1   **Title Page**

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10   **Full title**

11   Pressure and judgement within a dichotomous landscape of infant feeding: A grounded theory
12   study to explore why breastfeeding women do not access peer support provision

21   **Contributor statement**
22   Study design by LH and GT. Data collection and analysis by LH with support and guidance from GT.
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29   **Pressure and judgement within a dichotomous landscape of infant feeding: A grounded theory**

30   **study to explore why breastfeeding women do not access peer support provision**

31

32   **Abstract**

33   Lack of support is reported as a key reason for early breastfeeding cessation. While breastfeeding

34   peer support (BPS) interventions are a recommended tool to increase breastfeeding rates,

35   intervention studies identify that engagement with BPS is problematic. Due to a paucity of research

36   in this area, this study explores why breastfeeding women do not access BPS in South-West England.

37   Utilising Charmaz's (2006) constructionist grounded theory approach, twenty-four semi-structured

38   interviews were undertaken with 33 participants (13 women, six health professionals and 14 peer

39   supporters). Analysis involved open coding, constant comparisons and focussed coding.

40   One core category and three main themes explicating non-access were identified. The core category

41   concerns women's experiences of pressure and judgment around their feeding decisions within a

42   dichotomous landscape of infant feeding language and support. Theme one, 'place and space of

43   support', describes the contrast between a perceived pressure to breastfeed, and a lack of adequate

44   and appropriate support. Theme two, 'one way or no way', outlines the rules based approach to

45   breastfeeding adopted by some health professionals, and how women avoided BPS due to

46   anticipating a similar approach. Theme three, 'it must be me' concerns how a lack of embodied

47   insights could lead to 'breastfeeding failure' identities. A background of dichotomised language,

48   pressure, and moral judgement, combined with the organisation of postnatal care and the model of

49   breastfeeding adopted by health professionals, may prevent women's access to BPS. A socio-cultural

50   model of breastfeeding support providing clear messages regarding the value and purpose of BPS

51   should be adopted.

52

53   **Key words:** Breastfeeding; Peer support; Non-access; Qualitative; Grounded Theory.

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57

58   **Introduction**

59   Observational evidence suggests that poorer health outcomes for both mothers and babies are

60   linked to formula feeding when compared to breastfeeding (Ip *et al*. 2007). The *Global Strategy for*

61   *Infant and Young Child Feeding* (World Health Organisation (WHO) 2003) recommends that babies

62   are exclusively breastfed up to the first six months of life, with continued breastfeeding up to 'two

63   years and beyond'. However, no OECD country currently meets these recommendations

64   (Organisation for Economic Cooperation and Development [OECD] 2009). Increasing exclusive

65   breastfeeding rates in the first six months of life to at least 50% is one of the six global nutrition

66   targets for 2025 (WHO/UNICEF 2014). While socioeconomic variation in breastfeeding rates is well

67   reported (McAndrew *et al*. 2012), a lack of suitable support is identified as a key reason for

68   breastfeeding cessation (Schmied *et al*. 2010; Hoddinott *et al*. 2012). In the UK it is estimated that

69   moderate increases in breastfeeding could lead to a saving in treatment costs of seventeen million

70   pounds per annum in relation to four acute diseases in infants; gastrointestinal disease, respiratory

71   disease, otitis media and necrotising enterocolitis (UNICEF 2012a).

72   Breastfeeding peer support (BPS) is advocated as a tool to increase breastfeeding rates (WHO 2003;

73   WHO/UNICEF 2014; DH 2004; NICE 2005, 2008). Peer support may be defined as:

74   '*The provision of emotional, appraisal, and informational assistance by a created social*

75   *network member who possesses experiential knowledge of a specific behaviour or stressor*

76   *and similar characteristics as the target population'* (Dennis 2003,p.329).

77   While qualitative research highlights the value of peer support in breastfeeding continuation and

78   maternal well-being (Thomson *et al*. 2012), trials of breastfeeding peer support (BPS) interventions

79   in the UK and other developed countries have been found to be ineffective in increasing

80   breastfeeding rates (Jolly *et al*. 2012). However, authors such as Hoddinott *et al*. (2011) and

81   Thomson & Trickey (2013) call attention, amongst other issues, to the heterogeneous and

82   reductionist trial designs, implementation difficulties including the influence of contextual factors,

83   the lack of underpinning theory concerning possible mechanisms of efficacy, and a lack of high

84   quality evidence.

85   In a recent UK national survey, 69% of breastfeeding women were given contact details of voluntary

86   organisations or community groups that support women with breastfeeding (e.g. BPS provision) at

87   discharge from the maternity hospital. However, only approximately a quarter sought support from

88   these sources (McAndrew *et al*. 2012). Several UK and international trials also note that access to

89   BPS is problematic (Jolly *et al*. 2012). For example a UK trial conducted by Graffy *et al.* (2004)

90   reported that 38% of women in their intervention group received no post-natal BPS. Non-access to

91   support was also reported in almost half of the intervention group in a trial of BPS for young

92   mothers in the US undertaken by Di Meglio *et al.* (2010). These insights thereby add to the

93   difficulties in interpreting existing intervention data as it impossible to determine whether a lack of

94   effect was due to the intervention, or a lack of uptake. This therefore poses problems in determining

95   the relative importance of non-access in relation to the efficacy of BPS interventions.

96

97   There is some evidence suggesting that the quality of the peer-professional relationship is important

98   in facilitating access to BPS. Raine (2003) attributed variability in referral rates by health

99   professionals to BPS to an initial lack of acceptance of peer support provision, although it was

100   anticipated that this reluctance would decrease as the intervention became embedded. However

101   others have noted that some health professionals did not want lay people involved in the care of

102   women (Muirhead *et al*., 2006), particularly if there were concerns of women feeling pressurised to

103   breastfeed (Thomson *et al.*, 2015). Furthermore, while Bronner *et al*. (2001) considered that good

104   relationships directly facilitated effective peer support via increased access, Kaunonen *et al*. (2012)

105   suggests that these relationships require ongoing work and investment.

106

107   To date, there are no published studies that specifically focus on the reasons why breastfeeding

108   women do not access BPS. Insights into this issue are important as many women stop breastfeeding

109   before they intended, and a lack of support is reported to be a key reason for early cessation. BPS

110   interventions are part of current strategies for increasing breastfeeding rates via increased support,

111   yet there is evidence of non-engagement within trial data. Exploration of these issues from a

112   professional-peer-woman perspective would help to identify the difficulties and barriers faced, as

113   well as insights into how breastfeeding support should be provided. The aim of this study was to

114   elicit the reasons for non-access amongst women, health professionals and peer supporters within a

115   specific geographical region in South-West England. Key factors that might serve to facilitate

116   increased access to BPS, as identified by study participants, are considered in the discussion.

117

118   **Methods**

119

120   **Study context**

121   Cornwall ranks 143rd out of 326 local authorities in terms of overall socio-economic deprivation

122   (Cornwall Council 2015). Whilst breastfeeding initiation in Cornwall in 2012/2013 was 79.8%, some

123   5.9 points above the English national average (73.9%), continuation rates in Cornwall at 6-8 weeks

124 were 46.7%, 0.5% below the English average of 47.2% (ChiMat 2015). Full UNICEF Baby Friendly
125 status has been in place for all Hospital, Community and Children's Centre services in Cornwall since
126 2012 (UNICEF Baby Friendly 2012b). BPS training, developed by County Infant Feeding Co-ordinators,
127 is delivered by not-for-profit social enterprise 'Real Baby Milk'. BPS services consist of weekly drop-in
128 groups (n=33) at Children's Centres, run and 'owned' by peer supporters (~n=120 at the time of the
129 study). This BPS provision is the only additional breastfeeding support available to women aside
130 from standard maternity and health visiting care, or contact with national voluntary help lines.
131 Maternity care at the time of the study consisted of women receiving a phone call from a midwife on
132 day one or the day after discharge, when the contact venue for face-to-face contact could be
133 discussed and agreed. On days five and ten face-to-face contact would take place, usually in a clinic
134 environment. Some areas also had maternity support assistants who could provide home visits for
135 additional feeding support. Health visiting care comprised a pre-birth visit, one home visit between
136 days 11 and 14, another between weeks 12 and 20, and access to a health visiting team member via
137 the phone or in a clinic environment. The BPS service estimates that around 70% of women who
138 initiate breastfeeding in Cornwall do not access BPS.

139

140 **Study design**

141 Grounded Theory (GT) was developed in the 1960s as a way of developing theory about social
142 processes. As an emergent method it is regarded as a useful approach when studying under-
143 researched areas (Charmaz 2008). GT's positivist roots of assumed researcher objectivity and the
144 'discovery' of social processes are acknowledged by Charmaz (2006), who argues that '*we can use*
145 *basic grounded theory guidelines with twenty-first century methodological assumptions and*
146 *approaches'* (p9). Charmaz's interpretivist theoretical perspective informs her constructionist GT
147 methodology. This method is focused on the interactions between the researcher and participants
148 and how theories are constructed from and between these interactions. The resulting theories are
149 offered not as exact versions of the worlds in question, but rather co-constructed interpretations
150 (Charmaz 2006). Charmaz emphasises the importance of staying grounded in data when creating
151 interpretations, and suggests broad guidelines, rather than strict rules and procedures.

152

153 Reflexivity was central to this study. The first author has breastfed three children and been involved
154 with BPS provision in the study area for ten years. The likely impact of personal experience was
155 recognised and participants were recruited from areas where she was unknown. A reflective
156 interview designed to identify prior values and assumptions was undertaken with the second author

157 before data collection began. A reflexive journal was also kept throughout, and ideas were shared
158 and discussed between the authors.

159

160 **Ethics**

161 Full ethical permission was obtained via the National Research Ethics Service (NRES) system of
162 proportional review (REC reference 13/LO/0775), with subsequent permission gained from Cornwall
163 NHS Research and Development Department (reference 2013.CFT.08), Cornwall Council ethics
164 committee and the Built Environment, Sport and Health (BuSH) ethics subcommittee at the
165 University of Central Lancashire (reference BuSH180).

166

167 **Recruitment and data collection**
168 Purposive and theoretical sampling methods were used to recruit three groups of participants;
169 mothers who had initiated breastfeeding and continued for five days or longer, and had not
170 accessed BPS (n=13); health professionals who signpost mothers to BPS (n=6); and peer supporters
171 who provide BPS (n=14). Mothers were given study information sheets and reply slips and recruited
172 either by health visitors (n=4), or at Children's Centre baby groups (n=9). Peer supporters and health
173 professionals were recruited via covering letters and information sheets sent to their work
174 addresses.

175

176 In order to engage with broad theoretical insights from the beginning, initial sampling aimed to
177 recruit participants with a wide range of backgrounds, ages, and breastfeeding histories (see Table
178 1). Interview schedules were adhered to throughout. However, during later interviews, particular
179 areas of theoretical interest formed a focus. For example, health professional interactions were
180 explored in greater depth with participants recruited later in the study, in order to illuminate
181 theoretical ideas about the manner by which health professionals discuss breastfeeding. Rather than
182 seeking population representativeness, the sampling strategy aimed to exhaust theoretical ideas
183 associated with non-access.

184

185 All participants were offered the opportunity to have the main themes of the study sent to them,
186 and to take part in a second 'member check' interview. Following analysis, the main themes were
187 sent to all participants who had requested them. Seven participants (two women, four peer

188 supporters and one health professional) opted to take part in a second telephone interview and
189 were in broad agreement with the main themes identified.

190

191 The socio-demographic profile of women (Table 1), and the job roles and interview types for
192 participating health professionals and peer supporters (Table 2), are presented below.

193

194 <insert Tables 1 and 2>

195

196 Two semi-structured interview schedules were developed, one for service users, and one for health
197 professionals and peer supporters. Both schedules covered participants' awareness and perceptions
198 of BPS, barriers to and facilitators of access to the service, and recommendations for service
199 development. For women, their infant feeding experiences and support needs were also explored,
200 while health professionals and peer supporters discussed women's referral to the service. All
201 participants were asked to sign a consent form (face-to-face interviews) or provide verbal consent
202 (telephone interviews) prior to data collection.

203

204 Data collection and analysis were undertaken concurrently, with field notes written immediately
205 following interviews. All interviews took between 25-90 minutes to complete, were audio recorded,
206 transcribed verbatim, and uploaded onto qualitative data analysis software (MAXQDA) for analysis
207 purposes.

208

209 **Data analysis**
210 Analysis was initiated as soon as data collection commenced using Charmaz's broad analytical
211 guidelines. First, transcripts were read multiple times and open coding was used to categorise the
212 text. Second, constant comparisons were undertaken. Comparisons were drawn between codes or
213 events in the data, and written memos of such were recorded. These comparisons and subsequent
214 questioning of the data were undertaken on an iterative basis until theoretical ideas emerged. Third,
215 focussed coding took place when prominent codes that occurred frequently or seemed important
216 were identified and compared against other sections of data (Charmaz 2006). The codes were then
217 grouped to form categories. Links between tentative categories were made, and diagrams were
218 drawn to represent these links. Discussion of theoretical ideas and diagrams were shared with the
219 second author until consensual validation was obtained. During this process one category emerged
220 that held multiple links to others and acted as a reference point for other categories. This

221 subsequently became the core category. Recruitment and concurrent analysis continued until no
222 new theoretical ideas arose.

223

224 **Findings**

225 Overall one core category and three key themes were identified in the data set. The core category
226 concerned **pressure and judgement within a dichotomous landscape of infant feeding**. Pressure
227 and judgement operated as the social, personal, and cultural backdrop to many women's infant
228 feeding decisions and experiences. Women sensed pressure (from professionals, media, and social
229 networks) to breastfeed, and moral judgement around their feeding decisions. It was felt that
230 women were made to feel *'guilty and bad'* if they chose not to breastfeed and felt like a *'failure'* if
231 breastfeeding difficulties arose. Dichotomous discourses and practices were also prominent across
232 all the themes that explained non-access. Discourses around infant feeding frequently employed
233 dichotomised language. For example *'can'/'can't'*, *'success'/'failure'*, *'you either breastfed or bottle-*
234 *feed'*. Dichotomies in terms of how support was offered and provided were also apparent. Theme
235 one, 'place and space of support,' relates to the tension in the early postnatal period between
236 promoting breastfeeding and a lack of appropriate forms of support. Theme two, 'one way or no
237 way,' relates to the sense of there being only one correct way to breastfeed. A 'rules-based' model
238 of breastfeeding support was employed by some health professionals, and refers to the mechanistic
239 manner by which breasts and breastfeeding were often constructed. The final theme, 'it must be
240 me', concerns how health professionals and women's lack of insight into the value and purpose of
241 embodied breastfeeding knowledge can lead to non-access, and to women forming 'breastfeeding
242 failure' identities. It is important to reflect that, while the aim of this study was to explore reasons
243 for non-access to BPS among breastfeeding women, this study also highlighted operational and
244 practice-based issues as to why women discontinue breastfeeding early, thereby rendering BPS an
245 unviable option. These issues are now discussed in-depth, contextualised by participant quotes.

246

247 **Theme one: Place and space of support**

248 This theme illustrates that while some women felt pressurised to breastfeed their infants, the
249 contrasting realities of inadequate or inappropriate early support may lead to it being *'too late to*
250 *support'*, and to early breastfeeding discontinuation. *'It's not what you need'* explains the
251 inappropriateness of the group nature of BPS during the early post natal period.

252 **Too late to support**

253 Despite the 'breast is best' rhetoric, some women reported minimal breastfeeding support in the
254 hospital and that postnatal contact came *'too late'.* As reflected in the wider literature (e.g. Graffy *et*
255 *al*. 2005; Hoddinott *et al*. 2012), participants considered that practical help *'earlier on'* was crucial in
256 order for 'successful' breastfeeding to be established:

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

260 The lack of early support directly impacted on access to BPS due to many women discontinuing
261 breastfeeding before they felt able to get *'out and about'*:

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

265 **'It's not what you need'**

266 During the postnatal period women were often perceived to be '*vulnerable*' due to recovering from
267 the birth and coping with the demands of caring for a newborn baby:

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

270 The prospect of accessing a group at this sensitive time, and when they had '*no confidence already*'
271 to breastfeed was described as *'nerve wracking'*. General social anxiety about *'going to groups'* and
272 *'walking in through the door'* also formed an important barrier. While many women identified their
273 need for support, and were aware of its availability, the group environment was often not
274 considered appropriate:

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

280

281 Peer supporter and health professional participants mentioned practical barriers to access such as
282 group timings and transportation issues more frequently than women. These issues however, were

283 perceived to be 'add on' barriers and were often discussed after more central concerns had been
284 expressed.

285

286 **Theme two: One way or no way**

287 This theme refers to dichotomies in relation to how support was provided and subsequently
288 internalised by women. *'These are the rules'* outlines how some health professionals employed
289 'rules' in explaining how breastfeeding ought to be performed, giving the sense of there being only
290 one correct way to breastfeed. *'If it works, it works'*, relates to some women's mechanistic
291 constructions of breasts and breastfeeding. The *'telling and advising'* communication style of
292 breastfeeding support delivered by some health professionals, and the detrimental impact this had
293 on women's perceptions of and subsequent access to BPS, are also described.

294

295 **'These are the rules'**

296 Peer supporters and women reported that many health professionals employed a functional,
297 theoretical paradigm of infant feeding whereby breastfeeding correctly was a matter of following
298 'the rules' and adhering to guidelines. Women and peer supporter participants recalled 'rules' in
299 relation to a wide range of breastfeeding related practices (e.g. the necessity for exclusive
300 breastfeeding, demand feeding, breastfeeding rather than expressing and breastfeeding until six
301 months of age). Some women perceived that for these health professionals there was only one right
302 way to breastfeed:

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

306 There was no notion that what might be 'right' for one mother might not be 'right' for another, or
307 that 'the answer' might need to be personalised or adapted. This led women to place themselves
308 either as rule 'followers', or rule 'breakers'. While a number of women described similar
309 experiences, Dana's case formed an illuminating example. Dana's baby wanted to feed for *'three*
310 *hours at a time'.* She wondered whether he was *'feeding for the whole time he's on there'*, and how
311 to manage this whilst simultaneously caring for her two year old child. Although her health
312 professional did not observe a breastfeed, discuss active feeding, or follow-up at a later point, Dana
313 was advised to *'tell'* her body to *'produce more milk'* by letting her baby feed for as long as he

314   wanted. The rule communicated was *'if he's still latched on properly and it doesn't hurt, then let*

315   *him'*. This advice relied wholly on physiological knowledge, with no discussion, adaptation or

316   application to the social situation at hand. Dana could not continue breastfeeding in line with this

317   advice and decided to break the 'exclusivity' rule and give her baby formula. She explained that, in

318   the end *'you just give up'* and follow '*what I think is best* [gestures towards heart]'.

319   **'If it works, it works'**

320   Several women constructed their bodies and breasts as machines and accepted that with

321   breastfeeding, '*if it works, it works'*. Like a machine, the women's descriptions appeared to suggest

322   that when the 'on' switch is pressed, either success or failure ensues. In this way breastfeeding was

323   not seen in terms of a continuum, or a process, rather a dichotomy: *'Some people can do it, some*

324   *people can't do it, some babies take to it, some babies don't'* (Esme, mother). Some peer supporters

325   and health professionals also recognised this construction:

326   *'I feel like it's you try and you fail, or you try and you succeed and it's easy, there's no kind of*

327   *middle ground.'* (Laura, peer supporter)

328   Some women discussed antenatal education in terms of how breastfeeding was presented

329   theoretically, with its emphasis on functionality. Like the women's mechanistic constructions of

330   breasts and breastfeeding, on occasion this could sound like a mechanical sequence culminating in

331   milk entering the baby:

332   *'They show you the theory of you know how it should happen, um, you know, you hold your*

333   *baby like this and they do this, and that and this happens and,*[...] *so it was very, I don't, I*

334   *don't know, it's very, um, text book.'* (Esme, mother)

335   Breastfeeding was constructed to be about the body, often *'portrayed to be really simple to do*' and

336   without *'the grit'* of reality being addressed.

337   **'Telling and advising': Health professional's communication style**

338   Women frequently recounted how professionals would 'tell' and 'advise' how to perform and adopt

339   the functional and theoretically informed rules of breastfeeding. This was explained by Belinda:

340   '*It was more, 'you've got to do this' and 'you've got to' the words used* [...] *weren't like*

341   *helping, it was more telling me what to do.'* (Belinda, mother)

342   One peer supporter reflected:

343   *'You spend a lot of your early mothering experiences being told what to do by lots of*

344   *different people.'* (Pippa, peer supporter)

345   For a number of women in this study, their *'failure'* to follow the 'right way' often led them to *'give*

346   *up hope'* and to discontinue breastfeeding. For other mothers, it was the anticipation of a similar

347   approach from the peer supporters, together with concerns of judgement due to non-compliance

348   with 'the rules', i.e. mixed feeding, that prohibited their access to BPS:

349

350   *'I felt like um every professional I'd spoken to, the nurse, midwife, doctor, GP, anybody at the*

351   *hospital, they were very "these are the rules" you know "you should breastfeed until he's six*

352   *months old, exclusively you shouldn't start food till then, and breastfeeding's best and"* [...]

353   *the people I met were very, like pushy to do things like as the book said, and I was a little bit*

354   *afraid of you know, afraid's not the right word, but, of being judged, if I couldn't do it,* [...]*in*

355   *my mind I was afraid that they* [peer supporters] *were going to judge me and make me feel*

356   *bad for perhaps finding it difficult and not being able to do it.'* (Esme, mother)

357

358   **Theme three: 'It must be me'**

359   This theme concerns women's experiences of embodied and theoretical knowledge of

360   breastfeeding. The seeming lack of awareness of the possible value of experiential as compared to

361   theoretical knowledge by health professionals is outlined in their *'sales pitch'* of BPS. For women, the

362   divergence between their theoretical and embodied breastfeeding knowledge, and lack of vicarious

363   insights could lead to feeling that *'there's something wrong with me'*, and subsequent non-access to

364   BPS due to feeling *'not like everyone else'* at the breastfeeding groups.

365   **'The sales pitch'**

366   Congruent with a techno-medical construction of breastfeeding, many of the health professional

367   participants did not appear to value breastfeeding groups as somewhere where women could learn

368   about, and benefit from other women's varied experiences. The messages recounted in health

369   professional's 'sales pitches' were reflected in a quote provided by a Community Nursery Nurse:

370   *'I just sort of say 'are you aware of the group?' and direct them to the page in the book which*

371   *has got the information about groups, let them know actually how to get there if they need*

372   *to and that's about it.'* (Clare, Community Nursery Nurse)

373   Peer supporters were described by health professionals as people to go to for *'advice and help'* if

374   breastfeeding *'problems'* were experienced, and when health professionals were unavailable. On

375   one occasion a health professional who had been invited to attend a breastfeeding group reported:

376   *'They've* [peer supporters] *had breastfeeding training, it's not that I'm going to be doing any*

377   *different, to what the peer supporters would.'* (Phillipa, Health visitor)

378   Phillipa assumed it was only the theoretical knowledge imparted via training that peer supporters

379   would use in their supportive interactions with women. Additionally, several health professionals

380   seemed unclear about the purpose of peer support, and explained that women would be directed to

381   groups *'for* [their] *support'*, and how peer supporters were *'supporting other mothers'* in a very

382   general way. Mothers described how health professionals did not explain *'how it* [peer support]

383   *worked'*. When Chrissy was asked about the main reasons for non-access, she suggested:

384   *'The fact that we're not really told what it is, or what the point of it is, or how it differs to*

385   *other baby groups, really I think, they could, ought to a tell pregnant women a little bit more*

386   *about it.'* (Chrissy, mother)

387   **'There's something wrong with me'**

388   As reflected in previous research (e.g. Thomson & Dykes, 2011), many women referred to the

389   contrast between their theoretical knowledge of breastfeeding and the *'shock'* of *'actually doing it'*.

390   One mother described how she:

391   *'Naively thought before I had him that it would all come naturally, and they know, babies*

392   *should know what they're doing and, it should just happen.'* (Esme)

393   Several women also revealed their lack of vicarious insights into other women's infant feeding

394   experiences; *'[I] didn't really have a lot of experience of seeing anybody do it* [breastfeed] *before'*.

395   Women and peer supporters spoke of how *'if* they [babies] *don't take to it straight away'* it became

396   easy to assume that *'you're not doing it right',* or even that *'there's something wrong with me',* when

397   the experience did not match their expectations. The self-blame in women's accounts is evident in

398   Heidi's depreciating remarks about the 'quality' of her breast milk:

399   '[My] *milk wasn't thick enough* [...] *when I expressed it, it was really watery, runny,*[...] *lots*

400   *there but just not thick enough'*. (Heidi, mother)

401   Heidi knew *'what the problem is'*, i.e. the seemingly inadequate quality of her milk, and assumed

402   that nothing could be done. Indeed, Heidi, like other mothers in this study, had no knowledge of

403 cluster feeding, growth spurts, different breastfeeding trajectories, or other women's varied
404 experiences of breastfeeding.

405

406 **Not like everyone else**
407 Women's mechanistic impressions of infant feeding, reinforced by those of health professionals, and
408 a lack of embodied insights, often resulted in the perception that breastfeeding was '*easy*' for peer
409 supporters and for those mothers who accessed BPS groups:

410

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

414

415 The conflict between women's self-perceptions of being '*a failure'* doing '*a crappy job'* and the
416 imagined '*successful'* breast-feeders who accessed the groups was a key barrier to access: '*I'm not*
417 *one of those* [successful breast-feeders]*, so how can I go into that* [group]*?'* In this way breastfeeding
418 was not perceived to be a skill that is gradually learned. This reflection was echoed by some of the
419 peer supporters who could empathise with the women's reticence in entering an environment
420 where '*everybody else is doing it'*.

421

422 **Discussion**
423 In this study we report on a dichotomised landscape of infant feeding that worked in several ways to
424 impact upon access to BPS. Mechanistic constructions of breastfeeding and a rules based approach
425 contributed towards women polarising themselves as those who could, or could not breastfeed, and
426 did, or did not comply with the 'rules' for 'successful' breastfeeding. Women who did not access BPS,
427 often lacked vicarious insights and were surprised at the disparity between their expectations and
428 embodied experiences. They struggled to follow 'the rules' and perceived themselves to be 'failing';
429 thereby identifying themselves as a mother who 'can't' breastfeed. Non-identity with peer
430 supporters and other breastfeeding women at groups arose as women assumed that group
431 attendees were successful breast-feeders who had complied with 'the rules'. As the public group BPS
432 environment contrasted with the personal, internalised nature of women's emerging self-identities,
433 this made it an inappropriate environment for support.

434   To our knowledge, this is the first study to specifically explore why women who initiate
435   breastfeeding do not engage with BPS provision. As an original interpretation, this study has utilised
436   a theoretically informed method to generate hypotheses for non-engagement that are relevant to
437   policy and practice. Incorporation of mothers, health professionals and peer supporters perspectives
438   is a strength of the study, enabling consideration of diverse viewpoints. Women were recruited
439   across a broad range of ages and backgrounds. Rigour was considered from the outset and sought
440   through reflective practices, member checking and consensual validation between the authors.
441   Overall, however, the data set was limited, and drawn from a restricted geographical area in which
442   only one model of BPS was utilised. The findings interpret and give voice to the experiences and
443   views of the participants at a particular time, place and context, hence may not be generalizable to
444   others. Further qualitative research in other areas where differing models of BPS are in use could
445   enable greater understanding of common or divergent influences.

446   Women in this study accepted moral responsibility for infant feeding, experienced pressure to
447   breastfeed, and anticipated judgement of their infant feeding decisions. These findings are similar to
448   those of Larsen *et al*. (2008) and Murphy (2003). The theoretical ideas of Michel Foucault (1991)
449   which Larson and Murphy employ to explain their findings, can also help to interpret the insights
450   generated in the current study. In the eighteenth century the family became an important area of
451   medicalization, meaning that moral responsibility for the welfare of children was imposed upon
452   women (Foucault 1991). By means of subtle pressure and multiple small 'technologies' (for example
453   breastfeeding 'rules'), the state, acting via 'disciplines' (for example the 'discipline' of medicine)
454   simultaneously increased the 'utility, docility and obedience' of the people' (Foucault 1995, p137-8).
455   'Disciplines' operate through sciences that appear to be 'the foundation for society' (Foucault 1995,
456   p223), and through them standards of normality are established (Foucault 1995). Expert discourses
457   which suggest that one course of action is healthy, and thereby ought to be undertaken, and other
458   actions are unhealthy, and thus ought not to be undertaken, form an understated form of control
459   (Murphy 2003). Everyone in society knows what ought to be done, and subtly, people become
460   subjectified, self-regulating citizens (Murphy 2003).

461   Women in this study adopted a mechanistic can / can't conception of breastfeeding similar to that
462   described by Dykes (2005a). The dichotomised discourses in infant feeding were also similar to those
463   recounted in relation to women's interactions with health professionals in Hoddinott *et al's* (2012)
464   study. In addition to leading women towards a sense of 'failure', this language, rather than
465   suggesting a continuum of breastfeeding experiences, drew women towards polarisation and to
466   contrast themselves against those who are 'successful' and for whom breastfeeding is 'easy' (i.e.

467 those who do attend group provision). Avoidance of those assumed to be successful can be viewed

468 as behaviour associated with self-regulation. Foucault (1991) explains how in a society where 'the

469 disciplines' (e.g. medicine) are dominant, 'value giving' normalizing judgements impose standards

470 which everyone strives to achieve (p195). By avoiding others assumed to be reaching the prescribed

471 'normal' (i.e. who follow the rules and are successful breast-feeders), participants in the current

472 study, and similar to the findings of Murphy's (2003) study, acquiesced to the validity of the

473 dominant discourse and internalised themselves as breastfeeding failures. Many participants in the

474 current study referred to the value of 'personal bridges' for peer support access, such as knowing

475 the peer supporter in attendance or arriving with a friend, as highlighted by others (Hoddinott *et al.*

476 2006; Thomson *et al.* 2012). These 'bridges' were considered to have the potential to mitigate

477 negative feelings associated with differences in perceived identity and should form part of standard

478 care.

479

480 The functional-theoretical 'disciplines' based model of breastfeeding utilised by health professionals

481 in the current study can be seen in terms of Foucault (1991)'s subtle control. The technical-medical

482 knowledge of such state agents of medicalization is privileged, and acts to exert power over women

483 (Murphy 2003). Echoing the findings of Burns *et al.* (2010) and Murphy (2003), women in the current

484 study talked about health professionals telling them what to do, and that for health professionals

485 there was one right way to breastfeed. Burns *et al.* (2010) and Bartlett (2002) recognise a shift in

486 authority regarding breastfeeding in western societies from women's embodied knowledge, to

487 expert knowledge. In the current study it appeared that only theoretical knowledge of breastfeeding

488 was known about. Problems were often interpreted in strictly functional-theoretical terms, and

489 without the practicalities of everyday life being considered. Previous research has identified how

490 women's anticipation of 'being told' what to do formed a barrier to their accessing health

491 professional support (Hoddinott & Pill 1999). While Hoddinott *et al.* (2006) report that some women

492 were 'put off' peer support due to concerns peer supporters might be 'snooty' (p144), in our study

493 women anticipated that peer supporters would adopt the same mechanistic, functional approach

494 they had experienced from health professionals. Our findings also support those of Dykes (2006a) in

495 that women appear to value a manner and model of breastfeeding support that moves away from

496 the medical model towards a more socio-cultural, woman centred model of infant feeding.

497

498   Coupled with the privileging of medical knowledge, and forming a further reason for non-access was

499   the lack of clear messages about the purpose or value of peer support, and how it might differ from

500   health professional support. While authors such as Raine (2003) and Muirhead *et al.* (2006)

501   identified variability and reticence among health professionals when referring women into BPS

502   services, a lack of clarity regarding how BPS might work has not previously been described as a

503   reason for non-access. In the current study health professionals rarely mentioned experiential

504   knowledge as a reason why peer support may be valuable. These insights thereby indicate that when

505   only theoretical knowledge concerned with function is legitimised, experiential knowledge has the

506   potential to be rendered irrelevant. In the current study the BPS service did not have a clear

507   underpinning theoretical base which health professionals understood and could articulate. This

508   finding supports those of Thomson & Trickey (2013) who highlight a lack of underpinning theory

509   regarding peer support projects which makes the interpretation of trial results difficult. In the

510   current study the lack of underpinning theory impacted directly on the practical functioning of the

511   BPS intervention, hence future exploration of this issue among stakeholders would prove valuable.

512

513   The finding that women need practical help in the early postnatal period is supported by a wide

514   body of research (e.g. Graffy *et al.* 2005; Hoddinott *et al.* 2012; Schmied *et al.* (2010); Thomson &

515   Dykes 2011; Thomson *et al.* 2012; Thomson *et al.* 2015), as is the variable quality of support

516   provided by health professionals (e.g. Dykes 2005b; Hoddinott *et al.* 2012; McInness & Chalmers

517   2008; Thomson *et al.* 2015). Participants in this study, and as reported by Dykes (2006b) emphasised

518   the importance of place and space in relation to breastfeeding as a public or private activity. One of

519   the key facilitators of access to BPS identified in the current study was that it be delivered by

520   telephone or face to face in the women's own home. Emotional and physical vulnerability meant

521   that women want support to come to them. The finding that a group environment was not

522   appropriate in the early postnatal period also supports the findings of Hoddinott *et al.* (2009), and

523   emphasises the need, as reported in the NICE guidelines, of early and proactive support (NICE 2008).

524

525   The group environment can place breastfeeding in the sphere of the community, society, and

526   culture, and can value the embodied knowledge of women. This positioning contrasts with the way

527   many study participants situated breastfeeding, and the medicalization discourse that can explain

528   many of the findings of this study. Hoddinott *et al.* (2012) highlight 'pivotal points' of support that

529   arise from dissonance between idealism and reality, and suggest a family centred discursive

530   approach to anticipating them. Discussion between women and health professionals about the
531   function of peer support and perceived barriers to access, could facilitate deeper discussion
532   concerning expectations and realities of breastfeeding, family context and support. In this way
533   although access to peer support can represent the confluence of two contrasting ways of thinking
534   about the very nature of breastfeeding (i.e breastfeeding as a socio-cultural practice, or
535   breastfeeding as a technical-medical bodily function), it also represents an opportunity to explore
536   this in the context of women's personal circumstances.

537

538   **Conclusions**

539   Perceptions of pressure and judgement experienced within a dichotomised landscape of infant
540   feeding prevented breastfeeding women's access to peer support. Dichotomies in language, the
541   structure of services, and the manner of support were reported; with these dichotomies highlighting
542   how the medicalization of infant feeding and the hegemony of technical and medical knowledge
543   undermined and de-valued embodied insights, leading to early breastfeeding cessation, and
544   castigations of failure. Mothers and health professionals' lacked insight into the value of other
545   women's embodied knowledge. Non-identity with peer supporters and attending women arose as
546   women assumed attendees had followed 'the rules' and were 'successful' breast-feeders. This
547   meant that BPS was not a viable option for many women. While postnatal feeding support needs to
548   be re-evaluated to ensure it is acceptable and appropriate for women, these findings emphasise the
549   need for a socio-cultural model of breastfeeding, providing clear messages regarding the value and
550   purpose of peer support.

551

552

Key messages:

Reasons for breastfeeding women's non-access to breastfeeding peer support have not been

previously explored.

Pressure, moral judgment, and dichotomous language and practices impacted on breastfeeding

women's access to peer support provision.

Mechanistic constructions of breastfeeding, and the rules based approach adopted by some

health professionals, led women to polarize themselves as either those who could, or could not

breastfeed.

A socio-cultural model of breastfeeding that provides clear messages regarding the value and

purpose of peer support should be adopted.

References:

Bartlett A. (2002) Breastfeeding as headwork: Corporeal feminism and meanings for breastfeeding.

Women's Studies International Forum **25**, 373-382.

Bronner Y., Barber T., Vogelhut J. & Resnik A. K. (2001) Breastfeeding peer counseling: Results from

the national WIC survey. *Journal of Human Lactation* **17(**2), 119-125.

573   Burns E., Schmied V., Sheehan A. & Fenwick J. (2010) A meta-ethnographic synthesis of women's

574   experiences of breastfeeding. *Maternal & Child Nutrition* **6**, 201-219.

575   Charmaz K. (2006) *Constructing grounded theory: A practical guide through qualitative analysis.*

576   London: Sage.

577   Charmaz K. (2008) Grounded Theory as an Emergent method. In Hesse-Biber S. N. & Leavy P. (eds.).

578   *Handbook of Emergent methods* New York: The Guilford Press.

579   ChiMat child health profiles (2015) [Online] Available from:

580   http://atlas.chimat.org.uk/IAS/dataviews/breastfeedingprofile [Accessed on: 23.10.15]

581   Cornwall Council (2015) *Indices of multiple deprivation* [Online] Available from:

582   http://www.cornwall.gov.uk/council-and-democracy/data-and-research/data-by-

583   topic/deprivation/indices-of-multiple-deprivation/ [Accessed on: 23.10.15]

584   Dennis C. (2003) Peer support within a health care context: A concept analysis. *International Journal*

585   *of Nursing Studies* **40**(3), 321-332.

586   Department of Health. (2004) *National service framework for children, young people and maternity*

587   *services*. DH: London.

588   Di Meglio G., McDermott M. P. & Klein J. D. (2010) A randomized controlled trial of telephone peer

589   support's influence on breastfeeding duration in adolescent mothers. *Breastfeeding Medicine* **5**,

590   41-47.

591   Dykes F. (2005b) A critical ethnographic study of encounters between midwives and breastfeeding

592   women in postnatal wards in England. *Midwifery* **21***,* 241-252.

593   Dykes F. (2005a) 'Supply' and 'Demand': Breastfeeding as Labour. *Social Science & Medicine* **60**,

594   2283-2293.

595 Dykes F. (2006b) Resisting the gaze: The subversive nature of breastfeeding. In M. Kirkham (ed.). *The*

596   *dirty side of women's health.* London: Routledge.

597 Dykes F. (2006a) The education of health practitioners supporting breastfeeding women: time for

598   critical reflection. *Maternal and Child Nutrition* **2**, 204-216.

599 Foucault M. (1995) *Discipline and Punish The Birth of the Prison.* New York: Random House Inc.

600 Foucault M. (1991) The politics of health in the eighteenth century. In Rabinow P (ed.). *The Foucault*

601   *reader: An introduction to Foucault's thought*. London: Penguin.

602 Graffy J., Eldridge S., Taylor J. & Williams A. (2004) Randomized controlled trial of support from

603   volunteer counselors for mothers considering breast feeding. *BMJ: British Medical Journal*

604   *(International Edition)* **328**(7430), 26-29.

605 Graffy J. & Taylor J. (2005) What information, advice, and support do women want with

606   breastfeeding? *Birth* **32**(3), 179-186.

607 Hoddinott P., Britten J. & Pill R. (2009) Why do interventions work in some places and not others: A

608   breastfeeding support group trial. *Social Science & Medicine* **70**(5), 769-778.

609 Hoddinott P., Chalmers M. & Pill R. (2006) One-to-one or group based peer support for

610   breastfeeding? Womens' perceptions of a breastfeeding peer coaching intervention. *Birth-*

611   *Issues in Perinatal Care* **33**, 139-146.

612 Hoddinott P., Craig L. C. A., Britten J. & McInnes R. M. (2012) A serial qualitative interview study of

613   infant feeding experiences: Idealism meets realism. *BMJ Open* **2**(2), e000504-e000504.

614 Hoddinott P. & Pill R. (1999) Nobody actually tells you: A study of infant feeding. *British Journal of*

615   *Midwifery* **7**(9), 558-565.

616   Hoddinott P., Seyara R. & Marais D. (2011) Global evidence synthesis and UK idiosyncrasy: Why have

617   recent UK trials had no significant effects on breastfeeding rates? *Maternal & Child Nutrition*

618   **7**(3), 221-227.

619   Ip S., Chung M., Raman G., Chew P., Magula N. & DeVine D. (2007) Breastfeeding and maternal and

620   infant health outcomes in developed countries. *Evidence Report/Technology Assessment* **(153),**

621   1-186.

622   Jolly K., Ingram L., Khan K. S., Deeks J. J., Freemantle N. & MacArthur C. (2012) Systematic review of

623   peer support for breastfeeding continuation: Metaregression analysis of the effect of setting,

624   intensity, and timing. *British Medical Journal* **344***(*1), d8287-d8287.

625   Kaunonen M., Hannula L. & Tarkka M. (2012) A systematic review of peer support interventions for

626   breastfeeding. *Journal of Clinical Nursing* **21**(14), 1943-1954.

627   Larsen J. S., Hall E. C. & Aagaard H. (2008) Shattered expectations: When mother's confidence in

628   breastfeeding is undermined- a metasynthesis. *Scandinavian Journal of Caring Sciences* **22**, 653-

629   661.

630   McAndrew F., Thompson J., Fellows L., Large A., Speed M. & Renfrew M. J. (2012) Infant feeding

631   survey 2010. *The Information Centre for Health and Social Care.* [Online] Available from:

632   .http://www.hscic.gov.uk/catalogue/PUB08694/Infant-Feeding-Survey-2010-Consolidated-

633   Report.pdf [Accessed on: 23.10.2015]

634   McInnes R. J. & Chambers J. A. (2008) Supporting breastfeeding mothers: Qualitative synthesis.

635   *Journal of Advanced Nursing* **62** (4), 407-427.

636   Muirhead P. E., Butcher G., Rankin J. & Munley A. (2006) The effect of a programme of organized

637   and supervised peer support on the initiation and duration of breastfeeding: A randomized

638   trial. *The British Journal of General Practice* **56**(524), 191-197.

639   Murphy E. (2003) Expertise and forms of knowledge in the government of families. *The Sociological*

640   *Review* **51**, 433-462.

641   National Institute for health and Clinical Excellence. (2008) *A peer support programme for women*

642   *who breastfeed: Commissioning guide*. NICE: London.

643   National Institute for health and Clinical Excellence. (2005) *The effectiveness of public health*

644   *interventions to promote the duration of breastfeeding: Systematic review*. NICE: London.

645   Organisation for Economic Cooperation and Development. (2009) *Breastfeeding Rates.* [Online]

646   Available from: http://www.oecd.org/els/family/43136964.pdf [Accessed: 23.10.2015]

647   Raine P. (2003) Promoting breast-feeding in a deprived area: The influence of a peer support

648   initiative. *Health and Social Care in the Community* **11**(6), 463-469.

649   Schmied V., Beake S., Sheehan A., McCourt C. & Dykes F. (2010) Women's perceptions and

650   experiences of breastfeeding support: A metasynthesis. *Birth* **38**(1), 49-60.

651   Thomson G., Balaam M-C. & Hymers K. (2015) Building social capital through breastfeeding peer

652   support: Insights from an evaluation Insights from an evaluation of a voluntary breastfeeding

653   peer support service in North-West England. *International Breastfeeding Journal,* **10**:15

654   Thomson G., Crossland N. & Dykes F. (2012) Giving me hope: Women's reflections on a

655   breastfeeding peer support service. *Maternal and Child Nutrition* **8**(3), 340-353.

656   Thomson G. & Dykes F. (2011) Women's sense of coherence related to their infant feeding

657   experiences. *Maternal & Child Nutrition* **7***,* 160-174.

658   Thomson G., Ebisch-Burton K., Flacking R. (2015) Shame if you do –shame if you don't: Women's

659   experiences of infant feeding. *Maternal & Child Nutrition* **11***,* 36-46.

660   Thomson G. & Trickey H. (2013) What works for breastfeeding peer support: Time to get real?

661   *European Medical Journal - Gynecology and Obstetrics* **1**, 15-22.

662   United Nations International Children's Emergency Fund. (2012a) *Preventing disease and saving*

663   *resources: The potential contribution of increasing breastfeeding rates in the UK.* London:

664   UNICEF.

665   United Nations International Children's Emergency Fund (2012b) *UNICEF baby friendly awards.*

666   [Online] Available from: http://www.unicef.org.uk/BabyFriendly/Awards/ [Accessed:

667   22.10.2015]

668   WHO/UNICEF (2014) *Global Nutrition Targets 2025: Breastfeeding policy brief.* [Online] 2014.

669   Available from:

670   http://www.who.int/nutrition/publications/globaltargets2025_policybrief_breastfeeding/en/

671   [Accessed: 21.10.2015]

672   World Health Organization (2003) *Global strategy for infant and young child feeding.* World Health

673   Organization: Geneva.

674

675

676

677