, and what we ignore, are constructions that are socially and culturally informed (Crotty, 1998). Hastrup (1995) states that there *'is no way of seeing from 'nowhere in particular'* (p.4), and illustrates this by talking about horizons. A horizon (which relates to a person's individual view point) is not fixed, but what can be 'seen'. How far we can 'see' is determined from our socio-cultural standpoint. This can be problematic because our own meaning-making system bestows on us a particular standpoint from which we are able to 'see' some things, but not others (e.g. a woman who has successfully breastfed may not 'see', i.e. comprehend or appreciate, the views of mothers who choose to formula feed). Each of us holds certain assumptions and givens about the world that may make it difficult to perceive or

pay attention to the perspectives or standpoints of others. Oakley (1992) explains how recognition of the standpoint of the researcher is imperative, and that so long as the researcher's subjectivity is recognised and reflected upon, this should be seen as a strength rather than a limitation of the research process.

In this study I recognise the impact of my standpoint. I identify that some 'givens' may remain unsaid, and how that it is important to notice and reflect on assumptions that can be so obvious that they would never be considered or discussed. Reflexivity was therefore an integral process throughout this study. It has enabled me to be more aware of my standpoint and potential biases that in turn could influence how I listened to, and engaged with participant voices. The reflexive processes adopted in this study are discussed below (refer to section 4.5-2).

4.4 Methodology

A methodology is a plan or way of using specific research methods. It connects the use of these methods to the desired outcomes of the study (Crotty, 1998). In this study, I will be employing Grounded Theory (GT) methodology. When Charmaz (2006) reflects at the end of her book about what GT is, she explains how as a grounded theorist *'you'll enter the studied phenomenon with enthusiasm and open yourself to the research experience and follow where it takes you'* (p.185). This statement explains what grounded theorists do, but what does this involve and how did this approach come into being?

4.4-1The history of GT methods

Barney Glaser and Anselem Stauss developed GT in the 1960s as a way of developing theory about social processes. As the system of steps that makes up GT is undertaken, it is important that the theories are 'grounded' in the data collected in the study (Charmaz, 2006). Oakley (1992) suggests that *'theory is imaginative construction – a story' (*p.335). Field Belenky, Mattuck Tarule, Rule Goldberger and McVicker Clinchy (1986) suggest that *'theories become not truth, but models for approximating experience; . . . theories are "not fact, but educated guesswork"'* (p.138). GT therefore aims to use research methods in a particular manner by which a useful 'story' about the social processes involved may be theoretically understood and explained.

In Glazer and Strauss's original book, *The Discovery of Grounded Theory* (1967) GT had a positive focus in terms of how social processes were there to be 'discovered', and the 'truth' about the social processes involved was there to be 'found' (Glaser & Strauss, 1967). Due to differences in their perspectives, Strauss subsequently teamed up with Juliet Corbin, and in their book *Basics of Qualitative Research; grounded theory procedures and techniques* (Strauss & Corbin, 1990) a different version of GT was developed. This revised approach favours specific analytic techniques that Glaser argued forced the data into preconceived categories, thus going against the original premise of GT as enabling theory to emerge from data (Charmaz, 2006). In her constructionist approach, Kathy Charmaz (2006) explains how there is no reason why the original GT guidelines (now divorced from their positivist beginnings), cannot be used in a new way. '*We can use basic grounded theory guidelines with twenty-first century methodological assumptions and approaches'* (Charmaz, 2006, p.9).

4.4-2Constructionist GT

Charmaz (2006) explains that GT methodology is able to help researchers understand the worlds of research participants (in line with the central aim of symbolic interactionists; to understand the world of the 'other'), whilst simultaneously constructing theories to help us understand them. Unlike Glaser and Strauss at the beginning of GT history, the theories are not 'discoveries' of theories that are there waiting to be found, quite separate from the researcher. Rather, as interaction with participants takes place, grounded theories are constructed from and between these interactions (Charmaz, 2006). Charmaz (2006) makes it clear that the theories offered are not exact pictures of the worlds in question, but rather co-constructed interpretations. This version of GT is congruent with my theoretical perspective and epistemological underpinnings, and is the version of GT that I will be utilising in my study.

In Charmaz's GT methodology she emphasises the need to examine processes, make the study of action central, and create abstract interpretive understandings of the data. Geertz (1973) explains why it is important to study behaviour, or *'social action'* (p.17) carefully. He suggests this is because out of the flow of behaviour, culture is made obvious. *'Whatever, or wherever, symbol systems "in their own terms" may be, we gain empirical access to them by inspecting events'* (p.17). Charmaz (2006) adopts this approach through flexible guidelines rather than set rules or recipes. She explains how the fundamental aim of GT is to be open to what is going on in the studied area, trying to learn about what the participant's lives are like.

4.4-3 Study design

In order to fulfil the study aim of gaining a greater understanding of why some women who initiate breastfeeding do not access local peer support provision, I planned to use semi-structured interviews to gather data from three groups of participants: Women who had recently initiated breastfeeding, but had not accessed peer support with their current baby, health professionals who signposted women to the service, and peer supporters who provided the service. Glazer and Strauss (1967) suggest that when undertaking a GT study, data can consist not just of transcripts of interviews, but also of other diverse data sources. In addition to interview data I also kept field notes and a reflective diary enabling other incidents to be recorded and reflected upon. Following the initial interviews, the opportunity for a second interview was planned.

4.4-4 Rigour

The epistemological and ontological underpinnings of the study outlined above make clear that no claims to be searching for 'the truth' about this research question are made. As the researcher, I do not stand on the outside apart from the data being gathered. Rather, the desired outcome is a co-construction, within which I interact with participants and develop understanding. Charmaz (2006) recognises that quantitative researchers have questioned the reliability of individual, possibly biased qualitative researchers work, and highlights how in the past this challenge has been met by way of qualitative researchers distancing themselves from their interactions with participants and claiming more objectivist stances (Charmaz, 2006). However by focusing on interaction and adopting a reflexive stance, the strength of interaction in fostering abstract interpretations may be recognised (Charmaz, 2006). Morse, Barrett, Mayan, Olson and Spiers (2002) explain how responsibility for rigour must be assumed by the person undertaking the research, and rigour must be built into the research process by means of the methods themselves. This has been an aim in the design of this study. Rigour has been inbuilt by means of my reflexive work throughout the study. This has formed an attempt to identify how I might have influenced the study. Additionally, clear and simple analysis that used participants' own words as much as possible was important. The exercise of member checking also contributed.

4.5 Methods

4.5-1Ethical considerations

Ethical permission for the study was sought and obtained from three ethics committees. Firstly an application was submitted via the National Research Ethics Service (NRES), and the Integrated Research Application System (IRAS) of proportional review. Permission was gained from London Stanmore Ethics Committee, with subsequent permission given by the Cornwall NHS Research and Development Department. Secondly permission was granted by Cornwall Council Ethics Committee, and thirdly the Built Environment, Sports, Tourism and the Outdoors, and Health (BuSH) University of Central Lancashire (UCLan) ethics sub-committee. In addition I also gained a research passport which enabled me to conduct interviews with health professionals on NHS property. All the study paperwork, information sheets, reply slips, covering letters, posters, interview schedules, consent forms and protocols were submitted for ethical clearance.

The possible and likely impact of taking part in the study was considered for each group of participants. It was possible that recounting painful or distressing experiences might be upsetting. For health professionals and peer supporters, there was also the possibility that interviews might touch on areas of professional conduct for themselves or colleagues. I prepared for these issues by compiling a list of contact details for local health professionals and Patient Advice and Liaison Service (PALS) organisations for all local trusts, compiling a list of union representatives and Children's Centre managers (who hold line management responsibility for peer supporters), and by having tissues in my bag. No participants became distressed as a result of the interviews, and no issues were raised regarding professional conduct. Following one interview during which a mother recounted poor levels of care from health professionals, I telephoned my supervisor for support. Following discussion, I rang the County Infant Feeding Co-ordinators and discussed the incident without disclosing the geographical area it pertained to. Whilst it was not anticipated that participants would gain from taking part in the study, several women expressed how much they had enjoyed talking about their experiences. One health professional stated that the interview had prompted consideration of practice in this area, and that this was considered helpful. Several peer

supporters stated that this area was of particular interest to them and that they had enjoyed discussing their views.

For myself, ethical considerations included the possibility of becoming distressed as a result of interviews. Ongoing support from my supervisor was available, and I felt well supported throughout. There was also the potential danger associated with conducting interviews alone in participants' homes. I prepared for this by writing a lone working risk assessment which was adhered to. This included letting my supervisor know the address to which I was going and the time of the interview. Once the interview was over I then rang or texted my supervisor to let her know that I had finished. No untoward incidents occurred.

4.5-2 Reflexivity

Charmaz (2006) explains how reflexivity is the way in which the researcher looks at her own experience of the research, her decisions, interpretations and the ways by which she is brought into the process. It also relates to the participants and ensures they are represented in the written outcomes of the research. Field Belenky et al. (1986) explain the importance of self-knowledge and awareness, and how by respecting and being aware of one's own reactions, one is enabled to use those reactions, '*not as final truths, but as starting points for understanding*'(p.122). Reflexivity brings all this into the light and enables the reader to consider how, and to what degree the researcher and her own assumptions have influenced the study (Charmaz, 2006). Hastrup (1995) explains that reflexivity is important in ethical terms because it acknowledges theoretically that there can be no claim to completely know the worldview of participants, and that participants '*are irreducible'*. Not to acknowledge this would *'violate'* participants (p.160).

In this study the ways in which reflexivity has been consciously brought to the fore and used to help identify these issues are by way of keeping a reflexive journal, considering the differences between myself and participants, sharing and discussing ideas and incidents that arise, and completing of a reflective interview before data collection commenced.

The reflective interview was undertaken with a personal friend who is a trained counsellor. During this interview the study area was discussed in terms of my prior assumptions, feelings and expectations, and how my own personal life experiences relate to this area. This interview was valuable because it clarified some of my own standpoints and allowed me to reflect upon them at the start.

Identification of prior assumptions

I assumed that peer support was about supporting women in breastfeeding their babies for as long as they wanted, in the way that they wanted, no matter how long or short that might be, with no pressure. I assumed that asking for help with breastfeeding would be a difficult thing for women and that being able to breastfeed might be bound up in ideas about becoming a mother. I realised that for me, breastfeeding was important, and integral to the way in which I valued myself as a mother. In my own experience of miscarriage, social influences such as family and friends were of utmost importance and influenced the way in which services were accessed. Similar influences might apply to infant feeding. Reflecting back on my own early mothering experiences, I would have valued peer support as an opportunity to speak about my experiences and to receive empathy and encouragement from other mothers. It was the social isolation I experienced following the birth of my first baby that prompted my involvement in peer support.

I identified that because of my own personal investment in the idea of peer support, I may find it difficult to see and hear anything negative or contrary to my own understandings. It was also possible that because of the significant support for breastfeeding within my own family, and my relatively straightforward experience, I might find it difficult to understand and empathise with women in different situations. I also acknowledged that my personal experiences of being both a mother and a health professional impact on my ability to understand participants with varying backgrounds.

Throughout the study, time was frequently spent writing down my responses and feelings about situations that arose using a reflective cycle (Gibbs, 1988). This enabled me to identify issues that had stimulated my response and think about why this was. I could then apply this knowledge to understanding issues in my study. An example of this was my shock at the stories I heard from very early in the interview process about judgement of infant feeding decisions, particularly by peer supporters. I reflected on my feelings and reactions to the stories and tried to make sense of this information from several different people's points of view. This enabled me to learn more about myself and the participants' worlds. This learning could then be brought into play during subsequent interviews. For example next time similar stories were encountered I was less shocked, and more ready to explore how the participant felt and responded to the situation. This process made me think about my assumptions and about what is not said, as much as what is said. It helped me to imagine what attending a peer support group might be like from several different points of view. I also came to realise that

there probably have been times when I haven't realised how pressurised women feel, and so have been unable to acknowledge those feelings.

Secondly, consideration was given to how differences between myself and participants may affect the interviews, and the possible assumptions that may be made by both participants and myself. Charmaz (2006) explains that where we come from affects what we can actually see, as well as what we pay attention to. However reflexive we are we can never remove ourselves from the situation or be totally self aware and aware of our effect on others, or completely understand another's view of the world, hence the work is a construction. This is acknowledged in this study.

In view of my current voluntary role of breastfeeding counsellor in my local town, I planned to recruit participants from elsewhere in the county. This would minimise both the likelihood of participants knowing about my involvement with the service and minimise consequent assumptions about my views, or my likely reactions to their views. Because I had stopped working as County Peer Support Co-ordinator two-and-a-half years before the start of this study, it was unlikely that any participants would remember me in this role, and indeed, to my knowledge this did not happen.

Participants may have made particular assumptions about me and my views based on my clothes, age, class and ethnicity. Participants may have assumed that I had children, and perhaps breastfed. I considered this carefully. I tried to dress in clothes that were fairly plain and casual. When necessary and appropriate I did mention that I too am a mother, but explained that my children are much older and that peer support services were not available when I had my babies, hence I had not had experience of the situation under study. I did not talk about my infant feeding experiences, although saying that these services were not available to me implied I initiated breastfeeding. When participants directly asked me about myself, this level of disclosure served to identify me with their situation, but centralised their experiences, dimming my own. This also served to establish rapport.

4.5-3 Inclusion criteria

While the study was being designed, I discussed my plans with the Infant Feeding Co-ordinators. They suggested that instead of including any woman who had initiated breastfeeding as a potential participant, I should include only those who had continued for five days or longer. This would avoid those who did not plan to breastfeed for any length of time and thus would not have considered peer support. I now consider this detrimental to recruitment, and perhaps to the findings of the study. When I was speaking to women at baby groups about the study I suspected that this timeframe and the impression it gave of the value of short-term breastfeeding or breast milk giving affected involvement. Looking back, perhaps I did not explain the grounded theory methodology (including theoretical sampling) adequately to the Infant Feeding Co-ordinators, and perhaps had not fully recognised it myself. They were concerned that I would spend a lot of my time with women who had breastfed for a short time only. This criteria also seemed to imply a basic assumption that deciding to breastfeed, and following this through, is the mothers responsibility and that if a mother stops before day five, she couldn't have really wanted to do it. This assumption forms an example of the kind of theoretical underpinnings that were identified in my findings to be detrimental to accessing of peer support. In reality I found it more difficult to recruit women who had fed for a short time, and perceived judgements about infant feeding decisions were an important finding of my study.

The other inclusion criteria for women in the study were that they must be aged eighteen or older and must be able to speak English. These criteria were adopted in order to avoid issues of consent for persons under eighteen and because of the lack of funds available for interpreters. One potential participant aged seventeen responded, and I was unable to interview her as a result of her age. However I was able to recruit several other young mothers, the youngest of whom was twenty. One participant was of Eastern European origin but had good English skills. All other participants and potential participants spoke English as their first language. I did not feel that the requirement to be able to speak English prevented any women from participating.

4.5-4 Study information sheets and covering letters

Study information sheets were drawn up (see Appendix 1, p.123-138), one for health professionals and peer supporters and one for women. These used simple language to explain the purpose of the study, including the general topic areas. The sheets stated that the potential participant was free to choose the time and venue for the interview, had the right not to answer any questions, and could stop the interview at any time. Information was given about the right to withdraw data from the study for a one month period after an interview had taken place, information about safe data storage and how anonymity would be preserved. I included contact details for myself, my supervisor and the Dean of the faculty. For the health professional and peer supporter participants the information sheet also stated that any issues of professional conduct arising in interviews would be referred to management. These participants were also asked not to use the names of colleagues during the interview.

Reply slips were drawn up stating the study inclusion criteria (see Appendix 1, p.139-142), one slip for health professionals and peer supporters and one for women.

Covering letters (see Appendix 1, p.143-148) about the study were sent to Health Visiting teams who might help with the recruitment of women participants and to peer supporters and health professionals who might consider participation themselves. These letters explained who I was and the nature of the study.

4.5-5 Informed consent

Freely given informed consent is fundamental to all ethical research projects and is required by the declaration of Helsinki (WHO, 2001). Informed consent requires that participants have a full understanding of exactly what the research project involves for them, and that they agree to participate freely. To do this it is vital that the participants have capacity to understand and make decisions. The researcher must be sure of this capacity (Royal College of Nursing [RCN], 2011). In this study a consent form was drawn up (see Appendix 1, p.149-151). Participants were given the written study information sheet at least one week before the interview. This allowed time for them to read the sheet, discuss their potential participation with family and friends and think about it themselves. At the time of the interview I asked the potential participant whether they had read the information sheet and if they had any questions about it that they would like to ask. Several spare copies were available if needed. On all occasions potential participants had read the information sheet before meeting with me for the

interview. Following this the main features of the information sheet were reiterated verbally before the consent form was given. The end of the consent form included a section where the participant could indicate whether they would like to be contacted for a second time in order to complete a second interview, or to have the main themes of the study sent to them. Of the thirty two participants, eighteen asked to be re-contacted again in order to arrange a second interview, and twenty-eight indicated that they would like the main themes sent to them (some participants wanted only the themes sent, others only to be contacted for a second interview). Adequate time was allowed for the potential participant to read the consent form thoroughly and ask questions before signing it. When interviews were undertaken via the telephone, the same procedure took place, except that the consent form was read to the potential participant and verbal consent was given. This was documented on the form.

4.5-6 Recruitment

Recruitment proceeded via the following means:

Women

There were three routes for recruitment of women. The first was via posters displayed in Children's Centres (see Appendix 1, p.122). The lead manager of Cornwall's Children's Centres was contacted and asked to forward information about my study to all the Children's Centre managers in the County. Following this I approached six Children's Centre managers via email to ask for permission to display posters at their Centres. The posters gave a brief explanation of the study and asked women to call or email me for further information, and let the Children's Centre receptionist know. Potential participants would then be sent the study information sheet, reply slip and stamped addressed envelope by post.

This method of recruitment did not attract any participants. At the end of the recruitment period I contacted the Children's Centre managers, thanked them, and asked them to take the posters down.

In the Children's Centres where the posters were displayed, I also gained permission from the managers to attend baby groups held there. I visited six different Centres on nine occasions. Before visiting I telephoned the Centre and spoke to the play leader running the sessions. I outlined my study and emailed the information I would provide to any potential participants. When visiting the baby sessions I chatted to the mums and explained who I was. I left packs of

study information sheets, reply slips and stamped addressed envelopes with any women who were interested and who met the inclusion criteria. This method of recruitment resulted in nine participants. Of these women two sent back the reply slip and arranged to be interviewed at their local Children's Centre, two sent back the reply slip and arranged to be interviewed at their homes, three took away the information, read it and then volunteered to be interviewed the following week in a separate room while the baby group was taking place, and one mother read the information and the following week at the baby group session requested a telephone interview.

Snowball sampling

At the end of each interview I asked participants whether they had any friends who might feel able to participate. I asked them to ask their friends, and to pass on contact details to me only once permission had been obtained. Although several participants said they could think of somebody who might be suitable, this method of recruitment did not result in any participants.

Recruitment via Health Visiting teams

After gaining full ethical and managerial permission, three Health Visiting teams were contacted via the Infant Feeding Co-ordinator. Team members were asked to give potential participants packs that included study information sheets, reply slips and stamped addressed envelopes. This method of recruitment resulted in four participants. Although this was a small number, three of these four women had not accessed any Children's Centre services. Of these women, two requested a telephone interview, one a face to face interview at the Children's Centre and one a face-to-face interview at her home.

In total three women were interviewed in their own homes, seven were interviewed at Children's Centres and three were interviewed via the telephone.

Peer supporters

Information for peer supporters was issued at five out of the six Children's Centres where the posters were displayed. Peer supporters from four of the areas responded. In two areas the

peer supporters asked if I might visit them and interview them as a group. These group interviews were undertaken at the Children's Centre either before or after a breastfeeding group session. The first group interview involved four peer supporters, the second seven. The other areas requested three individual interviews, one via the telephone, and two face to face at the peer supporters own homes.

In total five interviews took place involving fourteen peer supporters.

Health professionals

The Infant Feeding Co-ordinator approached three Health Visiting teams asking if they would consider involvement in the study. This resulted in four health professionals participating. All were interviewed at their offices. Two were Health Visitors, one with one years experience and the other, two years experience, and two were Community Nursery Nurses, both with over ten years experience. Following this, recruitment slowed. A lead Health Visitor who had been working in my home town was moved to a different area. This Health Visitor forwarded my study information to colleagues and two participated in interviews via the telephone. One of these was a Health Visitor of over ten years experience, and the other a student Health Visitor with a non-midwifery background. The six health professional participants were geographically spread across the County.

4.5-7 Demographic characteristics

I planned to interview a maximum of fifteen women participants and fifteen peer supporter and health professional participants, forming a maximum of thirty. Because in two areas peer supporters asked to be interviewed as a group, the resulting total number of participants was thirty three; thirteen women, fourteen peer supporters and six health professionals.

In accordance with ethical permissions, demographic information was gathered from all women participants. The women's postcodes were used to identify the LSOAs within which they lived and the level of deprivation associated with this. It is recognised that this does not give a definitive measure of deprivation, but more a rough guide (Communities and Local Government, 2010). Figure 3 shows the characteristics of the participants.

Figure 3Demographic characteristics of participants

Women

Pseudonym	Age.	Deprivation level of LSOA.	Highest qualification.	Parity.	Breastfeeding history.	Participation in member check interview.
Cassy	20	Least deprived 30-40%	A levels	1	Exclusively breastfeeding. Five weeks.	No
Dolly	24	Most deprived 30-40%	No formal qualifications.	1	Breastfed with some formula for six weeks.	No
Mel	33	Most deprived 0-10%	Diploma.	5	Initiated breastfeeding with all except eldest. Fed middle babies for up to three months, fed youngest for eighteen months.	Yes- formal interview via telephone.
Sienna	32	Most deprived 40-50%	School level (in Eastern Europe)	1	Exclusively breastfeeding four month old baby.	No
Amber	44	Most deprived 30-40%	Degree.	1	EBM and formula, baby now two months.	Yes- formal interview via telephone.

Kirsty	25	Most deprived 30-40%	Diploma	1	Exclusively breastfeeding baby now five months.	No
Sara	36	Most deprived 30-40%	Degree	2	First baby now aged two born prem, expressed for three months, directly breastfed for three months. New baby being exclusively breastfed, now nine weeks old.	No.
Belinda	22	Most deprived 40-50%	NVQ level 2.	1	Breastfed for ten days.	No
Heidi	36	Most deprived 20-30%	Degree	2	Breastfed both older child and baby for under two weeks.	No
Gail	33	Most deprived 30-40%	Degree	2	Breastfed older child for two years, breastfeeding baby eleven months, plus solids.	No

Dana	26	Most deprived 40-50%	NVQ level 3	2	Breastfed first baby for six weeks, now mixed feeding second baby who is four weeks old.	No
Chrissy	25	Most deprived 40-50%	Degree	1	Breastfeeding plus solids, baby now eleven months.	No
Esme	27	Most deprived 40-50%	NVQ level 3	1	Breastfed for six months.	No
Helena					Helena contacted me once recruitment had stopped, so I sent her the main themes via email and she replied with comments. I gained consent to use her comments.	N/A

Peer supporters

Pseudonym.	**Time in this job.**	**Participation in member check interview.**
Carys	Two years.	Yes- formal telephone interview.
Tina	One year.	No
Beth	Two years	Yes- email feedback.
Hope	Two years	Yes- informal telephone conversation.
Gemma	One year	No
Laura	Two years	No
Jacky	Three years	Yes- informal telephone conversation.
Pippa	Five weeks	No
Helen	Five years	No
Shelly	Two years.	No
Mary	Two years	No
Jess	Five weeks	No
Megan	Five weeks.	No
Naomi	Five weeks.	No

Health Professionals

Pseudonym.	Job title.	Time in this job.	Participation in member checking interview.
Kerry	Assistant Family Health Practitioner (Registered Nurse).	Two years.	No
Jane	Community Nursery Nurse.	Over ten years.	No
Clare	Community Nursery Nurse.	Over ten years.	No
Julie	Health Visitor	1 year.	Yes- informal telephone conversation.
Kim	Student Health Visitor.	Five months.	No
Phillipa	Health Visitor and Practice Teacher.	Over ten years.	No

4.5-8 Storage of data

All data pertaining to the study were stored in accordance with the requirements of ethical permissions. Completed consent forms were given a code, scanned and uploaded onto the university password protected computer system. All personal information contained on reply slips was kept in a locked filing cabinet at my home for the minimum possible length of time.

All participants agreed that I might record their interviews. As soon as possible after the interview I transcribed and anonymised the data by using pseudonyms. While this process was taking place the recording device was kept in a locked filing cabinet at my home. Once transcription was complete and correct, the recording was deleted. A table was kept of the

code linked to participants' real names and their pseudonyms. This table was kept separately from other study information in a locked filing cabinet at my home.

4.5-9 Semi-structured interviews

Semi-structured interviews were used in this study[4]. Interviews are considered to be an effective way of *'eliciting each participant's interpretation of his or her experience'* (Charmaz, 2006, p.25). The interview differs from usual conversation because the interviewer's role is to listen, observe and facilitate, and it is the participant who speaks for most of the time (Charmaz, 2006). Interview schedules were developed in the form of prompt sheets (see Appendix 1, p.152-157), one for use with mothers and the second for health professionals and peer supporters. For mothers the main topic areas covered in these sheets were her own infant feeding experiences and support needs, her awareness and perceptions of peer support, barriers to and facilitators of the service, and recommendations. For health professionals and peer supporters the main topic areas were awareness and perceptions of peer support and women's referral to the service, perceived barriers to and facilitators of the service, and their recommendations. Interviews were expected to take no longer than 45 minutes. In practice most interviews did take approximately this long, but one interview with a peer supporter took an hour and an half.

Before an interview took place, and once informed consent had been given, I gathered demographic information as outlined above. When conducting an interview I first made sure that the participant was comfortable and tried to put her at her ease by chatting and /or complimenting her on her baby.

The interview schedules were used as prompts to initiate conversation. I tried to maintain eye contact with participants and use active listening techniques to encourage them to speak freely about their experiences. This included making noises such as 'uh huh', or 'mmmm', asking the participant if she could tell me more about that area when a point seemed unclear, adopting open body language, and repeating back to the participant what they had just said to me. I tried to allow silences, letting participants break them. An example interview transcript is included in Appendix 2, p.164.

[4]Semi-structured interviews involve using an interview guide that has been prepared in advance to ask participants open-ended questions relevant to the topics of interest (Given, 2008).

4.5-10 Data analysis

Data collection and analysis was undertaken concurrently. As soon as possible after an interview field notes were written. Following this, the recording of the interview was transcribed, checked for accuracy and uploaded onto qualitative data analysis software (MAXQDA) for analysis purposes. The analytical procedures adopted are outlined as follows:

Open coding

According to Charmaz (2006) data within the transcript must be 'named', or 'coded' with a label that names, categorises, and explains it. Coding *'distils data, sorts them, and gives us a handle for making comparisons with other segments of data'* (Charmaz, 2006 p.3). Each transcript was read through many times and codes were added. Initially I found this process difficult. I made many similar codes that were highly descriptive. I coded many segments with lots of different codes, and this proved confusing. Gradually, after several re-starts I felt more comfortable with the codes I was creating, and I tried to make them more analytical. The following is a brief example.

Figure 4.**Sample coding**

Quotation.	**Code.**
Mother: 'I still felt like I'd failed in some way by giving up, you know so I think, so even though I'd thought 'I'm not going to be', I think you are, without realising it, I think you are kind of pushed, cos I, otherwise I'd have just thought 'Oh well, that's it, I've tried and I'll move on', whereas I thought 'God, if I don't do this. I'm failing in some way' you know?'	Feeling like a failure.

Constant comparisons

The second step in GT data analysis is making constant comparisons between data. This technique starts with the very first interview. Here codes or events in the data are compared with other codes or events, and notes or memos are written about the comparisons. This happens again and again, both within and between transcripts. By consistently making comparisons and asking questions of the data, theoretical ideas emerge. These are noted and spark new questions to be asked of the data and yet more comparisons. The following excerpt is from a memo written following the comparison of incidents and demonstrates the manner in which this exercise serves to create yet more questions to ask of the data:

> *Comparing 'aims' codes and 'views of the group' codes. These two sets of codes seem to relate to each other. Comparisons bring up yet more questions. For example, when someone says the group is 'nothing special, just another group', what do they understand the aim to be? How would a 'positive social link' relate to any aims? Why are there lots of different views and aims expressed? Are there patterns in these views?*

This work resulted in the construction of some tentative categories. A category may be conceived as a code that has real significance, or an abstraction of common themes in the data (Charmaz, 2006). The technique of simultaneous data collection and analysis was difficult to effect in practice. It was difficult to find enough time to transcribe, code and make comparisons before the next interview took place.

Focused coding

As I proceeded with open coding and making comparisons, I developed a large number of different codes, some of which could be submerged. Some of these codes seemed particularly important, and thus became the subject of focused coding, where data is compared to the code (Charmaz, 2006). Gradually groups of codes related to one another aggregated and became tentative categories. Links between tentative categories emerged as the process of continued data gathering and analysis continued. For example, the following excerpt is from a memo written whilst undertaking constant comparisons:

Whilst comparing examples of 'telling and advising' by health professionals. I wonder, how does this relate to judgement and its anticipation at groups? Does it? How? When? Why do these health professionals do this? Need to make comparisons between these incidents and times when health professionals do not do this.

As I moved groups of codes around and thought about the links between them, I saved each copy of my MAXQDA file before making changes. As described by Charmaz (2006) this process of analysis is not linear. I found that new concepts and ideas arose at different points during the process. Sometimes this meant I needed to go back to earlier transcripts and look again at my coding to see whether areas relating to new ideas had been glossed over earlier on. An example of this was the reference to colour in terms of black, white and grey that heightened my awareness of other similar phrases about halfway through the data gathering and analysis process. Here is the memo written when I first noticed these phrases:

I want to note the issue of 'black and white', breastfeeding either 'works or doesn't work', 'all or nothing', and the phrase used by Gail of 'meeting the grey'. Why do these kinds of phrases keep coming up again and again? What do they mean? Are they related? How? Who has said these things? About what? How do the phrases differ? How are they similar? I need to go back and look through all the interviews and see how this fits in.

The process of remaining open to the data and looking for links between ideas continued as data collection proceeded.

Axial coding

Charmaz (2006) discusses the potential advantages and disadvantages of using the technique of axial coding suggested by Strauss and Corbin (1990). In response to this discussion, I re-read the chapters pertaining to it in Strauss and Corbin's book (Strauss & Corbin, 1990). After consideration, I felt that undertaking this process seemed to require considerable focus on the technique, and that proceeding with it might be at the expense of my focus on the data. I decided not to undertake this technique, but rather continued to follow Charmaz (2006)'s '*flexible guidelines'* (p.61), as described above in order to develop ideas about categories and the links between them.

4.5-11Sampling

Initial sampling

At the outset I aimed to recruit participants with a wide range of backgrounds, ages, and breastfeeding histories. This would enable me to interact with a broad range of participants and remain open to their worlds and ideas. As an example, most women I interviewed at the beginning of the study had breastfed for a relatively long period of time. These women could discuss why they did not access peer support at various different time points. However, I also wanted to include women who stopped breastfeeding in the early period. I felt this was important in order to determine whether their experiences were the same or different. Health professionals were therefore asked to help target women who had stopped early. This broad start formed a grounding point, from which further data collection concerned with theory development could follow (Charmaz, 2006).

Theoretical sampling

Once I had created some tentative categories and had made links between them, theoretical sampling could take place. Theoretical sampling '*means seeking and collecting pertinent data to elaborate and refine categories in your emerging theory*' (Charmaz, 2006, p.96). This kind of sampling is all about theory development. It does not seek population representativeness, or to increase the generalisability of any outcomes (Charmaz, 2006).

While recruiting for the study it became obvious that there was a tension between undertaking a GT study as described by Charmaz (2006) and reality. Whilst in theory, theoretical sampling proceeds in relation only to theoretical ideas, keeping the subject of the interviews narrow to include only those areas of the emerging theory on which the researcher requires more information, in reality, ethical permissions and values meant that I could not just dispense with my interview protocols and discuss only particular areas that were pertinent to me. Also time constraints meant that finding participants with particular experiences was difficult. However, when approaching later interviews I had in my mind the areas I was particularly interested in, and whilst I followed the interview protocols in every interview, I encouraged later participants to expand on their experiences in particular areas. For example later in the study I had noticed how the manner in which health professionals talked about breastfeeding seemed to affect the way mothers responded to their situation. Hence, in my final interview there was particular focus on the mother's interactions with health professionals.

4.5-12 Member checking

I worked to develop two A4 sheets covering the main themes of the study I had tentatively identified (see Appendix 1, p.158-163). One sheet pertained to women participants, and the other to health professionals and peer supporter participants. The relevant main theme sheet was then sent via email or post to every participant who had indicated a desire to have the main themes of the study sent to them. One week after the main theme sheets were sent, participants who had requested a second interview were telephoned and second interviews arranged. It proved difficult to make contact with many of the participants in order to arrange a second interview. I left friendly messages and emails, but remained mindful of respecting participants own space and time. All the second interviews took place via telephone. Figure 3, p.58-62 includes a column detailing which participants took part in member checking. In addition to formal second interviews, I also undertook three informal second phone conversations with participants. This was because they were very busy and had only limited time available. The responses of the participants to the main theme sheets made me feel more confident about my ideas because participants recognised and were in broad agreement with the themes identified.

Theoretical sampling was also employed during the second interviews as it provided an opportunity to ask particular participants specific questions. For example, my main themes had identified that there was a lack of clarity regarding the aims and ethos of peer support in general, and also that many women felt that health professionals aimed to make sure that they kept breastfeeding. The second interview gave me the opportunity to ask a particular health professional how these ideas related to her own practice. This yielded important information regarding the tension between the two differing imperatives of her role. On the one hand she knew she had public health messages to put across, on the other hand she wanted to enable and empower parents to parent in the way they wanted. She described times when she had altered her behaviour in relation to these conflicting imperatives depending upon whether particular colleagues were listening to her interaction or not. This information was valuable to me and served to 'fill out' emerging categories to some degree.

4.5-13 Saturation

Saturation is the fourth step of GT analysis. Saturation of categories occurs when gathering new data fails to generate any new theoretical ideas or new properties of the categories

(Charmaz, 2006). I felt confident that by the end of the data collection period no new ideas emerged. However I undertook more analysis once data collection had finished. Looking back, I wonder whether my understanding of saturation was somewhat unclear. After all the interviews had been undertaken I could still think of further questions I could ask of the data where additional interviews would have been helpful. Thus, strict adherence to GT methodology was not necessarily followed in this study. For example, a key theoretical idea of the study was that many health professionals construct breastfeeding in a functional-theoretical manner. This affects how women think about breastfeeding and impacts upon their ideas about what constitutes knowledge about breastfeeding, and hence their access to peer support. What would have happened if I had been able to interview a health professional who did not construct breastfeeding in this manner? If I had interviewed health professionals who constructed breastfeeding differently, when they recounted talking about breastfeeding and peer support what phrases would have been used? What about the women they cared for? What would they think? In this way I can see that my theoretical renderings in this study remain tentative.

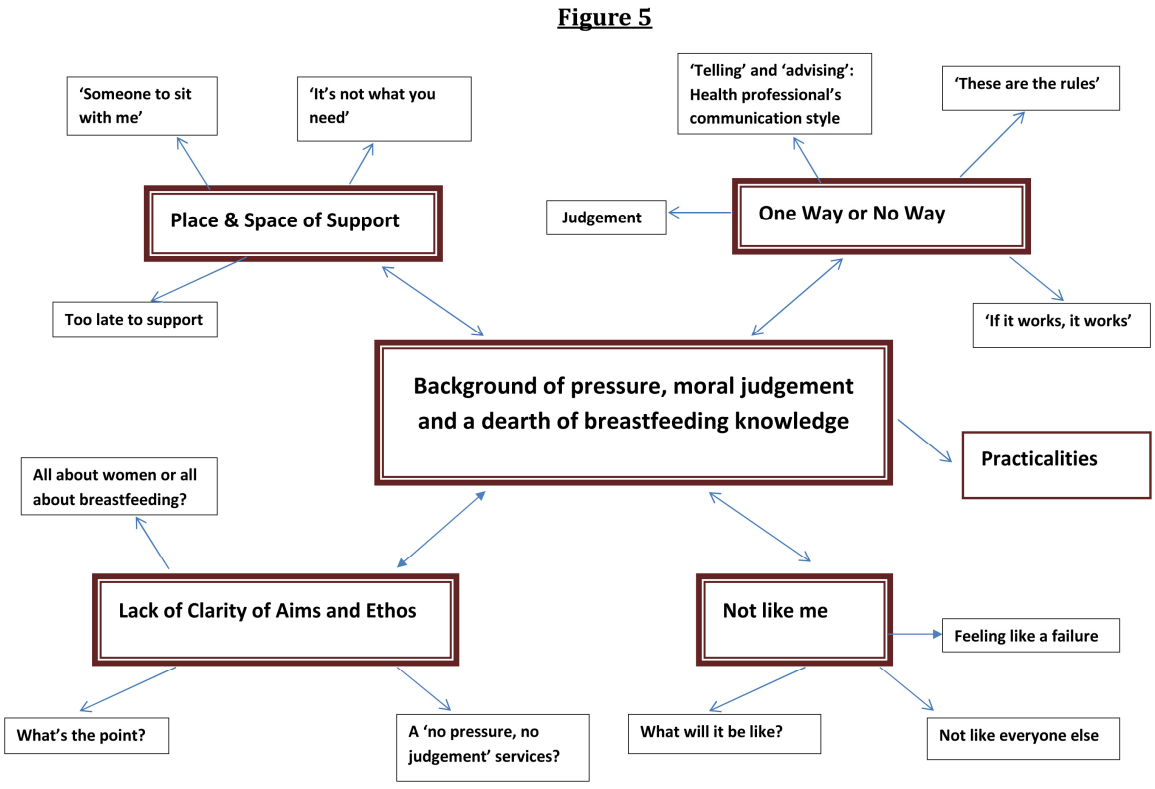
4.5-14 Theory construction

The final step of GT analysis is theory construction. As referred to earlier, Oakley (1992) defines theory as the construction of a story. This imaginative work is echoed by Charmaz (2006) who states that GT methodology is valuable in that it is able to provide a way of 'doing' theoretical practice, rather than the provision of *'a blueprint for theoretical products'* (p.129). Theory construction is not treating categories as variables and showing relationships between them, rather it is the inductive linking of categories into some kind of comprehensible whole (Charmaz, 2006). Whilst I found this daunting, when revisiting online training and textbooks I realised that theory construction had already been taking place. Throughout the process I had been constructing many diagrams showing emerging links between the various ideas I was working with. It was these diagrams that formed the basis of my emerging theories. The literature pertaining to this area of study was then revisited and theoretical issues mentioned by others were considered in relation to this study.

5 FINDINGS

This chapter begins with the core category of 'a background of pressure, moral judgement and a dearth of breastfeeding knowledge' which reflects the underlying issues common to all other themes. This is followed by five main themes that outline why women who initiate breastfeeding do not access peer support groups. Finally, facilitators of access to peer support are outlined, and a summary of findings provided. The interpretations highlight how dichotomies and dualisms are intertwined throughout as women are led to place themselves and their experiences within dichotomised discourses. See figure 5.

Figure 5 Diagram of findings



5.1 Core category: A background of pressure, moral judgement and a dearth of breastfeeding knowledge

The core category evokes the underlying issues from which all other themes emanate. Here the manner by which breastfeeding and bottle feeding are seen as two distinct and opposing

options is outlined. The presence of a strong moral dimension running through infant feeding discourses is explained. The pressure associated with these issues as experienced by women participants is described, and finally a general lack of knowledge about breastfeeding is highlighted, along with a concurrent want of awareness about different types of breastfeeding knowledge.

5.1-1 Breast vs bottle

Many participants in the study held a perception that breastfeeding and formula feeding were two discrete options. One mother explained how she knew *'you either breastfed or bottlefed'*. Moreover, when Kim, a trainee Health Visitor with a non-midwifery background was asked if she was aware that mothers who were mixed feeding would be welcome at breastfeeding groups, she explained how she *'just kind of presumed it was one thing or the other',* and had not considered the mixed feeding scenario. Similarly Gail, a mother, talked about the expectations and anxieties in her sister-in-law's family around the two feeding options:

> *' I, I think that with her part of it was family pressure as well, they weren't a family who breastfed for very long and so there was pressure there; 'what are you going to do, you've got to make your mind up, your mind up you've got to decide what you're going to do' sort of a thing'* (Gail).

5.1-2 'Good vs bad': The moral dimension

In addition to the generally accepted idea of mutually exclusive feeding options, women, peer supporters and health professionals' stories revealed the presence of moral judgement. Several women and one of the peer supporters expressed feeling '*disappointed*' if other mothers chose not to breastfeed. Whilst they often appreciated that these decisions can be personally or clinically determined, they '*couldn't help but silently judge'*.

Kirsty, a mother, talked about meeting another mother who decided not to breastfeed because she was '*just so tired after giving birth'*. Kirsty did not directly report that she felt *'being tired'* after the birth was not a legitimate reason not to breastfeed, but this was implied by an awkward pause in our discussion. Helena mentioned 'legitimate' reasons for bottle feeding, such as medical reasons. Correspondingly another mother explained how because health professionals suggested her baby be fed formula, the associated moral tension was eased as it became '*their'* decision:

'And they [health professionals] *were the ones who introduced formula, and I felt quite happy that my baby was being given that, it wasn't the perfect solution at all, it wasn't what I would have chosen, but you don't want someone to judge you for the decisions that had been made, and why they'd been made as well, you know, there was a reason for it'* (Amber, mother).

Some peer supporters reported how a doctor had a moral expectation that women should breastfeed, but that once they have done 'enough', why continue? :

' I've even personally, let alone within the group, been told by doctors 'oh you've done six weeks'(Jacky, peer supporter).

'*You've done long enough, yeah'* (Mary, peer supporter).

The peer supporters' recognised how many mothers had been made to feel '*guilty and bad'* because of their decision to formula feed their infant. Many women were also considered to experience self-blame due to letting themselves and their baby 'down':

'Quite a lot with people', [there is] '*that feeling of they've let the baby down, or they've, they've let themselves down'* (Mary, peer supporter).

In one incident at a breastfeeding group, breastfeeding was starkly juxtaposed with formula feeding in moral terms:

'And we had a really awful experience a few, quite a few years ago of a mum who overheard some other mothers talking about formula and how bad it was and she left in tears and never came back because she was combined feeding and she'd had a really, really horrendous time with her breastfeeding and ended up having an abscess in her breast and having surgery and it, you know, it, it couldn't have been much worse for her and she felt really, it was awful[. . .]*I mean it was hard for her, I mean she felt really, like you know, everyone else there thought she was poisoning her baby'*(Jane, Community Nursery Nurse).

This incident brings into the open the often unspoken sentiment that breastfeeding is seen as 'good' and formula feeding as 'bad'. Even as the story was retold by the participant, the legitimising conditions of how the mother came to be feeding her baby formula were explained.

Jane referred to women talking about how bad formula is as '*other mothers*' in the above extract, implying that they were mothers attending the group. However as Jane continued to re tell this story she revealed that '*sadly and frustratingly'* the person saying these things was in fact *' one of our peer supporters'*. This was one of several incidents revealing that peer supporters, like other mothers, make judgements about other women's decisions.

Moral judgements about infant feeding decisions may not always be clearly outwardly expressed, but were often there under the surface. The moral dimension was evident through participants mentioning 'legitimate' reasons for formula feeding, and the stories suggest that mothers automatically accept personal responsibility for their feeding decisions.

5.1-3 'They're all boob, boob, boob': Sensing background pressure

Many women emphasised a background pressure to breastfeed. Women reported how messages from health professionals and the media emphasise that *'breast is best and you should breast* [feed]*'*. One mother attributed pressure to '*a government initiative*.' Although she could not remember exactly what the initiative was, she felt it suggested that women ought to breastfeed, and subsequently some women felt that they '*had to'*. Another source of pressure was from the family, for example:

> *' I remember my mother in law, she's lovely, I'm not criticising at all but she said to me before the baby was born 'you will be* [breast] *feeding?' and I just said yes, I hadn't given it a moment's thought at all, I really hadn't'* (Amber, mother).

A number of women perceived that the sense of pressure to breastfeed from professionals was more evident in the postnatal period. This was described by Belinda:

> *' Yeah, it wasn't like, when the woman first gave me the leaflet for breastfeeding she said 'it's not, it's something that we do recommend, but it's not pushed upon you', where as I felt that* [postnatally]*it was very, very pushed'* (Belinda, mother).

Alternatively, others explained how they experienced pressure right from the beginning:

> *'I felt a lot of pressure, I think everybody you speak to; midwives, health visitors, they're all boob, boob, boob,'* (Dana, mother).

The lack of reference to this pressure within most health professional and peer supporter interviews suggested a lack of awareness of the pressure that women can experience.

5.1-4 A dearth of breastfeeding knowledge

Several women disclosed a lack of knowledge about breastfeeding. For example when Heidi's baby wanted to feed frequently she felt:

> '[My] *milk wasn't thick enough[..] when I expressed it, it was really watery, runny,[..] lots there but just not thick enough'*(Heidi, mother).

Heidi knew *'what the problem is'*, i.e. the seemingly inadequate quality of her milk, and assumed that nothing could be done about this. In this example, Heidi did not know about the changing composition of breastmilk throughout a feed, or growth spurts, or possible courses of action that other women have taken in such situations, or even who might hold such knowledge. For Heidi breastfeeding was about the physical action of the baby removing milk from the breast, and because Heidi had no problem with this, she understandably felt that seeking help would be futile. Consequently, Heidi (and other women in this study who were experiencing different breastfeeding issues) did not seek support with breastfeeding from health professionals or peer supporters. There appeared to be a lack of awareness amongst many participants (both women and professionals) of the different types of breastfeeding knowledge that could be helpful to women. Although many women spoke of the contrast they experienced between theoretical knowledge about breastfeeding and the embodied experience of '*actually doing it*' (see section 5.2-1), they were unaware of the embodied knowledge of peer supporters or other breastfeeding women. For these participants it seemed a 'given' that theoretical knowledge of breastfeeding is the only knowledge available (see section 5.3-2).

5.2 Place and space of support

This theme outlines women's need for practical breastfeeding support in the early post birth period and how in some instances this support was not available or sufficient. The inappropriateness of the group environment and the possible impact of a lack of practical support on group access is discussed.

5.2-1 'Someone to sit with me'

After the birth, many women explained how the reality of breastfeeding is *'quite a shock at first'*. The embodied experience contrasted sharply with the mother's theoretical knowledge:

> *'When he was actually born, […] it's obviously a lot different talking about it to actually, 'Oh my God I've got this baby and he's got to feed from me'* (Belinda, mother).

Many women discussed the need for practical support with breastfeeding in the early postnatal period. Whilst some of the mothers' needs were met, others felt their care to be wanting in this respect. While in hospital Chrissy appreciated that the nurses and midwives were *'always there'* helping with practical issues. Likewise Heidi had *'a lot of help [..] with getting him latched on'*. Another woman participant, despite being discharged before she felt her baby was able to suck effectively, received good practical support at home when the community midwife '*show*[ed] *me how to properly put him on the breast'*.

Other women spoke of delay in the availability of help. One mother had to wait '*most of a day*' in hospital for a midwife to find the time to *'sit with me'* and provide the assistance required. Sometimes practical support was not available, and the postnatal contact with midwives was often minimal. For example, Belinda who was discharged from hospital within five hours of the birth reported that: '*The girls and things at the hospital definitely didn't make sure that I was feeding properly*'. Following this Belinda was not visited at home for several days. When the midwife did visit her, she did not provide the support Belinda wanted around using '*positions*'. Belinda found the length of time available for a postnatal contact was not adequate, and that she needed '*a tiny bit more time'* because it was difficult for her *to 'open up'* in '*ten minutes'*. By the time her baby was two-and-a-half weeks old, having lost a lot of weight, Belinda wondered if he might be tongue-tied. This was subsequently confirmed to be the case, but, despite having the tongue tie snipped, by this time:

> *'It was definitely too late, I mean, […] my milk hadn't properly come through , […] obviously there wasn't enough there for him'* (Belinda, mother).

Many women in this study felt that practical help '*earlier on'* was crucial in order for breastfeeding to be '*successful'*. Several health professionals and peer supporters concurred, and considered whether a *'more intensive'* service should be contemplated, given that the drop-off rates are '*quite steep'* at the beginning:

'There needs to be more preparation and more emphasis on trying to, if people are going to breastfeed, there needs to be more emphasis on the time when it's going to be optimum for them to try' (Kim, trainee Health Visitor).

Several peer supporters felt that the lack of early support impacted on breastfeeding group attendance due to many women discontinuing breastfeeding before they felt able to get out and about:

'I think if you're not getting it [early support from a health professional] *properly,[ ] women aren't carrying on long enough to the point where they can get out of the house'*(Jacky, peer supporter).

5.2-2 'It's not what you need'

In this early postnatal period women are perceived to be in a '*vulnerable*' state because they are recovering from the birth and coping with the demands of caring for a newborn baby:

'I was trying to feed him, [ ] 'he was so hungry and I just couldn't do it, I was just like a mess' (Dolly, mother).

The thought of accessing a group at this sensitive time and when they have '*no confidence already'* to breastfeed was described as *'nerve wracking'*. Whilst many women needed support at this time, and realised it was available at groups, the group environment was often not considered appropriate:

' I didn't want to go to somewhere where there are lots of ladies breastfeeding, I didn't want to sit there and have somebody show me how to breastfeed in a room, I wanted to be at home where I usually am going to be doing it, and be shown [..]different ways to lay like in the bed to feed him [..] which I wasn't shown, [..] the breastfeeding support group is there, but yeah it's not what you need, not when they're that young'(Belinda, mother).

5.3One way or no way

In this theme women's constructions of breasts and breastfeeding are described in mechanical terms. The manner in which health professionals often employed a functional-theoretical

model of breastfeeding is outlined. The necessity of rules and advice in this paradigm and the frequent anticipation of judgement is explained, as is the impact of this model on access to peer support.

5.3-1 'If it works, it works': Mechanistic constructions

Several women participants constructed their bodies and breasts as being like machines and accepted that with breastfeeding, *'some people can do it, some people can't do it'* and '*if it works, it works'*. Like a machine, the women's descriptions appeared to suggest that when the 'on' switch is pressed, either success or failure ensues. In this way breastfeeding was not seen in terms of a continuum, or a process, rather a dichotomy.

In contrast to this machine analogy, some women and several peer supporters discussed how they expected breastfeeding to be *'natural and it will just come to you*'. One mother described how she:

> *' Naively thought before I had him that it would all come naturally, and they know, babies should know what they're doing and, it should just happen'*(Esme).

A couple of the women, including Esme, discussed antenatal education in terms of how breastfeeding was presented theoretically, with emphasis on functionality. Like the women's mechanistic constructions of breasts and breastfeeding, on occasion this could sound like a mechanical sequence culminating in milk entering the baby:

> *They show you the theory of you know how it should happen, um, you know, you hold your baby like this and they do this, and that and this happens and*,[..] *so it was very, I don't, I don't know, it's very , um ,text book'* (Esme, mother).

Both these constructions accepted breastfeeding as being about the body, often *'portrayed to be really simple to do*' and without *'the grit*' of reality being touched upon.

5.3-2 'These are the rules'

Peer supporters and women reported that many health professionals employ a functional, theoretical paradigm of infant feeding whereby breastfeeding correctly was a matter of following the rules and sticking to the guidelines. This can be viewed as a continuation of the antenatal construction of breastfeeding and women's mechanistic conceptions of breasts and breastfeeding. Some women perceived that for these health professionals there was only one right way to do things:

'You've got midwives and things like that who have to follow certain rules, [..] some of the nursery nursing teams are very strict and 'these are the rules, and you follow these', and they're not, they don't move very much'(Gail, mother).

There was no notion that what might be 'right' for one mother, might not be 'right' for another, or that 'the answer' might need to be personalised or adapted. Once again, this led women to place themselves either as followers of the rules, or not.

One mother, Dana, asked her health professional how she might be able to manage breastfeeding her new baby who wanted to feed for *'three hours at a time',* whilst simultaneously caring for her two year old. Although her health professional did not watch her baby feed, or discuss the situation further with her, Dana was advised that she should allow her baby to tell her body to *'produce more milk',* and no matter how long her baby wanted to feed for, she should *'let him'*. Following this, no further attempts were made by the health professional to find out what happened. The answer provided relied wholly on technical knowledge, with no discussion, adaptation or application of physiological knowledge to the social situation at hand. For Dana, there was only one way, which placed utmost importance on maintaining the breastfeeding relationship. In this particular situation, Dana decided that she could not continue breastfeeding in line with this advice and decided to give her baby formula. She explained that, in the end *'you just give up'* and follow '*what I think is best* [gestures towards heart]'. This can be seen as an example of a participant being aware of only the theoretical knowledge of health professionals, as discussed in section 5.1-4.

5.3-3 'Telling' and 'advising': Health professional's communication style

The manner in which this theoretical, 'one right way', functional advice is often given is explained by Belinda:

'*It was more, 'you've got to do this' and 'you've got to' the words used [..] weren't like helping, it was more telling me what to do'* (Belinda, mother).

Keeping breastfeeding going is seen to be the most important aim for these professionals, hence when Belinda asked about how she would go about cleaning and sterilising bottles and formula feeding, she found that *'they* [midwives] *weren't interested at all in telling me',* rather she was told to keep breastfeeding.

One peer supporter reflected that:

'*You spend a lot of your early mothering experiences being told what to do by lots of different people'* (Pippa, peer supporter).

The effect of this kind of support was that by day fourteen, after women have tried to follow the 'one right way' they don't want to be told anymore and '*lose hope'*. Being told what to do is '*very confusing, and disempowering'*.

5.3-4 What if I can't do it?

Several women receiving care from health professionals who adopted a rule based, breastfeeding-centric, functional approach, anticipated judgement when they were unable to follow the rules. In some instances, this led to women lying, or not informing professionals about their infant feeding method:

'In the end I stopped but I didn't tell them, [..] I felt that I'd be looked at funny if I wasn't' (Belinda, mother).

When women admitted to having stopped, for example when attending a weight clinic, they perceived judgement from health professionals and felt they had to field *'loads of questions'* in order to explain why they had *'failed'.* Several women talked about wanting to avoid being placed in a situation where their sense of self, of being a good mum, was put at risk in this way:

'If I ring and say to them [health professionals] *'oh, I'm thinking of not doing it', are they going to say 'oh no you shouldn't'* (Heidi, mother).

One peer supporter explained that she felt this kind of advice inhibited future contact with health professionals because women experience their support as *'intimidating'* through being told *'I need to do this, or I need to do that'* rather than helping.

In turn some women and peer supporters believed this type of support impacted on access to peer support because women anticipate 'more of the same'. For example one mother reflected that if women are considering going to a peer support group for the first time, they might think '*What is my experience of that* [breastfeeding support] *so far?'* Another mother commented:

'I felt like um every professional I'd spoken to, the nurse, midwife, doctor, GP, anybody at the hospital, they were very, they were, ahh, 'these are the rules' you know 'you should breastfeed until he's six months old, exclusively you shouldn't start food till then, and breastfeeding's best and' [..] the people I met were very, like pushy to do things like as the book said, um and I was a little bit afraid of you know, not afraid, s not the right word, but, but, of being judged I suppose, if I couldn't do it, [..] for example when I was introducing rice powder at five months old, I just felt like they were looking at me like I was you know, really judging me, and so to go, to go to some, somebody like that [peer support], *I think, you know if I was considering stopping breastfeeding, I would have felt a lot of pressure to carry on regardless,[..] in my mind I was afraid that they were going to judge me and, and make, make me feel bad for perhaps finding it difficult and not being able to do it'* (Esme, mother).

Several women explained how anticipating moral judgements around infant feeding decisions directly affected their access to groups:

'I'd just be this struggling mess that occasionally gave my child a bottle and it would be like 'Uhh, you bad mum' [sharp intake of breath](Dolly, mother).

Like other mothers, the thought of this happening prevented Dolly from accessing the peer support groups.

5.4 Lack of clarity of aims and ethos

This theme outlines peer supporter and health professionals' understandings of the aims and ethos of the peer support service, and how these play out in service delivery. 'Sales pitches' given by health professionals are considered and contrasted with women's perceptions.

5.4-1 All about women, or all about breastfeeding?

Many peer supporters demonstrated a lack of agreement about the aims and ethos of their service. For some peer supporters women's personal goals and preferences were central in terms of:

'[To] *give mums the, the tools to, to continue the breastfeeding journey for as long as they want to basically'* (Carys, peer supporter).

This included supporting mums to feed *'in the way'* that they would want to. In doing this the peer supporters felt it would be important to be a *'listening ear'*, and to try to facilitate mums to *'make the decisions for themselves'* in order that the mum is able to decide what she thinks *'is best'* for her own baby.

However, another peer supporter explained how *'we would like to educate people, em to ideally breastfeed their children'.* Other peer supporters outlined the aim to *'reach mums*' who are in need of support, without mention or consideration for the women's personal situation or goals. Furthermore, the group would be somewhere where women can get *'some advice'*.

In the same way, whilst several health professionals did not express clearly their understanding of the service aim, differing ideas about aims were expressed. For example a trainee Health Visitor felt that the aim *'wouldn't be to make people breastfeed'* rather '*enabling*' and '*supporting each other'* were the phrases employed. An alternative view of the aim of peer support was to:

> '*Support those mums that want to breastfeed, to ensure that they continue to breastfeed [..] to encourage those that aren't actually one hundred percent sure if they want to carry on breastfeeding, to encourage them to carry on breastfeeding, um and I'd like to think that a greater aim would be to encourage families that aren't breastfeeding to breastfeed*' (Julie, Health Visitor).

Neither peer supporters nor health professionals were in agreement as to the aims and the ethos of the service. This was felt to be particularly important because, as discussed in section 5.3, when women are told what to do and experience or anticipate judgement in relation to their feeding decisions this has a negative impact on future access to services.

5.4-2 A 'no pressure, no judgement' service?

The lack of agreement around the aims and ethos of the service is played out in its delivery. Health professionals' and peer supporters' views revealed times when peer supporters acted judgementally (as referred to in section 5.1-2). There were also times when peer supporters demonstrated woman-centred non-judgemental support. For example when a mum at a group talked furtively about giving her baby a bottle of formula:

> *'One of us as peer supporters said 'please feel open to talk about it' because that will make other mums feel less pressured'* (Beth, peer supporter).

Hence there is a lack of consistency in the way in which peer support services are delivered. As discussed in section 5.3, several women anticipated judgement and being told what to do by peer supporters. There may be times when these anticipations would be correct, and other times when they would be unfounded.

5.4-3 'What's the point?'

Some peer supporters reported that women were not told about peer support by their health professionals. *'They're not getting signposted to us, there's a break in the connection'.* The peer supporters knew this because they themselves had sometimes not been told about peer support by their health professionals. Whilst a couple of the women had not been told about the peer support service by their health professionals, many women knew of their existence and '*that's about it*', i.e. they were not told *'an awful lot'*. Mothers described how health professionals did not explain *'how it* [peer support] *worked'*. An example of a typical 'sales pitch' would be:

> *'I just sort of say 'are you aware of the group?' and direct them to the page in the book which has got the information about groups, let them know actually how to get there if they need to, um and take it, that's about it'*(Clare, Community Nursery Nurse).

When Chrissy was asked what the main barriers to accessing peer support might be, she suggested:

> *' The fact that we're not really told what it is, or what the point of it is, or how it differs to other baby groups, really I think, they could, ought to a tell pregnant women a little bit more about it'* (Chrissy, mother).

Some peer supporters felt frustration that the messages were minimal. Several felt that health professionals do not value peer support, and that if they were to take peer support *'seriously'* and treat it as a *'valuable'* resource, this would make a difference.

5.4-4 Why go?

Several health professionals talked about women attending peer support *'for your support'*, and how peer supporters are '*supporting other mothers'* in a very general way, with no further explanation about in what sense peer supporters are supportive. Health professionals also talked about peer supporters as people to go to fo*r 'advice and help'* if breastfeeding *'problems'* were experienced. This is reflective of the awareness of theoretical knowledge only, as explained in section 5.1-4. Although some health professionals made sure women

understood that they did not need to have a '*problem*' in order to attend, they did not clarify other reasons for accessing peer support. The '*social thing'* is occasionally mentioned, but health professionals do not refer to experiential knowledge or why it might be valuable.

5.5 'Not like me'

This theme details how women encountering breastfeeding problems often feel like a '*failure*'. It is in the matter of breastfeeding competence that women often do not identify with peer supporters or other breastfeeding women, and this inhibits access. Social anxiety associated with group situations is also a barrier. Finally, other aspects of identity and their relative importance with regard to access are discussed.

5.5-1 Feeling like a failure

Several professionals considered that if women encountered difficulties, these were internalised as failure:

> *'Any problem, they do see that as a failure or 'not doing it right' [..] they still think 'Oh I, I didn't breastfeed, you know, it didn't work for me breastfeeding'* (Phillipa, Health Visitor).

This was confirmed by several women who tried to breastfeed and experienced a problem. They described feeling like '*a failure*', or that '*I'm failing'*. Some mothers explained how this feeling formed a barrier to access:

> *'It just wasn't for me at the time, I was just so tired I just felt like I was doing such a crappy job of everything'* (Dolly, mother).

Some professionals and peer supporters thought that these feelings could be one of the *'hurdles'* that stop women attending peer support. Linking back to issues raised in section 5.3, Laura, a peer supporter explained how she thinks women '*are not primed*' during pregnancy to anticipate issues or problems with breastfeeding, and this causes their subsequent feeling of '*perceived failure'* when issues arise. For Laura, this is a reason why women do not access peer support:

> *' It's a real culture of shock,* [ ] *for a mum, to suddenly find herself in a situation where things aren't happening as smoothly,*[as she expected] *and it's very difficult* [ ] *to kind of go along* [to peer support] *and ask for help* [ ] *some women will go and ask for help, but I think most women don't'* (Laura, peer supporter).

When Laura had her first baby, she felt that she was '*failing*', in consequence she:

> *'Definitely didn't access help with Rhian* [first baby] *because, other than my midwife coming to see us, because I definitely thought, you know my mum successfully breastfed six children, my closest female friends successfully breastfed their children, why the hell was I having all these problems?*'(Laura, peer supporter).

Other peer supporters concur, for example Jacky felt that her neighbour, who was mixed feeding did not attend because: *'She feels like she's failed now and [ ] she's just going to grit her teeth and bear it until it fizzles out'* (Jacky, peer supporter).

5.5-2 Not like everyone else

Several women appeared to assume that those who access the groups are those for whom breastfeeding is '*easy*':

> '*When you hear the term peer supporter you're definitely going to be assuming that they, they've had no problems,* [ ] *I think that you just assume that they're just going to be pros at it and have had no issues'* (Chrissy, mother).

The same idea was also expressed by a health professional:

> *'If you're a peer supporter, if you're breastfeeding, you found it easy, you've done it really well, you must be an expert at this you haven't ... I think sometimes that's people's perception [..] that they're these mothers that have had no trouble at all with breastfeeding'* (Kerry, Assistant Family Health Practitioner).

Indeed when a group is thought of as somewhere for those who are '*successful*' breastfeeders, women can feel *'I'm not one of those, so how can I go into that?'* In this way breastfeeding is not seen as a skill to be gradually learned. Peer supporters showed awareness of this situation, and explained that they could understand why women would not want to come to a group if they feel like they are *'failing'* while *'everybody else is doing it'*. Several women who experienced difficulties reported how it is hard to identify with other breastfeeding women because of the difference in breastfeeding competence, and that this acts as a barrier to access:

'They might feel a bit intimidated really, and especially if they are having problems and everyone else is sat there feeding you know relaxed and they're thinking 'well I'm the only one who's', they might feel like they're the only one having problems'(Heidi, mother).

Women participants often discussed not identifying with women at groups in terms of breastfeeding competence in relation to the early period of breastfeeding. However, even when breastfeeding was well established, some women still reported feeling intimidated by the thought of meeting highly competent women that *'might have done it before'*.

Some health professionals were aware that women did not identify with peer supporters and other breastfeeding mothers in terms of breastfeeding competence and assumed that if a peer supporter was '*someone who's gone through similar difficulties, that would be important'*. However, having the peer supporter having been there in the past is not enough for the women to forge a feeling of identity:

They've [peer supporters] *probably got through all their hurdles and then they are at that strong place, whereas if you're beginners and you're having difficulties you're in that tricky time, and really, you want someone that knows how to get you out of the tricky times, but at the same time the peer supporter isn't in that difficult place, so I can imagine them feeling quite intimidated by that'* (Julie, Health Visitor).

When I asked a mother who about these feelings, she explained that when you are in the situation you*, 'feel like the only person in the world that is struggling and everyone else is, got the knack'*.

5.5-3 What will it be like?

Several women participants discussed the social anxiety they experienced at the thought of accessing support in a group environment. Not knowing what people are going to '*be doing'*, what will they be '*talking about*', and wondering whether they are '*already friends*' were common concerns:

'Part of it is walking in through the door into a room full of strangers, um I think that was the biggest fear of mine' (Mel, mother).

Getting through the door was mentioned as a barrier by several women, peer supporters and health professionals. Experiences in other social situations when other mums are '*very very*

cliquey', meant that women sometimes wondered whether the same kind of behaviour would occur at a group. Indeed the thought of walking into a group of people '*you don't really know'* and bringing up a question might feel *'a little bit intimidating'*. One mother explained how her anxieties are *'a general thing about going to groups, definitely'.*

5.5-4 'A similar kind of background'

Several health professionals and peer supporter participants discussed how they felt other aspects of identity might be important with regard to access to peer support. They felt that a '*similar kind of background'* would be important, that women might perceive peer supporters as '*hippy types'*, and that differences in '*class perceptions'* might be inhibiting access.

However, a number of women anticipated that there would be a *'good mix'* of people at the groups, and felt that:

> '*I wouldn't walk down the street and think 'oh she breastfeeds you can tell', different person, it's not like that at all'* (Kirsty, mother).

Although age was mentioned by two younger mothers in connection with their anticipation that 'older' women at the group would be competent breastfeeders, age was not identified as a significant barrier in general. One of the younger women in this study reported that:

> '*They could be a hundred as long as they are giving me the correct information or guiding me in the right direction'* (Cassy, mother).

Class backgrounds and anticipating '*hippy types*' were not mentioned by women. When asked whether there are certain attributes they would like in a peer supporter, almost all of the women talked about the importance of being non-judgemental:

> *'I don't know whether they do this, that they respect the choices that you've made along the way [..]understand the position that you're in, and, I'm sure that is a concern before you meet somebody, and I'm sure the person wouldn't judge, but you just don't know'* (Amber, mother).

5.6 Practicalities

This theme outlines the practical issues that participants felt could act as barriers to peer support, and their relative importance.

5.6-1'Logistics'

Peer supporters and health professionals talked about practical barriers to access more often than women. Their concerns were wide ranging from a lack of parking spaces to the availability of hot drinks. The '*logistics'* of getting to a group were an important concern:

> *'Our children's centre is certainly, up the biggest hill in the world, [..] if you've had a caesarean, you can't drive, or if you don't have a car, it's really tough to get there, there are buses, but [..] it still takes quite a lot of planning, when you've got a baby'* (Jane, Community Nursery Nurse).

For a few women the timing of groups was identified as a barrier. For example if a mother was busy at group time or her baby was asleep, then a *'whole week goes by'* before she can attend again. If the group ran too early in the morning it was *'difficult'* to get everybody ready in time. Having older children was also a concern raised by some mothers, peer supporters and health professionals. One mother referred to how she was not sure whether she would be *'allowed'* to bring her older child along, whereas another did not think her toddler would find the group environment *'very fun'*.

For all participants, although these practical barriers were important, they were 'add on' barriers, often talked about after more central concerns.

5.7 Facilitators

This theme outlines how a different way of organising peer support could better facilitate access, how selling peer support as a way of accessing other women's experiences has potential to facilitate access, and how personal 'bridges' to peer support are deemed to be the most powerful facilitators.

5.7-1 The way it's organised

Section 5.2 outlines why the group environment is inappropriate for women needing practical support when their baby is very young. Several women spoke about how they would like to access practical support from peer supporters, but that a different setting was needed, such as via the phone or through home visits: *'I think it would be useful if it could be done, something that could be done in your home'.* Several health professionals also felt that home visiting and telephone support would facilitate access, although for one health professional *'all sorts of problems'* were associated with a home-visiting service. Some peer supporters explained how they *'used to get quite a few mums'* via a now decommissioned peer support telephone service whereby peer supporters proactively contacted mums.

Many participants considered that a different way of organising peer support would better facilitate access, however, given the way in which the peer support service is currently organised, there were two factors that were important regarding facilitation these were access to other women's experiences and 'personal bridges' which are discussed below.

5.7-2 Access to other women's experiences

One mother and one health professional spoke of a different kind of knowledge about breastfeeding, and how it can be accessible at peer support groups. Gail accessed peer support with her first baby, but did not with her current baby, she explained:

> *'Sometimes somebody might say, somebody from a completely different background to you, somebody with a completely different life experience to you might say something and it might make all the difference to how you view something or how you do something, so* [...]*you might want one person who says 'oh, I'd do it like this' and you think 'yeah that's how I'd do it too' but actually you might really need somebody to say 'oh but have you looked at it from this point of view have you tried this, cos actually I did that and it worked really well for me'* (Gail, mother).

This kind of knowledge was experiential. Clare, a Community Nursery Nurse demonstrated awareness of experiential knowledge and how it might be helpful:

> *'Actually your baby waking at night for feeds is normal, go and speak to other mums and you know, see what they've experienced with it'[..] or you could say, 'go along and*

chat and see if they've had any tips as to how to make it better for you' (Clare, Community Nursery Nurse).

Clare recognised the value of the experiential knowledge that the peer supporters and other women at the group possessed. However this was the only example of a health professional mentioning access to peer support as a means of gaining experiential knowledge.

The idea of gaining access to other women's experiences can be seen as a potential facilitator of access to peer support because it is the reason non attending women most often gave for considering accessing. For example:

'I could have probably picked up some tips on um managing to feed [a baby] *with teeth'* (Mel, mother).

The phrase 'tip' implies non prescriptive, 'take it or leave it' type information, quite different from prescriptive help or advice. Several women described how it was the thought of connecting with other women who found themselves in exactly the same position as them that caused them to consider access:

'I would have liked to have gone somewhere, and spoken to other mums going through it at the same time' (Esme, mother).

This was important because women could '*feel quite alone'* with a new baby, and when none of their friends had children, there was a need to connect with others '*going through'* similar situations. Despite not accessing group-based peer support, one mother accessed online support from other mothers in order to verify the normality of her experiences: '*It's like knowing that you're not an alien or that you're doing it right'*.

5.7-3 Personal 'bridges'

Actions and practices involving personal links to peer support were regarded as '*powerful*' facilitators by some peer supporters, and were also discussed by many women and health professionals. These links were sometimes referred to as '*bridges*' and can be seen as the main facilitators of access to peer support. Whilst peer supporters frequently mentioned '*word of mouth'* as a method of bringing new women to their groups, several of the women talked about being able to come with a friend as a possible way of enabling access: '*If I was to go, I'd like to go with a friend'.* This was mirrored by several peer supporter participants who

discussed how the first time they attended a peer support group they came with a friend who had already been.

A health professional being present at a group was identified as a personal bridge by one mother, several health professionals and some peer supporters:

> *'Unless I kind of knew someone there I probably wouldn't have gone, or even I think if maybe the midwife or the trainee midwife had of been there'* (Dolly, mother).

Personal bridges can be seen to reduce the risks of any negative feelings women might anticipate and worry about, and ease the social anxiety discussed in section 5.5, for example:

> '*When I go with my mum places,[..] I suppose she's always with me, so I'm, she's always there to support me, so I've always got that person to refer back to and go back to'* (Cassy, mother).

Cassy had not been to a peer support group, and always took her mum with her to toddler groups. For Cassy her mum was there as 'back up'. These personal 'bridges' can be seen to buffer the likelihood of negative or awkward situations arising, for example:

> '*Often mums hunt us down online and almost sort of suss out the group and what's happening, and then come along to the group'* (Jacky, peer supporter).

One woman suggested that a way of facilitating access would be for women to meet peer supporters antenatally:

> '*If [...] the peer supporters had, [...] run a session for pregnant women, you know towards the end of your pregnancy, um, so you've met them and you know who they were'* (Chrissy, mother).

Several peer supporters discussed how following their attendance at the local antenatal class, women '*at least know the faces'*, and this had enabled several new mums to attend their group. A health professional talked about facilitating postnatal access to groups by doing better '*joined up working with ante natal care'* and getting a peer supporter to attend sessions.

Bridges involving personal contact appear to have the most potential to successfully facilitate access.

5.8 Summary of findings

Throughout the findings dichotomies were often used when breastfeeding was discussed, for example 'can'/'can't', 'breast'/'bottle', 'success'/'failure'. These terms led women to place themselves and their experiences within a dichotomised landscape of infant feeding where continuums were not often expressed.

Key findings highlight a background of pressure to breastfeed and moral judgement around feeding decisions, meaning that many women feel that breastfeeding 'ought' to be done, automatically accepting responsibility for doing it. Furthermore, many women know little about breastfeeding, and the theoretical knowledge of health professionals is the only knowledge of breastfeeding that is known about. Breastfeeding is often constructed as something functional, pertaining to the body. It is sometimes explained mechanistically, or in terms of nature. Many women experience dissonance between theoretical knowledge about breastfeeding and their embodied experiences of actually doing it. Many women express a feeling of vulnerability and being in need of practical support in the early postnatal period. However, a breastfeeding group is not an appropriate place for support at this time and some women have stopped breastfeeding by the time they feel able to access a group environment. Many health professionals employ a functional-theoretical model of breastfeeding whereby success ensues from 'following the rules'. Women need to be 'told what to do', in order that breastfeeding be maintained. When women struggle to 'follow the rules' they experience feelings of failure and anticipate judgement. This can affect the extent to which they ask for support. Many women presume that those accessing groups have found breastfeeding easy, and assume that access will exacerbate feelings of failure when everyone else can 'do it'. This, coupled with expectations of further judgement from peer supporters, can prevent women from accessing. Social anxiety that relates to any group situation was identified to act as a barrier. Some peer supporters and health professionals consider that the peer support service aims to keep women breastfeeding by giving advice, whereas others perceive it to be about supporting women to fulfil their own feeding goals based on listening. There is a corresponding lack of clarity regarding how peer support may differ from other forms of support, or why women might find it helpful. However, women themselves identified the opportunity to share the experiences of other women as the main reason why they might consider access. The confusion amongst peer supporters and health professionals regarding the aims, ethos and function of the service negatively impacts on access in two ways. Firstly it means that some women may be justified in anticipating a continuation of the functional –theoretical approach employed by many health professionals, and secondly it means that messages about the

possible value of accessing are not, and cannot be clearly conveyed to women. Health professionals and peer supporters often anticipated that women might be put off by specific cultural assumptions, for example an expectation that peer supporters might be 'hippy types'. In fact, the greatest concern of women themselves was whether peer supporters would be judgemental. Practical issues regarding venues and times were considered less important factors, and 'personal bridges', for example already knowing somebody at the group, had the most potential to facilitate access. In this sense practicalities mattered. Organising peer support differently so that peer supporters could initiate support in the home or via the telephone could enable the formation of 'personal bridges'.

6 DISCUSSION

In this chapter theoretical insights from the wider literature base are used to contextualize the findings, and insights from other research considered in order to determine whether they support or refute the findings of this study. The implications of the study for practice and further research are addressed, and the strengths and limitations of the study considered. The chapter concludes with a personal reflection on the research process.

6.1 Contextualisation with wider theory and literature

In this study some woman associated breasts and breastfeeding with machines; a finding reported by many others including Dykes (2005), Burns et al (2010), and Larsen et al. (2008). Other women held the conception of breastfeeding as natural. Burns et al. (2010) and Larsen et al.(2008) undertook metasynthesis of qualitative studies of women's experiences of breastfeeding. Both studies noted this construction, and Larson et al. (2008) considered its representation within the literature studied to be '*very strong'* (p.657). Dykes (2005) explains how enlightenment thought (Chapter 1) impacts upon ideas about infant feeding and the way in which women are conceptualised, in particular how the idea of dualism (Descartes's conceptual distinction between the mind and the body) has had an important legacy, not least because of women's association with nature. Crotty (1998) describes the Cartesian split; he outlines that the mind and thinking are separate from the body and other physical things in the world; '*This suggests we can engage in a scientific study of th*[e] *universe utterly divorced from any considerations of mind*' (Crotty, 1998, p.217). Breastfeeding as natural and breastfeeding as machine can be seen as manifestations of the unspoken, taken for granted idea that the mind and body are separate. Breastfeeding, pertains to the body, ergo, it must be separate from the mind. When bodies are conceived of in this way other influences such as society, culture and family are minimised. Rather than seeing breastfeeding as *'a complex relationship between mother and baby, the wider family and community*' (Dykes, 2005, p.2292), everything but the physical is diminished. Indeed, Larsen et al. (2008) note that in some of the studies they reviewed, health professionals' '*claim that all women are milk-producing machines that naturally can breastfeed if they only want to'* (p.660).

The idea that breastfeeding pertains to the body only is important in this study because it dictates the type of knowledge about it that is accepted as relevant. If a practice relates only to

the body, which forms part of the natural world, relevant knowledge about it must be derived from enquiry employing the scientific method (as per enlightenment thought, Chapter 1). The current study revealed that only technical knowledge of breastfeeding was known about. The legitimising of only technical medical knowledge concerned with function has the potential to render experiential knowledge irrelevant. One of the key ways in which access to peer support was found to be inhibited in this study was through a lack of clear messages about the purpose or value of peer support, and how it might differ from health professional support. Health professionals do not mention experiential knowledge as a reason why peer support may be valuable. Other authors, for example Raine (2003) found variability in the extent to which health professionals referred women to peer support, and Muirhead et al. (2006) found that some health professionals did not want peer supporters involved in breastfeeding support. However a lack of clarity regarding how peer support might work has not previously been described as a reason for non-access. Renfrew et al. (2007) and Thomson and Trickey (2013) note a lack of underpinning theory regarding peer support projects, which they suggest makes interpretation of trial results difficult. This finding could be seen as an example of the effect of a lack of underpinning theory on the practical application of a peer support intervention.

Women in this study accepted moral responsibility for infant feeding, experienced pressure to breastfeed, and anticipated judgement of their infant feeding decisions. Larsen et al. (2008) explain how techno-medical discourses affect women's confidence in breastfeeding, and how the discourse associated with medical knowledge '*imposes the responsibility on the mother to live up to the advice of breastfeeding experts to ensure the health of her child ...mechanisms of the discourses make the mother take the blame and lose confidence in her ability'*(p.659). Murphy (2003) draws on the ideas of Michel Foucault (1991) to explain how, by means of subtle pressure, standards of normality are established in society. These standards are communicated via networks of scientific and medical knowledge that seem benign and altruistic. Because the family became an important area of such medicalisation, moral responsibility for the welfare of children was imposed upon women. Expert discourses which suggest that one course of action is healthy, and thereby ought to be undertaken, and other actions are unhealthy, and thus ought not to be undertaken, form a crucial understated form of control. Everyone in society knows what ought to be done, and subtly, people become subjectified self-regulating citizens (Murphy 2003). The stories that participants in this study shared about judgement from other mothers, peer supporters and health professionals can be seen as manifestations of these theoretical ideas. These appeared to be the background circumstances upon which more specific influencing factors acted.

In the findings of this study, health professionals held functional-theoretical knowledge about breastfeeding. Oakley (1992) states that '*knowledge is power*' (p.341), and Burns et al. (2010) and Bartlett (2002) recognise a change in the location of authority regarding breastfeeding in western societies. Whereas once women's own embodied knowledge was definitive, now it is experts who impart the necessary knowledge upon unknowing mothers. This issue is important in the current study because it was found to affect the manner in which support was given, which in turn affected access to peer support. Women talked about health professionals telling them what to do, and that for health professionals there was only one right way to breastfeed. Burns et al. (2010) and Murphy (2003) found that scientific discourses imply that there is only one correct way to breastfeed. Furthermore, these discourses have been imposed upon women (Larson et al.,2008), and women have accepted them (Burns et al., 2010). Many health professionals in the current study appeared to have adopted a functional-theoretical model of breastfeeding similar to that described by Larsen et al. (2008). Several women in this study described how the problems they encountered with breastfeeding were interpreted by their health professionals in strictly functional-theoretical terms. The one correct solution advised was based on theoretical knowledge only, without the practicalities of everyday life being taken into account. Experiencing care from health professionals who adopted the techno-medical construction of breastfeeding served to inhibit women from seeking further advice from their health professionals, as was found by Hoddinott and Pill (1999). Many other studies have found that women often do not ask for help with breastfeeding, for example, Dennis (2002 b); Graffy and Taylor (2005); and Hoddinott et al. (2006b). Hoddinott and Pill (1999); Hegney et al. (2006); and Hoddinott et al. (2006b) found that women wanted to find their own solutions to problems. When health professionals in the current study adopted a 'one right way' approach, this appeared to prevent women seeking alternative solutions to their problems. Previous research has identified how women's anticipation of 'being told' what to do formed a barrier to their accessing health professional support and Hoddinott et al. (2006b) found in their study that some women anticipated that peer supporters would be 'bossy'. The findings of this study expand these insights to demonstrate how women expected similar approaches from peer supporters.

In addition to many women's expectations of a didactic manner from peer supporters, this study also suggested a dichotomy in the way peer supporters themselves explained their aims. Whilst some aimed to keep women breastfeeding by means of advice, others wanted to enable women to fulfil their own feeding goals through a focus on listening. The meta-synthesis undertaken by Schmied et al. (2011) identifies how approaches to infant feeding

support vary on a continuum. 'Authentic presence' is experienced by women as effective support, and forms one end of the continuum, whilst 'disconnected encounters', were experienced as ineffective and form the other end (Schmied et al., 2011). However, Hoddinott et al. (2012) and Murphy (2003) describe health professionals employing opposing or dichotomised approaches to support .The findings of the current study concerning the approaches of peer supporters mirrored more closely those of Hoddinott et al. (2012) and Murphy (2003). This is interesting as Schmied et al. (2011) identified peer supporters as being more likely to be women centred when compared with health professionals. Most studies reporting on the efficacy of peer support interventions either do not mention the ethos or underpinning values employed (Martens, 2002; Meier et al., 2007; Schafer et al., 1998), or mention only that the training was delivered by La Leche League, without further explanation (Arlotti et al., 1998; Morrow et al.,1999). In their review of Scottish peer support interventions, Britton et al. (2006) reported that training of peer supporters placed more emphasis on technical knowledge about breastfeeding, whereas the peer support training described by Dykes (2003) in her review of peer support interventions, found the focus to be more on listening skills. Britten et al. (2006) call for an evaluation of peer support training that concentrates on exploring which approaches and skills are acceptable and effective amongst the target women. The findings of this study would support this call with peer support hovering between supporting autonomy and imposing control. Some peer supporters appeared to be in danger of becoming additional, unpaid enforcers of techno-medical imperatives, whilst others adopted the alternative woman-centred stand.

Several women in the current study assumed that women at breastfeeding groups had found breastfeeding easy. It was this difference in identity between themselves as 'failures' and other breastfeeding women as 'successes' that formed an important inhibitor of access to peer support groups. Hauck and Irurita (2003) recognise this lack of awareness of the varied nature of breastfeeding experience, and they suggest that by accessing the experiences of other breastfeeding women it might be possible for mothers to learn about it, and also realise that they are not a failure if breastfeeding does not progress in accordance with particular expectations. Hoddinott et al. (2006b) found examples of women who had not contacted their peer supporter because they felt she had not encountered problems with breastfeeding. However, a lack of identification (with peer supporters) regarding breastfeeding competence was not identified as a major barrier to access in their study, which may be due to interviews not being undertaken with non-attending women.

Three possible reasons why women do not realise the diversity of breastfeeding experience have been identified. The first is the use of dichotomous language around breastfeeding. In line with the findings described above, Burns et al. (2010) discuss how the language of breastfeeding 'success' can lead to mothers feeling that they are 'failures' when things don't go to plan. In this study dichotomies in the language associated with breastfeeding were frequently articulated, and were evident in each key theme reported. This language led women to place themselves and their experiences within this dichotomised landscape. For example, would they breast or bottle feed? Were they good or bad; a success or a failure? Dichotomous language did not accommodate women themselves, nor allow other breastfeeding women to have breastfeeding experiences that might be highly varied.

Secondly, this study confirms the insights of Schmied and Barclay (1999) in that realistic, subjective information about other women's feeding experiences has not been made widely available. Women's accounts often challenge pro-breastfeeding and child centred mothering rhetoric and Schmied and Barclay (1999) suggest that this could be a reason for their lack of availability.

Third is the association of medical discourses with 'one right way' of breastfeeding (as discussed above). Andrews and Knaak (2013) suggest that in their study areas of Canada and Norway, medical discourses around breastfeeding dominate to the point of overpowering both familial grandmother-to-mother and lay experiential knowledge of breastfeeding. It could be that the dominance of this discourse gives rise to reduced awareness of varied breastfeeding experience.

The social anxiety of women accessing a group environment is discussed by Hoddinott et al. (2006b). Practical barriers to access such as inconvenient group timings were mentioned in the current study, but were less prominent than other concerns. Although there have been no other studies specifically examining the reasons why women do not access peer support, this finding reflects the frequency with which practical barriers are mentioned within other studies. For example Ingram, Cann, Peacock and Potter (2008) examined barriers to exclusive breastfeeding amongst particular ethnic groups and whilst access to breastfeeding groups is highlighted, practical barriers are not. Hoddinott et al. (2006b) found that access could be facilitated by health professionals meeting women outside the group venue or accompanying them to the group. In the current study 'personal bridges' (such as being accompanied by a friend or relative or already knowing somebody at the group) appeared to have the greatest potential to facilitate access. In light of this finding, it is interesting to reflect anew on the

definition of peer support provided by Dennis (2003). In the non-proactive system of peer support operating in this study area, people from within a woman's natural social network might act as bridges in order that the created social network may be accessed.

This study's finding that women need practical help in the early postnatal period is supported by a wide body of research (e.g. Ahmed et al., 2006;Graffy et al., 2005;Hoddinott et al., 2012), as is the variable quality of support provided by health professionals (Hoddinott et al., 2012; McInness & Chalmers, 2008). Participants in this study emphasised the importance of place and space in relation to breastfeeding as a public or private activity and its importance and problematic nature in the early postnatal period, as reported by Dykes (2006). Hoddinott et al.'s(2009) cluster randomised controlled trial of breastfeeding groups for pregnant and breastfeeding women, found that the mean length of time post-birth at which women attended a group was 36 days, with the range from 22-81 days. Although the reasons why the women did not attend earlier were not explored in this trial, this finding supports to some degree the current study's finding that the group environment is not appropriate in the early postnatal period. Hoddinott et al. (2009) suggest that resources would be better concentrated on support for women in the first two weeks post birth when the breastfeeding drop off rate is steepest. By making this suggestion they acknowledge, as identified by some participants in this study, that some women had stopped breastfeeding before the group environment was appropriate to access.

McVeigh and Smith (2000) identify the early postnatal period as a time when the self is re-defined and self esteem is an important factor. Hauck and Irurita (2003) and Marshall, Godfrey and Renfrew (2007) discuss the association between breastfeeding and 'good' mothering. Hauck and Irurita (2003) considered breastfeeding performance to be linked to mothering competency. Marshall et al.(2007) identified a more complex relationship in which the baby's behaviour and weight gain acted as mediating factors in whether breastfeeding was seen as an expression of good mothering or not. Larsen et al.(2008) found that in the immediate postnatal period, expectations of breastfeeding and the reality of breastfeeding were not in alignment, and that, *'breastfeeding was experienced as more complex than the medical discourse suggested'* (p.658). Not only do women who have assumed lone moral responsibility for the welfare of their babies have to adjust to a new sense of self and demonstrate that they are good mothers, they are also simultaneously faced with a reality of breastfeeding that does not match their expectations. This gap between expectation and reality has been reported by many other authors, such as Lavender et al. (2005), and Hoddinott et al. (2012) and was expressed by many women in the current study.

6.2 Implications

6. 2-1 Implications for practice

The findings from this study suggest that if more women are to be enabled to access peer support services, changes need to be made to the peer support service, the manner in which health professionals support women and how postnatal breastfeeding support is organised. Coordinated action and ongoing cycles of reflective practice are required from peer support service leaders, health professional leaders and commissioners.

An agreement is required amongst all partners regarding the aim of all infant feeding support, and whether and how peer support services fit within this aim. Hence the first requirement is commitment amongst partners regarding whether they want peer support services, and how they anticipate that these services should contribute in practice to wider aims. If peer support is to form part of future infant feeding support services, the following sections detail the possible actions that may enable increased access to it.

6.2-2 Actions for peer support leaders

Findings suggest that women would value a 'no pressure, no judgement' service where support is woman-centred rather than breastfeeding-centred, where individual circumstances and situations are acknowledged and accepted, and where access to other women's experiences can be gained. In order to build such a service, a fundamental re-examination of the aims and ethos of the local peer support service is warranted. Active peer supporters from across the county could be brought together to agree a shared goal and vision. The local peer support training package could then be re-assessed in light of this in order to ensure that the shared vision is reflected and embedded throughout. The theoretical content and approach of the training could also be re-evaluated to reflect a woman-centred, cultural-social model of breastfeeding. A short peer support update training session could be devised to incorporate the shared vision, which could be cascaded to all peer supporters.

Development of an ongoing pathway for feedback from mothers who use peer support services could be undertaken, as well as a mechanism for the supervision of peer supporters. Feedback could be generated via an anonymous form and stamped addressed envelope given to mothers at the end of their first visit to a group. This would be a means of establishing to

what extent the shared vision is being adopted and implemented, as well as enabling a greater understanding of the extent to which women's needs are being met. All local groups could keep records of the numbers of new mothers attending as this would enable monitoring of increased access. Supervision could take the form of opportunities for peer supporters to meet with experienced peer supporters, or health professionals in order to discuss their practice in relation to user feedback and numbers.

The shared vision of the peer support service could be communicated to health professionals via infant feeding training delivered by the Infant Feeding Co-ordinators. A lead peer supporter could be invited to speak briefly during the one-day infant feeding training session about the aims and ethos of peer support, and written information about this could be added to the health professional training pack. Clear, concise messages that health professionals can give to mothers about peer support could be devised and could form part of local group literature, including key reasons why women might consider attending. These messages could be disseminated via a diary-sized bookmark for health professionals, which would serve as an accessible prompt when engaging with new mothers. Local lead peer supporters could be invited to health professional team meetings in each geographical area. This would improve communication and would help to ensure that peer support remained in health professionals' consciousness. This would also provide an opportunity for peer supporters to feedback information about group attendance levels and generalised information from attending mothers' feedback forms. Such actions to increase communication and partnership working are similar to those suggested by Aiken and Thomson (2013).

6.2-3Actions for lead health professionals

Findings suggest the techno-medical approach adopted by many health professionals impacts upon access to peer support. Training for health professionals could include reflection on, and discussion of women's experiences of health professionals who adopt a techno-medical approach, their own practice, and the nature of breastfeeding, in order to foster the adoption of a more woman centred, cultural-social model of breastfeeding. The sometimes conflicting imperatives of health professionals' roles in terms of enforcing public health messages on the one hand, and supporting families to parent in the way that they want to on the other hand, could be explicitly considered and explored. Discussion of how peer support can be utilised in the adoption of a more socio-cultural model of breastfeeding could also be included in this

training. Audit methods could be adapted to include information about the ethos and manner of health professionals' support.

New literature could be developed that would support these changes of ethos and approach. For example a booklet or website of women's experiences in their own words could be created. This could be used as a resource for women, peer supporters and health professionals regarding the re-visioning of breastfeeding. Another example would be a change to the information about peer support contained within the local guide to caring for and feeding your baby.

6.2-4 Actions related to the organisation of postnatal support

The intensity and pro-activity of postnatal support, including the place of support available to women could be re-assessed, and steps taken to ensure that all women receive the support they need. Part of this could include changes to the way peer support is offered, for example by making it available earlier, and via telephone or home visits.

In the short term, mechanisms that enable personal 'bridges' to current peer support services could be adopted and embedded into standard postnatal care. For example health professionals could accompany women to groups or meet them outside. Likewise, peer supporters could attend antenatal and postnatal clinics or clinic waiting areas for informal conversations with women. The hospital based peer support project could be increased in scale and scope. These steps would increase the opportunity for personal bridges to be built-in in order for access to be improved. It would be important that health professionals and peer supporters understood the aim of these activities, that managerial commitment was sought and that mechanisms were put in place to monitor and assess the effectiveness of these actions in terms of group attendance and women's experiences.

6.3 Research implications

The implications for practice outlined in the above section involve actions for peer supporters, health professionals and commissioners. A study employing action research methodology could enable greater understanding of the challenges and practicalities associated with knowledge implementation in this area. Such a study might prove valuable in maintaining the

momentum of change locally. A review of studies examining non-access of other forms of peer support or of other parenting interventions could prove to be important and useful.

Study outcomes suggest that many women experience a sense of pressure and judgement around breastfeeding that impacts upon their access to both professional and peer support. Burns et al.(2010) identify the contribution of health professionals' discourses to women's sense of guilt and failure around breastfeeding, and call for further research in order that the language that creates these feelings may be identified and supportive discourses developed. An ethnographic study employing discourse analysis could observe and record health professional, woman, peer supporter interactions at different time points from pregnancy to several weeks post birth, together with focused follow-up interviews. This would enable close examination of the interactions between these different groups and identification of the occasions, methods and sources of pressure and judgement as well as the verbal and non-verbal interactions that convey these messages (i.e. through health professional interactions). Insights generated could be used to develop practical tools to be integrated into the training and practice teaching of professionals and peer supporters.

This study suggests that support is lacking in the very early postnatal period. Hoddinott et al. (2012) identify the period immediately after birth as the time when health service resources should be focused in order that support is made available during '*pivotal points*' (p.11) when families change their feeding method. The possible future study detailed above could also be used to examine this time frame with a view to gaining a greater understanding of the changing temporal support needs of women in the very early postnatal period. This would identify when and how additional support could be provided within this timeframe in order that Hoddinott et al (2012)'s recommendations may be implemented in practice with maximum effect.

Following their evaluation of Scottish peer support interventions, Britton et al. (2006) call for an evaluation of peer support training that focuses on exploring the approaches and skills that are acceptable and effective from the point of view of target women. Such a study could also incorporate examination of the aims, ethos and underpinning values, the manner of organisation, and the practicalities of delivery of each intervention which have been identified in the current study as being important factors. Several differing peer support interventions

could be selected and studied from the point of view of target women (those that engage with the intervention and those that do not). This might enable greater understanding of the importance of different factors and the sharing of effective practices.

6.4 Strengths and limitations

Qualitative research methods enable the voices and concerns of participants to be heard in their own terms. This study is the first to specifically elicit the views and perspectives of breastfeeding women who have not engaged with peer support provision. Incorporation of the perspectives of mothers, health professionals and peer supporters to consider this issue is one of this study's strengths. Women were recruited across a broad range of ages and backgrounds. The use of several different recruitment methods facilitated both the participation of women who accessed other post-natal services (general baby groups) and those who did not. Rigour was considered from the outset of this study, with methods such as reflexive practice, member checking and discussion of interpretations amongst the supervisory team employed to ensure that themes reflected participants' views. This study is an original interpretation that has utilised a clear and simple method to generate hypotheses regarding reasons for non-engagement that are relevant to current policy and practice.

Several features of the methods employed in this research are important to consider when assessing its validity. This study used only a small data set drawn from a restricted geographical area in which only one model of peer support was utilised. The findings interpret and give voice to the experiences and views of the participants and their particular time, place and context, hence they cannot be generalised to other situations. Further qualitative research in other geographical areas where differing models of peer support are in use could be undertaken in order to better understand common or differing influences. Because of the small data set, the views portrayed may not be fully representative of health professional, peer supporter and mother's views. It is possible that participants put forward views that they considered would be socially acceptable, whilst holding back other ideas. Future studies could include serial interviews which may enable trust to be built and reduce the likelihood of this occurring. The participation by many peer supporters in group interviews may have restricted the range of views expressed. Future studies could take this into account and could provide a balance between group and individual interviews. Although participants had encountered a range of infant feeding experiences, it proved more difficult to recruit women who had

stopped breastfeeding in the early postnatal period. This may have affected the range of views expressed.

6.5 Closing reflection

At the outset of this study I wondered whether peer support required a total revamp in order to enable more women who initiate breastfeeding to access it. Undertaking this study has made me question why I was so keen for those women to access and how exactly I thought peer support would be helpful. I now have a better understanding of the current breastfeeding landscape as experienced by non-engaging women, and of how peer support currently sits within it.

Initially I did not appreciate the extent to which I have taken the techno-medical approach to breastfeeding for granted. This study has enabled me to see my own practice from a new angle. It has also reminded me of a plan I formulated when my first baby was young to make a booklet consisting entirely of different women's experiences with breastfeeding. Reflecting back now, I wonder whether this was the moment when I realised the diversity of experience regarding breastfeeding. Since that time I have worked to gain technical and physiological knowledge about breastfeeding as well as improving my counselling and listening skills, yet now I can see the value of that epiphany moment.

Over the years I have increasingly come to realise that the more I learn, the more aware I am of how little I know. This study has served to confirm and deepen this understanding, but also to place it in a broader societal and cultural context that is difficult to see 'up close'.

Undertaking this study has been a thoroughly enjoyable process. Every stage has necessitated learning new skills and my love of learning has been re-awakened by it. My biggest challenge has been striking the balance between committing time to studying, and to my family and other commitments. This has been a struggle throughout the two-year process that has at times required creative approaches in both spheres, and tolerance of a feeling of 'I could be doing more' for most of the time. Undertaking the research interviews was a privilege I particularly enjoyed and I appreciated adopting the role of the researcher. Whilst I also enjoyed reading in preparation for writing my methodology chapter, I found doing this alienating, having nobody around me keen to listen to my rambling on about what I was learning and how I was trying to make sense of it. I have thoroughly enjoyed the opportunity undertaking this degree has afforded me for meeting and working with my supervisory team

and the other students at UCLan, particularly the postgraduate seminar days. Gill Thomson has afforded me all the support I could have wished for throughout. Probably the most frustrating period was the process of gaining ethical approval by proportionate review via the IRAS system. This required considerable persistence and patience. I have learned that in order to complete a research study you need to be highly organised, dedicated, committed and able to stick to time deadlines. A need for good friends and a supportive family as well as the ability to switch off at times also seems critical. Overall, undertaking this study has been a positive personal experience and a considerable achievement.

7 CONCLUSION

Utilisation of a constructionist approach to grounded theory methods has enabled a greater understanding of the reasons why some women who initiate breastfeeding do not access peer support services. This insight into the views and experiences of women who do not access suggests the relevance of the use of dichotomies in infant feeding discourses. Dichotomies led women to place themselves in a divided landscape, leaving little room for continuums. Furthermore, a techno-medical construction of breastfeeding is dominant and that this works on many levels to impact upon access to peer support. Because of the acceptance of breastfeeding as pertaining to the body, and the consequent application of functional-technical knowledge, women's experiential knowledge is not considered to be relevant. This means that messages about the value of these perspectives are not provided. The ownership of functional-technical knowledge by health professionals who often suggest that there is 'one way or no way' of breastfeeding can mean that women feel they are failing if they are unable to follow 'the rules'. Some women anticipate the same approach from peer supporters, which in turn inhibits access to peer support. Peer supporters themselves are also not clear about the aims and ethos of their service, which also impacts upon access.

Peer support offers an important mechanism though which women can gain access to other women's rich and diverse infant feeding experiences. This affords insights into different conceptions of breastfeeding, with practices relating not only to biology, but also to culture, family and society. A construction of breastfeeding as bigger, more flexible, embodied and relational, as opposed to narrow and functional needs to be made. Women need to make sense of their own experiences and construct realities of breastfeeding in their own terms.

The barriers to peer support identified provide important insights into how they can be addressed. The peer support service could re-evaluate its aims and underpinning values. These could be embedded and overtly articulated throughout the service and to health professionals. Health professionals could re-evaluate their approach to support. Care is required in order to ensure close working partnerships amongst all groups, and a re-consideration of the manner in which peer support is provided is required.

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Appendix 1.

Poster

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A Grounded Theory study to elicit the reasons why women who initiate breastfeeding do not access local peer support provision.

Participants needed for research study.

I am undertaking a research project for a Masters by Research qualification. If you are a mum who recently breastfed for at least 5 days and did not attend a breastfeeding peer support group – I would like to interview you to find out your views and attitudes towards breastfeeding peer support services.

For more information about the study, please contact Louise Hunt (research student) on 07866 741 879, or lhunt@uclan.ac.uk

Please let the Children's Centre receptionist know if you are interested in taking part.

A Grounded Theory study to elicit the reasons why women who initiate breastfeeding do not access local peer support provision.

Information Sheet – Mothers.

This project aims to understand and explore the reasons why Cornwall's breastfeeding peer support services are not accessed by women. As part of this study we would like to talk to mothers who have started breastfeeding, continued for a minimum of 5 days, and not accessed any breastfeeding peer support services. We would also like to talk to peer supporters and health professionals about their views and experiences of peer support provision. Before you decide if you would like to take part, it is important for you to understand why the study is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. If there is anything that is not clear or you would like more information please contact a member of the team using the details provided at the end of the information sheet.

Why is the study being done?

This study is being undertaken for a Masters by Research qualification.
The aim of the study is to explore women's, peer supporter's and professional's awareness and perceptions of peer support services, and to understand the reasons why women do not access peer support provision.

As part of the study we want to speak to women, peer supporters and healthcare/community professionals. The results of the study will be fed back to local healthcare providers and Cornwall Council. The results may also be presented at conferences and written up for publication purposes.

Who is doing the study?

The study is being undertaken by Louise Hunt, a research student for a Masters qualification from the University of Central Lancashire. The study will take place from June 2013 to September 2014.

Why have I been asked to participate?

We want to talk to 10-15 mothers who have started breastfeeding, continued for at least 5 days and not used the peer support service. Mothers must be aged 18 or more and be able to speak English.

What will I be asked to do?

If you agree to take part, this will mean taking part in an individual interview. All interviews will be organised at a convenient time and location to suit you, and will take up to 45 minutes to complete. Alternatively the interview could be completed over the telephone.

During the interview, basic information about you will be recorded. We will ask for your age, your highest level of qualification, your postcode, how many children you have, whether you have breastfed before and whether you are breastfeeding now. We want to collect this information so that we can be sure we have gathered information from a broad range of people. Interview questions will explore your perceptions of peer support and why you did not access the service.

With your permission interviews will be digitally recorded. However, if you would prefer the interview not to be recorded, detailed notes will be undertaken.

At the start of the interview the researcher will answer any questions you may have and provide you with a consent form to sign indicating that you wish to take part. If your interview is completed over the telephone, the consent form will be read to you and your verbal consent will be documented.

After data analysis has been undertaken, we would like to organise a second interview (face to face or over the telephone) to share the findings and see whether the outcomes of the study match with your experiences. This interview will provide further opportunities to discuss and clarify your experiences and will be recorded following your consent. It will also be possible for the main themes of the study to be sent to you. If you are happy to be contacted again to arrange a second interview, or would like to have the themes sent to you, please leave your details on the consent form.

If I decide to take part, who will know I have participated?

If you decide to take part and the interview is arranged to take place at a local Children's Centre or other public venue, the other people using that venue may become aware that you are taking part via the signing in book or because they see you with the research student.

If you decide to take part and the interview is arranged to take place at your home, as part of lone working procedures the research student will ask your health visiting team if it is safe for her to visit your home. While no confidential information will be shared with the research student, the health visiting team would be aware you were taking part.

If a telephone interview is arranged, others will not be aware that you have taken part.

Who has approved the study?

In order to make sure the study is conducted in a professional manner, the study has been approved by the London - Stanmore Research Ethics Committee (NHS), Cornwall Council research and development department and the BUSH (Built Environment, Sport and Health) University Ethics committee.

What will happen to the data?

All data will be kept in a secure lockable filing cabinet, and /or on encrypted computer files. All personal data will be kept only until you have finished participating in the study (after the first or second interview

and after themes have been sent to you), and will then be destroyed. The anonymised data will be kept for future use to contribute to the overall knowledge of the subject and to contribute to future research.

Some of the things you say in the interview may be used in the form of a quote in a written report or at a conference. When this happens, there will be no way that the people reading the report or listening at the conference will be able to find out that it was you who contributed the quote.

Will the data be kept confidential?

All the information will be kept confidential. We ask that you do not disclose your name or that of other people during the interview.

Do I have to take part?

No – it is up to you to decide whether or not to take part.

Even if you do agree to participate you are still free to withdraw at any time and without giving a reason. During the interview you are free not to answer any of the questions presented and can stop/leave the interview at any time. If you decide that you do not wish your data to be used within the study, all quotes/information relating to yourself can be removed within one month following the interview. This is because if your data has been anonymised and added to the collective data set then it will not be possible to isolate it and remove it. However, please be assured that it will

also not be possible to identify any individual person from this data. Please contact the research team for more information.

Are there any benefits to taking part?

Whilst there are no direct benefits to taking part in this study, it is hoped that it will give you an opportunity to reflect on your views and experiences, and to uncover important insights into breastfeeding peer support provision. The results may also help inform future service delivery in this area.

Are there any risks to taking part?

Whilst no particular risks have been identified, if the discussions lead to sensitive or upsetting issues being raised, you will be provided with details of appropriate complaints procedures, as well as support from health professionals should this be required.

Will it be possible to claim travel expenses?

Unfortunately there are no funds available to pay for travel expenses.

What do I do if I want to take part in the study?

If you would like to take part in the study, please complete and return the reply slip within one week, and the researcher (Louise Hunt) will contact you to organise a convenient time for an interview.

Please note that if more women agree to be interviewed than intended for this study, I may not be able to organise an interview with you. However, should this be the case, I will write to inform you, and provide the option of receiving the key findings from the study.

What would participating mean for me?

To take part in either a face to face, or telephone interview, at a convenient time and/or location.

If you agree, having the researcher contact you at a later date to take part in a second interview (face to face or over the telephone) to find out whether the outcomes of the study match your experiences.

What do I do if I have any concerns or issues about this study?

If you have any complaints, concerns or issues about this study, please contact the project lead (Dr Gill Thomson) in the first instance on the contact details provided below. Alternatively you can contact the Dean of the School of Health, Dr Nigel Harrison, NHarrison@uclan.ac.uk; 01772 893701.

Thank you for reading this information sheet and considering taking part in this study.

For further information on the study

Contact:

Dr Gill Thomson 01772 894578 gthomson@uclan.ac.uk

Louise Hunt: - 07866 741 879 lhunt@uclan.ac.uk

Study information sheet for peer supporters and health professionals.

A Grounded Theory study to elicit the reasons why women who initiate breastfeeding do not access local peer support provision.

Information Sheet – Peer Supporters and Professionals.

This project aims to understand and explore the reasons why Cornwall's breastfeeding peer support services are not accessed. As part of this study we would like to talk to mothers who have started breastfeeding, continued for a minimum of 5 days, and not accessed any breastfeeding peer support services. We would also like to talk to peer supporters and health professionals about their views and experiences of peer support provision. Before you decide if you would like to take part, it is important for you to understand why the study is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. If there is anything that is not clear or you would like more information please contact a member of the team using the details provided at the end of the information sheet.

Why is the study being done?

This study is being undertaken for a Masters by Research qualification.
The aim of the study is to explore women's, peer supporter's and professional's awareness and perceptions of peer support services, and to understand the reasons why women do not access peer support provision.

As part of the study we want to speak to women, peer supporters and healthcare/community professionals. The results of the study will be fed back to local healthcare providers and Cornwall Council. The results may also be presented at conferences and written up for publication purposes.

Who is doing the study?

The study is being undertaken by Louise Hunt, a research student for a Masters qualification from the University of Central Lancashire. The study will take place from June 2013 to September 2014.

Why have I been asked to participate?

We want to talk to 10-15 professionals (peer supporters and health professionals) about their awareness, perceptions and experience of the local breastfeeding peer support services.

What will I be asked to do?

If you agree to take part, this will mean taking part in an individual interview. All interviews will be organised at a convenient time and

location to suit you, and will take up to 45 minutes to complete. Alternatively the interview could be completed via the telephone.

During the interview, basic information about you will be recorded. We will ask for your role and how long you have been in post. Interview questions will explore your perceptions of local peer support services, and your ideas about the reasons why women do not access peer support services.

With your permission interviews will be digitally recorded. However, if you would prefer the interview not to be recorded, written notes will be undertaken.

At the start of the interview the researcher will answer any questions you may have and provide you with a consent form to sign indicating that you wish to take part. If your interview is completed via the telephone, the consent form will be read to you and your verbal consent will be recorded.

After data analysis has been undertaken, we would like to organise a second interview (face to face or over the telephone) to share these findings and see whether the outcomes of the study match with your experiences. This interview will provide further opportunities to discuss and clarify your experiences and will be recorded following your consent. It will also be possible for the main themes of the study to be sent to you. If you are happy to be contacted again, or would like to have the themes sent to you, please leave your details on the consent form.

If I decide to take part, who will know I have participated?

If you decide to take part and the interview is arranged to take place at a Children's Centre , or other public venue the other people using that venue may become aware that you are taking part via the signing in book or because they see you with the research student.

If you decide to take part and the interview is arranged to take place at your home it is unlikely others would know you had taken part.

If the interview is completed via the telephone, others will not be aware that you have taken part.

Who has approved the study?

In order to make sure the study is conducted in a professional manner, the study has been approved by the London - Stanmore Research Ethics Committee (NHS), Cornwall Council research and development department and the BUSH (Built Environment, Sport and Health) University Ethics committee.

What will happen to the data?

All data will be kept in a secure lockable filing cabinet, and /or on encrypted computer files. All personal data will be kept only until you have finished participating in the study (after the first or second interview and after the themes have been sent to you), and will then be destroyed. The anonymised data will be kept for future use to contribute to the overall knowledge of the subject and to contribute to future research.

Some of the things you say in the interview may be used in the form of a quote in a written report or at a conference. When this happens, there will be no way that the people reading the report or listening at the conference will be able to find out that it was you who contributed the quote.

Will the data be kept confidential?

All the information will be kept confidential. We ask that you do not disclose your name or that of other people during the interview. We also ask that you do not disclose any identifying information regarding service users, or voice any professional concerns about colleagues.

Do I have to take part?

No – it is up to you to decide whether or not to take part.

Even if you do agree to participate you are still free to withdraw at any time and without giving a reason. During the interview you are free not to answer any of the questions presented and can stop/leave the interview at any time. If you decide that you do not wish your data to be used within the study, all quotes/information relating to yourself can be removed within one month following the interview. This is because if your data has been anonymised and added to the collective data set then it will not be possible to isolate it and remove it. However, please be assured that it will also not be possible to identify any individual person from this data. Please contact the research team for more information.

Are there any benefits to taking part?

Whilst there are no direct benefits to taking part in this study, it is hoped that it will give you an opportunity to reflect on your views and experiences, and to uncover important insights into breastfeeding peer support provision. The results may also help inform future service delivery in this area.

Are there any risks to taking part?

Whilst no particular risks have been identified, if the discussions lead to sensitive or upsetting issues being raised, you will be provided with details of appropriate complaints procedures, as well as support from union representatives should this be required. Please also note that should any issues of mal-practice be identified, then appropriate procedures will need to be followed.

Will it be possible to claim travel expenses?

Unfortunately there are no funds available to cover travel expenses.

What do I do if I want to take part in the study?

If you would like to take part in the study, please complete and return the reply slip within one week, and the researcher (Louise Hunt) will contact you to organise a convenient time for an interview.

Please note that if more professionals agree to be interviewed than intended for this study, I may not be able to organise an interview with you. However, should this be the case, I will write to inform you, and provide the option of receiving the key findings from the study.

What would participating mean for me?

To take part in either a face to face or telephone interview, at a convenient time and/or location.

If you agree, having the researcher contact you at a later date to take part in a second interview (face to face or over the telephone) to find out whether the outcomes of the study match your experiences.

What do I do if I have any concerns or issues about this study?

If you have any complaints, concerns or issues about this study, please contact the project lead (Dr Gill Thomson) in the first instance on the contact details provided below. Alternatively you can contact the Dean of the School of Health, Dr Nigel Harrison, NHarrison@uclan.ac.uk; 01772 893701.

Thank you for reading this information sheet and considering taking part in this study.

For further information on the study

Contact:

Dr Gill Thomson 01772 894578 gthomson@uclan.ac.uk

Louise Hunt 07866 741 879 lhunt@uclan.ac.uk

Reply slip for mothers.

A Grounded Theory study to elicit the reasons why women who initiate breastfeeding do not access local peer support provision.

Bodeglos,
Lewannick,
Launceston,
Cornwall.
PL15 7QD.
Email: lhunt@uclan.ac.uk

Date to be added.

Dear potential participant,

If you would like to take part in the study, please complete and return this reply slip to Louise Hunt (research student) at the address above which can also be found on the enclosed stamped addressed envelope. Alternatively you can email Louise on the email address above. Please can you reply within one week and Louise will contact you to organise a convenient time for an interview. Please note that if more women agree to be interviewed than intended for this study, I may not be able to organise an interview with you. However, should this be the case, I will write to inform you, and provide the option of receiving the key findings from the study.

Many thanks,

Louise Hunt.

I have read the information sheet about this study and would like to be contacted to arrange a time for an individual interview.

I confirm that I am aged 18 or older, am able to speak English, started breastfeeding and continued for 5 days or longer, and did not access breastfeeding peer support provision.

Name:

Contact details: Telephone:

Email:

I would like to take part in a (please tick the appropriate box):

Face to face interview ☐

Telephone interview ☐

Reply slip for peer supporters and health professionals.

A Grounded Theory study to elicit the reasons why women who initiate breastfeeding do not access local peer support provision.

Bodeglos,
Lewannick,
Launceston,
Cornwall.
PL15 7QD.
Email: lhunt@uclan.ac.uk

Date to be added.

Dear potential participant,

If you would like to take part in the study, please complete and return this reply slip to Louise Hunt (research student) at the address above which can also be found on the enclosed stamped addressed envelope. Alternatively you can email Louise at the address above. Please can you reply within one week, and Louise will contact you to organise a convenient time for an interview. Please note that if more professionals agree to be interviewed than intended for this study, I may not be able to organise an interview with you. However, should this be the case, I will write to inform you, and provide the option of receiving the key findings from the study.

Many thanks.

Louise Hunt.

I have read the information sheet about this study and would like to be contacted to arrange a time for an individual interview.

Name:

Base/Peer Support Group Name:

Role (please circle): Health Visiting Team Member Peer Supporter

Contact details: Telephone:

Email:

I would like to take part in a (please tick the appropriate box):

Face to face interview ☐

Telephone interview ☐

Covering letter for health visiting team helping with recruitment of women.

Bodeglos,

Lewannick,

Launceston,

Cornwall.

PL15 7QD.

Date to be added.

Health Visitor,

Address.

Dear ,

I am undertaking a Masters by Research qualification. I have a nursing background, a first degree in biological sciences and am also a breastfeeding councillor with the ABM, and a lactation consultant. My study is looking at the reasons why some women who initiate breastfeeding do not access breastfeeding peer support services.

I understand from Stephanie Heard and Helen Shanahan that they have spoken with you about helping with recruitment for my study. Thank you for agreeing to help me with this.

The study, including this method of recruitment, has been approved by the London - Stanmore Research Ethics Committee (NHS), Cornwall Council research and development department and the BUSH (Built Environment Sport and Health) University ethics committee.

I would like to interview women who meet the following inclusion criteria: aged 18 + years, able to speak English (this is because this is a small study and there are no funds available for interpreters), demonstrated some establishment of breastfeeding by having breastfed for at least 5 days, but did not access peer support with their current baby.

I would be grateful if, so far as is possible, you could tell women from differing areas, of differing ages and differing parity about the study, and give them a study information sheet, reply slip and stamped addressed envelope (included with this letter).

Women may also be recruited via posters displayed in children's centres and via other participants who will ask them if they would like to participate before passing contact details to me. Women will be able to choose where their interviews will take place (at their home or at a children's centre or other public venue). As part of lone working safety procedures, I may contact you before arranging to interview a participant at her home in order to check if it would be safe to do so. This procedure has also been agreed with the above organisations and this is explained in the information sheet given to potential participants.

Please do not hesitate to contact me, or my supervisor, Dr Gill Thomson, if you have any questions.

Many thanks for your support with this study.

Yours sincerely,

Louise Hunt, research Student. Tel: 07866 741879. Email: lhunt@uclan.ac.uk

Dr Gill Thomson. Tel: 01772 894578. Email: gthomson@uclan.ac.uk

Covering letter to health professionals who may consider participation.

Bodeglos,

Lewannick,

Launceston,

Cornwall.

PL15 7QD.

Date to be added.

Health Visiting Team,

Address,

Dear health visiting team member,

I am undertaking a Masters by Research qualification. My study is looking at the reasons why some women who initiate breastfeeding do not access breastfeeding peer support services. The study has received ethical approval from the London - Stanmore Research Ethics Committee (NHS), Cornwall Council research and development department and the BUSH (Built Environment, Sport and Health) University Ethics committee.

As part of this study, I would like to interview 6-8 health visiting team members to find out about your views on this topic. Your involvement would mean taking part in an interview, which should last no longer than 45 minutes.

Please find enclosed a copy of the information sheet. I would be very grateful if you would read this and if you would be willing to take part, please complete and return the attached reply slip in the stamped addressed envelope provided, or email me on

the address below. I will then contact you to make convenient arrangements for the interview to take place.

Please note that if more health professionals agree to be interviewed than intended for this study, I may not be able to organise an interview with you. However, should this be the case, I will write to inform you, and provide the option of receiving the key findings from the study.

If you require any further information please do not hesitate to contact me or my supervisor.

I hope to hear from you soon.

Many thanks,

Louise Hunt.

Research Student. Tel: 07866 741879. Email: lhunt@uclan.ac.uk

Covering letter to peer supporters who may consider participating.

Bodeglos,

Lewannick,

Launceston,

Cornwall.

PL15 7QD.

Date to be added.

Peer Supporters,

Group Address.

Dear Peer Supporter,

I am undertaking a Masters by Research qualification. My study is looking at the reasons why some women who initiate breastfeeding do not access breastfeeding peer support services. The study has received ethical approval from the London - Stanmore Research Ethics Committee (NHS), Cornwall Council research and development department and the BUSH (Built Environment, Sport and Health) University Ethics committee.

As part of this study, I would like to interview 6-8 peer supporters to find out about your views on this topic. Your involvement would mean taking part in an interview, which should last no longer than 45 minutes.

Please find enclosed a copy of the information sheet. I would be very grateful if you would read this and if you would be willing to take part, please complete and return the attached reply slip in the stamped addressed envelope provided, or email me on the address below. I will then contact you to make convenient arrangements for the interview to take place.

Please note that if more peer supporters agree to be interviewed than intended for this study, I may not be able to organise an interview with you. However, should this be the case, I will write to inform you, and provide the option of receiving the key findings from the study.

If you require any further information please do not hesitate to contact me or my supervisor.

I hope to hear from you soon.

Many thanks,

Louise Hunt.

Research Student. Tel: 07866 741879. Email: lhunt@uclan.ac.uk

Consent form.

A Grounded Theory study to elicit the reasons why women who initiate breastfeeding do not access local peer support provision.

Consent Form: Interview

Please initial the boxes to indicate 'YES' to the following statements:

I have read and understood the information sheet (version 3) and I have had the opportunity to ask questions	☐
I understand that I am free to not answer any questions during the interview and may stop the interview at any point	☐
I understand I will be able to withdraw my data from the study within a one month period (post interview)	☐
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	
I agree to anonymised quotes being used within reports, presentations or other publications produced from the study	☐
I agree to the interview being digitally recorded and/or hand written notes undertaken	☐
I agree to take part in the interview.	☐

Name (PRINT):	Date:
Position/Job Role:	
Signature:	

Name of researcher taking consent:	
Signature:	Date:

If you are happy for the researcher to contact you again in order to arrange a second interview to find out whether the outcomes of the study match your experience, or if you would like a copy of the main themes of this study, please indicate here including how you would prefer to be contacted and/or receive a copy of the themes i.e. through email or by post (home or work address) and give your contact details. Your personal details will be destroyed one month following the end of your involvement in this study.	I would like to be contacted again by the researcher to arrange a second interview to find out whether the outcomes of this study match my experience Yes/No I would like to receive a copy of the main themes of this study Yes/No I would like to be contacted and / or receive themes by Email/Post Contact details:

Interview schedule mothers.

A Grounded Theory study to elicit the reasons why women who initiate breastfeeding do not access local peer support provision.

Interview Schedule: Women.

Welcome.

Introductions.

Check participant is comfortable.

Key topic areas.

Infant feeding experiences.

Please tell me about your experiences of feeding your baby.

Prompts: Why was/ is breastfeeding important or not important? What difficulties did you face? How did things change over time?

Support needs.

Please tell me what (if any) support you accessed for infant feeding.

Prompts: Who provided this support? Did you receive the support you needed?

Awareness and perceptions of breastfeeding peer support.

Please tell me about your views of breastfeeding peer support.

Prompts: What were you told about it? Who told you about the services? Why didn't you access this support?

Barriers and facilitators.

What do you think are the main barriers to accessing breastfeeding peer support? (Explore answers in depth).

What do you think may have or could have encouraged you to access this support? (Explore answers in depth).

Recommendations.

What do you think could change or develop to enable more women to have the support they need?

Are there any other reasons why people don't go to breastfeeding support groups that we have not discussed and you think are important?

Closing.

Is there anything that you might not have thought of before that has occurred to you during this interview?

Is there anything you would like to ask me?

Thank you for taking part in this study.

Clarify what participant wants re being contacted again and themes of study. Confirm that I will make sure this happens.

Interview schedule peer supporters and health professionals.

A Grounded Theory study to elicit the reasons why women who initiate breastfeeding do not access local peer support provision.

Interview Schedule: Peer Supporters and Professionals.

Welcome.

Introductions.

Key topic areas:

Awareness and perceptions of breastfeeding peer support.

How would you define peer support for breastfeeding?

Prompts: What are the aims of the service? Who is it for?

Women's referral to the service.

How are women referred to the service?

Prompts: Are all women referred? When does it happen? Do you (health visitors) refer everyone? Are there some women who might be less likely to be referred?

Reasons for non access.

Why do you think many women who initiate breastfeeding do not access the service?

Barriers and facilitators.

What do you think are the main barriers to women accessing the service? (Explore in depth).

What do you think are the main facilitators to women accessing the service? (Explore in depth).

Recommendations.

What do you think needs to change or develop in order for more women to get the support they need?

Closing questions.

Are there any other reasons why people don't go to breastfeeding peer support groups that we have not discussed and you think are important?

Is there anything that you might not have thought of before that has occurred to you during this interview?

Is there anything you would like to ask me?

Thank you for taking part in this study.

Clarify what participant wants re being contacted again and themes of study. Confirm that I will make sure this happens.

Main themes for mothers.

A Grounded Theory study to elicit the reasons why women who initiate breastfeeding do not access peer support provision.

Main themes.

From the woman's perspective:

(1) **The background of pressure and judgement.** There is a background pressure to breastfeed, and moral judgement around it. It's the mother's 'responsibility' to do it. This affected women's anticipations about what accessing a group might be like.

(2) **'It's a shock': The embodied experience vs theoretical knowledge**. The experience of actually 'doing it' can clash with how breastfeeding is promoted (e.g. natural and normal).

Not anticipating 'the journey' or 'having to find my own way'. For example, issues were raised about women being surprised at having to find a path through or around issues that arise. When issues arise women often feel like they are 'failing', rather than issues being a normal part of the journey.

(3) **Practical support needs, and the available practical support.** The services available often combine pressure to keep breastfeeding with a lack of practical support that women need at the beginning. For example women wanted someone to sit with them at home, and give practical and emotional support in the very early days. Often this kind of support was not available. When help is really needed, especially in the early days, the group environment is not appropriate.

Support needs change over time. As time goes on the kind of support needed changes. For example, if women had continued to breastfeed through the early weeks and felt able to get out and about, their support needs were then different. For example women valued hearing about other women's experiences. This might enable

them to verify the normality of their own experience, or to gain 'tips' from others in their boat.

(4) **Issues re access to peer support. Not understanding the point of it**. When health professionals talk about peer support they don't give much detail or mention the factors that are of most concern, e.g. They might explain the group is there, but not explain what happens when you go, whether you can take a friend with you, or the aims and ethos of the service.

Reasons for not going:

Anticipating breastfeeding -centric advice. For example expecting that the main aim of peer support would be keeping the breastfeeding going, rather than listening to the woman's situation, and providing support that she needs.

Anticipating judgement: For example peer supporters would want to avoid talking about 'the f word' (formula).

Anticipating social discomfort: For example not having anyone to talk to, or other women in the group 'not being like me'.

Not identifying with the group: Peers are supposed to be your 'equivalent', but with regard to breastfeeding competence, they are not. You are in a 'tricky place', whereas they are in 'a strong place' (as they know what they are doing)

(5) **Factors that can facilitate access.**

Things that might enable you to go / act to buffer judgement and social discomfort.

For example bringing a friend, somebody personally recommending the group to you, meeting a peer supporter at an antenatal class or accessing them online first.

Main themes peer supporters and health professionals.

A Grounded Theory study to elicit the reasons why women who initiate breastfeeding do not access peer support provision.

Main themes.

From health professional and peer supporter's perspective:

(1) **The background of pressure and judgement.** There is a background pressure to breastfeed, and moral judgement around it, e.g. 'It's the mother's 'responsibility' to do it'. This affects women's anticipations of what going to a group might be like.

(2) **Practical Support needed, and the practical support available.** Women suggested that the services available often combine pressure to keep breastfeeding with a lack of practical support that they need at the beginning. For example women wanted someone to sit with them at home, and give practical and emotional support in the very early days. Often this kind of support was not available. Many health professionals and peer supporters were aware of this miss-match between the support needs, and availability of support. When help is really needed, especially in the early post-natal period, the group environment is not appropriate.

Support needs change over time. Issues suggest that women's breastfeeding support needs change over time. If women continued to breastfeed through the early weeks and felt able to get out and about, their support needs became different. For example women valued hearing about other women's experiences. This emotional and social support enabled them to verify the 'normality' of their own experience. Peer supporters and some health professionals felt that many women had stopped breastfeeding before they would feel able to go out of the house and visit a group environment.

(3) **No agreement on ethos and aims of peer support.** Insights from women, health professionals and peer supporters suggest that that there was a lack of agreement concerning the ethos and aims of peer support. For example some peer supporters suggest the main aim of peer support is to 'support women to breastfeed their babies for as long as they want to in the way that they want to', whereas others (health professionals and peer supporters) felt it was about 'supporting women to breastfeed',

with no mention of women's personal goals or feelings. Some peer supporters talked about providing woman centred support where listening was crucial, whereas others talked of 'advising'.

Being judged: Some health professional and peer supporter's stories indicated situations when peer supporters had acted in a judgemental manner. Furthermore, women often anticipated judgement as they felt peer supporters would want to avoid talking about the "F" (formula) word.

Anticipating breastfeeding-centric advice. Women spoke of not wanting to access peer support groups due to concerns that the main aim would be keeping the breastfeeding going, rather than listening to the woman's situation, and providing the support that she needs. This also extended to anticipating social discomfort, for example being left alone with no one to talk to.

Communication between health professionals and women about peer support. The lack of clear ethos and aims also affected health professional's encouraging access amongst women due to the fact that they could not always be confident that peer supporters would not judge women or provide the support that they felt the woman needed, which in turn may have affected whether and how peer support is discussed. Peer supporters also felt some health professionals talked more positively about peer support than others.

(4) **Theoretical v's embodied experiences:** Health professionals and peer supporters were often aware that the experience of breastfeeding can clash with how it is promoted (e.g. natural and normal), and that women were often not anticipating 'the journey' or having to 'find their own way' at the beginning. However the reality for women was that when issues arose women often felt like they were 'failing', rather than encountering 'a hic up'.

'Not like me': Women often thought of the peer support group as being a group of successful breast feeders, which, as they were 'failing', they did not identify themselves with. Health professionals and peer supporters views diverged from women's in this area, as they often mentioned peer supporters 'having been there', they assumed that women would understand that peer supporters and other women at the group had also had similar experiences very recently, but women did not perceive this.

(5) **Factors that can facilitate access.**

Things that might enable women to access act to buffer judgement and social discomfort, they include: Bringing a friend.

A personal recommendation.

Alternative access points to peer support, for example meeting a peer supporter at an ante natal class or accessing them online.

Appendix 2.

Sample interview transcript.

Heidi.

2/12/13. Interview at Heidi's home.

Louise: So can you tell me about your experiences of feeding your baby?

Heidi: Em, well I was in hospital for the first five days so I had a lot of help anyway with getting him latched on, so that was no problem, and he fed well, em but then by, by after two weeks he just was constantly hungry, and a, although he was feeding, he was feeding all the time, and he wasn't happy, and ah, so that's when I decided to change to formula really, but a, as for actually feeding, it went well to start with, you know latched on well and he took it, I just didn't have enough, I think my milk wasn't thick enough in a way, cos when I expressed it, it was really watery, runny, so I think it was there, lots there but just not thick enough, so.

Pause.

Louise: So when you were in hospital, who kind of supported you when you were in there?

Heidi: Well the midwives really, and there was a, not sure what they're called, they're like health care assistants kind of in there. They were really good, came round if you needed help, so yeah, so we weren't in there for that, but because we were in there, had a lot of help in there as well so that was good.

Pause.

Louise: So how did it kind of change over that period then?

Heidi: Um, I mean he was feeding pretty regularly anyway, you know, and um not going as long as he could, you know, as some babies do, but he just, well you know, by the end of that second week he just wasn't happy, was always grisly, I was always having to you know just always be trying to feed him or just holding him, he just, you could tell he wasn't satisfied really, so ah, as much as I didn't want to give up, but, cos you feel a bit like a f, like you've failed a bit don't you? Cos there's such pressure I think.

Louise: Is there?

Heidi: to breastfeed, I think there is, and you just kind of think 'oh, I've failed if I can't do it', ha, and I was like 'oh my god' and then, but my partner was like 'what formula are we going to have? I'm going up the shop', and actually he was so much happier and we were all happier after, so, because I was constantly holding him, and my son's saying 'oh you're not doing anything with me' and just, so it was the best decision.

Louise: Yeah.

Heidi: And he had that initial start with it so.

Pause.

Louise: Yeah,... so um, where do you think that pressure comes from?

Heidi: Um, I mean initially I thought, I didn't really feel overly pressured in that I thought, well if it works it works, and I'll do it if I can, but I do think there is a lot of, you know, I think generally from the health service and all the telly and everywhere you get this feeling that 'oh you know breast is best and you should breas..' you know, there's always there, even though I thought to myself 'I'll do what I feel is right', but you do kind of feel it is there, the pressure to do it in a way, and then when you stop, you think, 'oh people are going to think oh she stopped feeding' you know, you do kind of, but you do have to do what's right for you and the baby really, I think there is a pressure in a way.

Louise: So did you talk about it with your midwife or health visitors?

Heidi: Em,

Louise: Before you had him or after or?

Heidi: Not really, I mean they bring up about breastfeeding anyway, um, and I just said at the time 'well I'll try and if it works, it works', you know I wasn't going to feel too pushed into it, um, but you know it always come up in conversation doesn't it before hand? They always bring that up, but um, no I didn't really I don't think, it's just, I think after , before I changed him, I think I spoke to family more.

Louise: Did you, yeah

Heidi: Yeah, really, sort of spoke to my mum and you know, and just to get their view really, yeah,

Louise: Yeah, so maybe your mum, and anybody else?

Heidi: Um, my partner's mum, really, they were probably the main ones, because they'd been through it as well, you know, and you know they're going to give you their honest opinion really, like an unbiased opinion I'd say, although I know like health visitors and midwives say they're not going, you know, specifically push you towards breastfeeding, but you do kind of feel that that's their ... I don't know, I don't know, that that's kind of their preferred choice of you see what I mean?

Louise: So you kind of sense that

Heidi: Yeah, I think so, yeah think you do, even though they say you know 'we're not going to '.. but you do kind of feel that that is the, that

Louise: Whereas those people in your family....

Heidi: Well I think they, they obviously want you to do what's right for you, so they're not, they're not going to push you in either direction they're just, just kind of advised me on what they thought and, and their experience really, rather what, than saying 'well you should carry on, or you do what is right for you, and don't feel like you shouldn't stop, if that's right '...

Louise: So did you find, like you just said there about their experience, um, was that something, can you tell me more about that or?

Heidi: In what way?

Louise: That you, you valued that did you?

Heidi: Yeah I did, yeah, cos they're talking about, rather than just saying what they should be saying, if you see what I mean, they're actually just telling you their real experience and, rather than just sort of following, not that I think health visitors and that follow a text but, you know what I mean, it's almost like they have to say certain things, whereas you know, with your family they're just going to tell you, as it is and really, yeah, I mean I didn't feel really pressured, you know, it's not like it was a big 'you must breastfeed', 'you must', but you do feel like there's an underlying sort of ...pushing you to that.

Louise: So at that time you kind of um talked to your partner, talked to your mum and your mum in law

Heidi: Yeah.

Louise: Anybody else at all or?

Heidi: Em, well obviously when they, the midwives and health visitors called around, saw them, you know I did talk to them as well, um, I think that was it really.

Louise: How about with your other son, was it a similar sort of a thing?

Heidi: It was really, he was just constantly feeding, and in the end you just thought, 'I'm just sat here the whole time feeding', and it was pretty much the same, and it wasn't that I didn't have the milk there, there was plenty of it, it's just like it wasn't satisfying them, so yeah it was pretty much identical really, yeah.

Louise: So what had you been told about it all before then?

Heidi: Em, I don't know really, I mean you kind of get, I think you kind of get told that , you know that if you can breastfeed then that's the best way to go, but otherwise I don't know that I was told a lot really.

Louise: And were there any antenatal classes or anything like that?

Heidi: Um, what beforehand?

Louise: Yeah.

Heidi: Yeah, I did go to, I did go to an ante natal class, that covered quite a broad, broad, I went to a couple, um and there was one of those did cover breastfeeding and that, and obviously they bring up the cost issue which you know it covers all that and .. so again, you do kind of get the feeling that you, if you can breastfeed then that's the thing to do.

Louise: Did they talk about what it might be like in those sessions? You know what actually it might be like to do it or?

Heidi: Um, a little bit, they had one of the advisors there fro, you know one of them from one of the breastfeeding groups.

Louise: Oh did they?

Heidi: Yeah, she came along from the *** (town name) one I think it was, so she kind of gave a talk, but I don't think you can really get from that what it's really going to be like, until you actually do it, especially first time round, I mean obviously this time I knew I'd done it before, but I don't think you can really get a good understanding you know.

Louise: And was that a peer supporter then?

Heidi: It was, yeah, she came along and gave a talk.

Pause.

Louise: So was that the first time you'd heard about peer support or?

Heidi: Em, yeah I think it was, cos I don't think they had that when I had my first son, I don't remember that at all, so yeah, so that was the first time telling us about you know, 'there's someone here to support' yeah, yeah.

Louise: So how was it kind of put across to you then, what did you think that it kind of was?

Heidi: Em, what at the antenatal class?

Louise: Yeah.

Heidi: Em, well I suppose it was sort of to give you advice and guidance , em, but again you always got the, I dunno, maybe it's me, but you always kind of get the feeling that that's the kind of direction they're , not that you're being pushed in, but you do, I don't know, I think there's always about feeling that that's the area, that's the way that they want you to go, to go for breastfeeding rather than the bottle really.

Louise: So what you seem to be saying there was um, that they were there for your advice and guidance, but there was very much, it was very much

Heidi: Yeah you did kind of feel, and especially in they're, they're telling you all the, I mean we talked about all the pros and cons of it, of both, but you do, yeah, you do feel like they, there's more pros to it, it's very much 'oh it costs a lot all the bottles, this', and you know, so I do think there's a little bit of, pushing you a little bit, yeah.

Louise: That's really interesting, so was it led by a midwife with that lady there?

Heidi: Yeah, yes the midwife was running the class and then she came along to do part of it, that area.

Louise: Um, so with, with like you say maybe the point of it being them giving you advice and guidance, um, is there anything else that she said about it or?

Heidi: I'm trying to think, um, I mean it was useful cos she brought a doll along and got you to hold the doll and have a go, and em, little things like that, she got little props and that, so it was quite interesting and I think it was nice especially for, cos I think I was the only one that wasn't a first time mum, so for a lot of them it was probably good to get an idea of what it might be like, but a, I can't think what else it covered really, just really to give you an idea I suppose, to know that there is peer support there if you need it.

Louise: So would you be thinking of peer support as being mainly if you've got a problem, somewhere where you can go for help then? Is that what you were thinking?

Heidi: Well she did kind of say that there was a group and you could go along anyway, whether you needed help or not, it was you know a group where you can get together and meet people so there was that side which was, well I thought that's quite nice cos I don't remember that last time, um, that the peer support were there if you needed help.

Harry (baby) shouts a bit

Pause, Heidi goes to make bottle for Harry.

Louise: Talking to Harry.

Louise: Ok, so you think that you probably heard about peer support from that lady

Heidi: Yeah, yeah I don't remember that any other

Louise: Ok, so um, why didn't you access it then, or did it not come into your mind or?

Heidi: Em, I suppose cos I thought because he was latching on fine and actually feeding ok, that I didn't have a problem in that respect, so I suppose if I had, then I probably would, but I suppose I didn't think of it as, as I needed to in a way, in a way I kind of felt well I kind of know what the problem is, as much as I didn't want to give up, um, I suppose I could have done, but I thought because he was actually feeding ok, it was just the fact that he was ... that I felt that, well, I think if, like I say, if I'd had problems with him latching on and actually feeding then I probably would.

Louise: So it was kind of like er, um actually physical breastfeeding was fine, but it was just what was going on around it

Heidi: Yeah, I suppose that's why I didn't think about it really because he was actually feeding alright.

Louise: And did they, it sort of came across more as something that they were going to help you with the literally

Heidi: Well yeah, that's how you kind of, I know she said that they are for support, but you kind of think when they say 'if you're having problems breastfeeding', then that's what you think if they're not feeding or, and that's kind of what you think really.

Louise: Yeah, yeah, so did you think about ringing them or? Can you ring them?

Heidi: Well, I dunno, no I didn't really, because I knew that they ran a group one day a week up here, but I didn't have any other way of contacting.

Louise: Apart from just turning up

Heidi: Yeah, yeah.

Louise: So that would have been on a

Heidi: Wednesday, yeah, so, so no I didn't really, I don't know if I really thought about it as somewhere that I needed to, see what I mean? Yeah

Louise: That's really interesting.

Pause.

Louise: So what would you think might be the main barriers to, that stop people from going to a peer support group?

Heidi: Em, I suppose you might, I know she did say that if you had a problem that they, she would meet people individually, but some people might feel going to a big group like that and having to discuss in front of people, they might feel a bit intimidated really, and especially if they are having problems and everyone else is sat there feeding you know relaxed and they're thinking 'well I'm the only one who's', they might feel like they're the only one having problems you know, if everyone else, I don't know, just that group environment isn't always, might feel a little bit overwhelmed by it all probably, but I mean that's not the reason I didn't go, I think I didn't go just purely because I didn't think of my problems being what I needed to see them about, but that might put people off I think being in a group environment, and until you go and meet the peer support, you haven't really got that contact with them until you turn up at the group to be able to get hold of them and speak to them, I know you've got your midwife, that you can contact um, but yeah so that might be a reason why they feel put off a bit.

Pause.

Louise: So so from what you say it's maybe that walking into

Heidi: Well yeah, cos you're walking into a group and especially if you don't really know people there, you know, you've got to walk in and yeah walk in in front of all these people and then think 'well I've got to bring up a question', you know it might feel a little bit intimidating.

Pause.

Louise: So she kind of suggested that you might be able to see her

Heidi: Well she did, but she was form the *** (nearby town) one, she wasn't actually from the local one.

Louise: But actually, you couldn't have done that anyway cos it wasn't like you had her, clearly

Heidi: No, we didn't have any contact details no, we had obviously the list when the sessions were on, but thinking about it a couple of the ones from *** (home town) did come along, but again we weren't given, we were just told when they would be there, and yes, you could pop along but there wasn't any other way of contacting them, you know, and if you are having problems you might not feel like going out and going to somewhere like that you know, really I think, you might want to be able to deal with it at home within the comfort of your own home really, rather than go along to somewhere and feel a bit, in front of everybody you know? Yeah.

Pause.

Louise: So maybe then, it being, the support being available, but in a, a setting

Heidi: Yeah, I think it could be that first time walking in, you know, it's not like going to see someone one to one, which of course you could, but then you've got to ring them up, you've got to find the peer support in the group and, you know, that's what I would feel and think about it all a little bit, cos it's a bit...

Louise: And you also mentioned there about it, you might not know anyone.

Heidi: Well no, not necessarily no, although *** is a small town, there's a lot of people, when I first went to the group, that I didn't know, so you might walk in and not know anyone, so you then are thinking well who are the peer support? Yeah, so it's not necessarily obvious, like they , I don't know about **** (nearby town), but certainly up here it's not like they wear anything different, so you can't walk in and obviously see who it is, I think, which would be nice, cos some people might feel that they need to know who they are, to be able to identify them a bit more, and I know it's quite relaxed up there which is quite nice, but um, yeah, like being given contact information at the antenatal so you could sort of just speak to someone if necessary, just on the phone, praps rather than go anywhere.

Pause.

Louise: That's really interesting. Um, so um, what you were saying earlier about, of that whole thing of the pressure of, were you kind of , sensing what they are wanting you to do, not necessarily saying it, um, do you think that affects whether people go or not? Or?

Heidi: It might do, yeah, it might do cos I, even though I told myself beforehand 'I'm not going to feel pressured, and I'll do ', I still felt like I'd failed in some way by giving up, you know so I think, so even though I'd thought 'I'm not going to be', I think you are, without realising it, I think you are kind of pushed, cos I, otherwise I'd have just thought 'Oh well, that's it, I've tried and I'll move on', whereas I thought 'God, if I don't do this. I'm failing in some way' you know?

Louise: Ohhh

Heidi: So yeah it could put people off. Especially if you think, well everyone up there's going to be breastfeeding and if I walk in and I can't do it, I'm going to be different to everyone else you know, really, yeah which you shouldn't, you shouldn't be feeling like that really, I mean I still

stay, stay till the group anyway, cos I thought well why should I miss out just because I'm not breastfeeding anymore, but yeah you might feel a little bit uncomfortable maybe.

Pause.

Louise: So can you just explain, so they have the, can you just explain the groups, the timing?

Heidi: Yeah, well I think it's changed slightly but, it was, you go up for the weigh in, and then that just carries, if you want to stay, carries straight on, I don't know if they still call it the, that it's the breastfeeding group, or whether it's just sort of a stay and play kind of thing, but it always was initially, um, and then a peer support would turn up, the last few weeks I've not even seen a peer support.

Louise: Cos when I met you at that group, I think the lady said that it's just general group, and then at a certain time, yeah, like you say, they turned up, but I didn't see them on that day, but I didn't stay, we weren't there late were we?

Heidi: No, I haven't, the last several times I've been, when I first started going with him, someone always turned up, they came in obviously at the time when it was changing over to that and they would sort of, they would say hello to everyone and, but I don't know if they actually, I think some said 'I'm the peer support' but if you're not sure, you might just think it's someone coming along, yeah. Really.

Louise: So how old was he when you first started going to that group then?

Heidi; Em, oh he was only three weeks old, yeah.

Pause.

Louise: So how about things that might have, I know we've talked about this really, but things that might enable people to go to peer support or access peer support?

Heidi: Em, in what way, what would kind of make you go?

Louise: Mmm, I think you've kind of said haven't you, about if it had been really obvious how to contact them at a different time of the week or something

Heidi: Yeah, you might want to, yes, cos you are limited to that one day so, if I'm having problems on a Monday, you think well, you know, I might want to talk to someone then, the group isn't till Wednesday, so I mean by that time I might be tearing me hair out, so in a way it would be nice to have a contact specifically for that, that you could just speak to on the phone maybe, cos you might not want to, like I say, you might not want to go out but you might just want someone to say 'look, this is what's happening, am I doing it right?', you know, which I know is probably difficult maybe to arrange that, but, no I don't know how easy that would be but you might not be having problems on that day when it's on and, or like me think well 'it's not really the sort of thing I need to speak to them about', but then in hindsight, I probably could have done, you know, so...

Louise: But then it wasn't obvious, that wasn't obvious, so

Heidi: No, no cos he was actually feeding fine and taking the milk fine so I wasn't thinking that the actual breastfeeding was a problem, no

Pause.

Louise: And you also said about just actually walking in didn't you?

Heidi: Yeah, well it is a little bit especially when there's, cos you know people are sat around in their circles and if they've already been going for a few weeks, they already know each other, then you've got to then walk in and find your place, and it is a little bit, well I don't really know anybody, and for some people that's not a problem, they just walk in and not worry, but some people might feel a little bit, you know, shy or whatever to walk into something like that, and again you're not sure who is the peer support, so if you're turning up after they've already arrived and they're not dressed any different to anyone else, and sometimes they might have a child with them of their own, so then you don't actually know unless they say, 'it's me' sort of thing, you know, some people might feel a little bit 'I don't want to go up and go through all that' in a way, you know, to get that advice, you know when it can turn into a bit of an ordeal, you know in a way, yeah so.

Pause.

Louise: Um, so what do you think could change or develop to enable more women to have the support that they need?

Heidi: Well like I say, having that contact maybe, way of contacting them out of, out of the group, um, which I know once you've been, they probably would, but initially you haven't got that as a way of contacting them.

Louise: I see what you mean. If you'd been once they might say 'oh this is my number' or whatever, but if you haven't been

Heidi: Yes, then you don't know, no, em, and then also, I suppose there might be people who don't drive and that who live in outlying areas who can't necessarily get into the group, to access it, cos I mean obviously a lot of people come from outside in rural areas, can't actually, may not be easy to get there anyway, but yeah I think just having someone that you could contact about specifically that would be, that's quite a big thing isn't it? A big thing to, you know need help with and it, you know, and a lot of people do, and obviously the midwives and that are there, they're busy as well, you know, so if someone can spend time with you, just talking about that, that would be a good thing really.

Pause.

Louise: So your midwife, when did you, what, when you came home with him, so he was did you say five days

Heidi: Yeah, we didn't come home, he was born on the Monday and we didn't come home till late Friday, and she came the next day, um and I saw her then um, yes and then after that you go to them, they come initially, on that next day and then you go to them.

Louise: So did you see her, the midwife one more time or?

Heidi: Yeah, I think I did, she came here and then I went to see her, and then it switches over to the health visitor who initially came here and then you go to there, yeah.

Louise: So at about the time when it was getting really difficult, um, that would have been before the health visitor or after?

Heidi: Oh, it might have been, it was about the two weeks cos we were in for nearly a week and then home for a week, so, I'm not sure actually.

Louise: So you kind of really sensed that they were quite busy though

Heidi: Well you do, yeah really, yeah, and I know there was a lot of pregnant ladies at the same time, so I knew that they had a lot of people to see, and I know they are there, they would be there if you needed it but...

Pause.

Louise: Em. So are there any other reasons why people don't go to breastfeeding peer support that we haven't talked about

Heidi: Um, no, not sure.

Louise: Yeah, it's really interesting what you said earlier about kind of, that feeling of they would be all doing it fine and then you would be feeling

Heidi: Well yeah, cos initially, I know it isn't now, but initially it was kind of advertised as the breastfeeding group so you kind of think, 'well everybody's going to be breastfeeding' and I'm going to turn up and think you know 'oh god' you know, like if he's hungry, am I going to be able to do it? You might feel a bit..

Louise: And by that did you think they, they would be literally, like literally breast

Heidi: Well in a way , yeah really, cos obviously when a baby is hungry you've got to feed, so, you know that's what you think, you kind of picture it, you know they would be at some point, you know feeding them, and you then at some point have got to feed yours, and if you're having problems you're going to be the one who's not going to be able to do it like everyone else in a way, so yeah.

Louise: So did you kind of anticipate they, they had kind of had had no problems or that they

Heidi: I suppose you kind of in a way think 'well you know you're the one who's having trouble' you know, although lots of people do, you know, so probably, you don't think about it, but there are going to be other people who need that help as well, and I don't think you kind of think like that, cos at the time you're thinking 'well I'm the one who can't do it, and they all will be' in a way, yeah, which is not really the case probably, but that's kind of the way you think.

Louise: So the lady, the girl that came to your antenatal, did she talk about her own experience at all there or not?

Heidi: Yes, I think she did, yes because, um, yes she did talk about it because she said she'd had three children so she sort of said, you know, talked about it and how good it is and how she managed to do it, you know, and you're thinking 'well if I can', I think specially because for me it was second time around, so I knew that I'd struggled a bit last time, so, for me, I might have been looking at it differently to the others who were all first time mums, so they hadn't, they had no experience, then they may have been, looked at the whole experience differently than I did really, cos for me I was thinking 'well this is lovely, and yes it's a good thing if you can do it, but will I be able to?' you know in a way.

Louise: That's really interesting, so just before we finish, em, some people have said to me that it's important who the peer supporters are, or certain things about them, do you think that is important to you or not?

Heidi: It probably is, because you want, you want them to be, to feel that you can approach them, you know, that it's somebody that you would be able to speak to, yeah that you feel, cos it's obviously, it's quite a personal thing that you're discussing really, so you've got to feel that you can actually, that it's somebody that you can open up to and that they are approachable, yeah, which is probably nice then that there are several different ones in a way, cos you might think 'well I don't know if I want to speak to that one', but then you don't know who's going to be up there on the day you go, so that's, yeah, but then I suppose if you are able to drive then there's other groups, like I could have gone to the *** (nearby town name) one, they did make that clear that, you don't just have to go to your local one, go to ** or *** (two other local towns), whatever, you know so you could go to, you might want to go to one where you think they won't know you as much yeah.

Pause.

Louise: So is there anything that you might not have thought of before that has occurred to you while we've been talking?

Heidi: Em, don't know really, it's quite interesting thinking about you know, whether people, how people would feel about going to be honest, yeah, cos obviously I didn't think of going, but then it's interesting to think, well how would I have felt, turning up, if I had a problem, you know.

Louise: And um, sort of just from what you've just been saying, thinking about you in your position, is actually, um at that time you were the one who had to go and, you were the one who was having to think 'right who do I call, or what should I do

Heidi: Yes, yes

Louise: It's not like, so it would have been quite a big thing to have thought 'right I am gonna phone..'

Heidi: Well yeah, that's it, it is cos again, because I was thinking, well you know 'I'm a failure if I don't do it' you're think well if I ring and say to them 'oh, I'm thinking of not doing it', are they going to say 'oh no you shouldn't', you know, you do kind of, subconsciously I think you're thinking that, yeah, but it's...

Louise: That they may actually say that to you?

Heidi: I don't know whether they would, but I think you would get the feeling

Louise: There's a possibility they might

Heidi: You almost feel like people, kind of, I don't know that they do, but you kind of get the feeling that they look down on you because you're not, do you know what I mean, which is, is silly, because it's your baby, and you should do whatever you, but you kind of...

Louise: Because you, well it sounds like you're saying that because you'd sensed that right from the beginning, that

Heidi: So you kind of, yeah, so that's why I think I was more comfortable like ringing my mum and saying, cos I thought she's not biased towards it, she's just going to, tell me what she thinks really.

Louise: She's putting you at the front of her

Heidi: Yeah, yeah, she's not going to say 'well you have to do that', which they wouldn't but you have that underlying feeling, you know?

Louise: yeah, yeah, and, so fascinating, if you've got in your mind that they might say that to you, and you, you, yeah, how would that make you

Heidi: yeah, you're gonna feel, cos obviously yeah, something had made me, told me that obviously if I can't do it then I you know, obviously go that feeling, initially, like I say, I just thought 'well', before I'd had him I just thought 'well, I'll give it a go and', and , which is what I said to them when they brought it up I said 'well, you know I only managed to do a couple of weeks last time, but I'll give it a go and hopefully this time I'll do more', and I was very relaxed about it, but you do kind of, I think after you feel a bit more, ' I have to do this' and 'well this is what I have to do' which is a shame, yeah, there is pressure, as much as they say. 'Well we're not gonna say one's better than the other', 'we're not going to push you to do that', I think it is there, yeah, it's difficult isn't it to stop that, but then you do feel under a bit of pressure,

Pause.

Heidi: Cos it is something you are always asked, initially when you go 'are you'. 'are you still breastfeeding?' and it's like 'no I'm not actually' and you almost like they're looking at you as if to say 'You're not!', you know you do feel, 'well actually I've stopped' you know.

Louise: Really.

Heidi: Well I think so, it's like you don't want to say 'well actually I've stopped', and you think after, that's silly, you know, I'm doing what's right for, you know, but yeah, you feel a little bit like you shouldn't be saying it.

Louise: So, that, that sort of feeling of, if you do ring up somebody and say 'look this is the situation' and you think that they're going to really almost tell you 'You shouldn't stop, you

shouldn't do..' and tell you what you should and shouldn't do, um, did you feel that peer supporters might be like that as well then or?

Heidi: Well possibly, yeah, because like I say the one who gave the talk was very, you know, um kind of promoting it really, 'and I did this and it was really good and this is what I got from it' and you sort of thinking, yeah, in a way, yeah, they're probably going to be saying this is, not really, I dunno, it's difficult cos you don't think like they're going to say, 'well you must do it', but in a way they're kind of gonna be saying 'you should persevere' and 'you should' you know, but it gets to a point where you think 'I can't carry on any longer, it's just not working', yeah.

Louise: And actually the people who you felt, happy to talk to at that point were the people who you knew were going to hear you from where you were.

Heidi: Yes, yeah, and not have in their mind 'well breastfeeding's the best', they're just going to listen to you and say, 'Well look, this is what I did, this is, why don't you try this?' You know because it's, yeah, it's like you say, they're thinking of you rather than what you should be doing, yeah, yeah, cos my mum said, 'well you've done better than me, I couldn't do it at all', and then you think 'oh well actually, I've done a bit ' and I've got him started and that's, yeah, so in a way there is no pressure from it because they are literally thinking of you, but um, yeah.

Pause.

Louise: Thank you so much, it's really really helpful to me, um, so is there anything that you would like to ask me?

Heidi: Em, it'd be nice to know a bit more about what your research is going towards.

Louise: Well it's when I finish it it'll be like an MSc by Research, so I'm hoping that I'll be able to make some sense of what everybody had said and then maybe make services so that they are more helpful to people, I think that's the aim of it really, is so that, it's almost like exactly what we've been talking about really, if you've got all this stuff going on but kind of know that a lot of people don't access the service then, what is it about this service that isn't meeting people's needs? In a way if you are going to have a service it needs to be what people need or want

Heidi: That's good. So once you've gathered it all, then who has the information, who's going to sort of use it?

Louise: Well Cornwall Council definitely I have to do a report for Cornwall Council, and em, also the health service, too, and then em hopefully I will sort of publish articles that would be in a journal for everyone to see as well, but I think the main part of the challenge will be, it's one thing to do it, but it's another thing to make some impact from it as well, so that will be a challenge for me I guess as well.

Heidi; Are you doing a course then, is that what this is?

Louise: Well it's not really a course really, it's kind of like you're on your own doing it, and the University that I'm with who are in Preston in Lancashire so I've got people up there that

support me, my supervisor, and so I'm in email and on the phone and skype with them, but I'm just working away on my own really.

Heidi: Yeah, oh yeah.

Louise: And thank you very much, was there anything else?

Heidi: No, I think that's it.

Louise: Yeah massive thank you for your time, really appreciate it, um, and yeah I'll contact you, email you. That's brilliant, thank you very much.