

Understanding how a diverse sample of
women experience infant feeding care from
UNICEF UK Baby Friendly Initiative Gold
accredited health services: A narrative inquiry.

by

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of Doctor of Philosophy at the University of Lancashire

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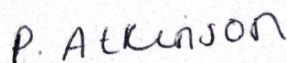
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Abstract

The UNICEF UK Baby Friendly Initiative (UNICEF UK BFI) is based on the Baby Friendly Hospital Initiative (BFHI), a global accreditation programme between UNICEF and the World Health Organization (WHO). Following a major review of the standards and to incorporate new evidence, UNICEF UK BFI introduced revised standards in 2012. These revised standards emphasise the importance of supporting and valuing the mother-baby relationship and promoting safe and informed infant feeding behaviours irrespective of infant feeding method. However, there is no research relating to how women experience the revised BFI standards over time and whether the woman's background influences the care she receives. Therefore, this qualitative longitudinal study using a narrative methodology was undertaken to understand how a diverse sample of women experience infant feeding care from UNICEF UK BFI Gold accredited maternity and community health services.

This research was underpinned by social constructionism and guided by public advisors and an advisory group comprising of a member of the UNICEF UK BFI team, local clinicians, and an academic. A systematic literature review and meta-ethnography which included fourteen papers, representing the views of 696 women, found that infant feeding communication which considers both the mother's context and individual circumstances is key to facilitate the equitable infant feeding communication women and birthing people want.

The empirical study was undertaken in an area in Northwest England where all services (maternity, health visiting and Children's Centres) providing infant feeding

care have been awarded BFI Gold accreditation. Ethics approval was obtained from the NHS Health Research Authority. Diaries and interviews were used to collect stories from a diverse sample of women (n=8), from 28 weeks gestation until around six months after birth.

After a full record of each participant's story had been obtained, re-storying identified sequence, content, and consequence for each story. From the women's stories, four meta-narratives were identified. These meta-narratives illustrate how interacting factors operating at the different levels of the Socio-Ecological Model (SEM) influenced women's infant feeding experiences and outcomes. When the women's stories were considered in relation to the revised UNICEF UK BFI standards, three constructs which enable positive infant feeding care were emphasised: a supportive health professional, personalised infant feeding care and an understanding of the woman's individual circumstances. To communicate the results of this research to organisations currently embedding the BFI standards a visual metaphor was created.

This research marks a unique contribution to knowledge by providing evidence of how a diverse sample of women experience infant feeding care from gold accredited UNICEF UK BFI organisations. Whilst the standards have been updated in 2024, this research suggests that incorporating a strengths-based approach which identifies the resources women have available to them could facilitate more equitable baby friendly care in the future. Further research is needed to confirm the findings and to explore how health professionals can provide more equitable and woman-centred care.

Presentations resulting from this thesis.

Peer reviewed conferences

Atkinson, P. (2022). What women want from infant feeding communication. Prioritising connections to understand mothers' contexts and circumstances. *Oral Presentation/Institute of Health Visiting Conference, 09/2022*

Atkinson, P., Crossland, N., Thomson, G., Byrom, A. (2023). A narrative inquiry approach to understand how women from different socioeconomic backgrounds experience the revised UNICEF UK Baby Friendly Initiative (BFI) standards. *Oral Presentation/ Nutrition and Nurture in Infancy and Childhood Conference (MAINN), 04/2023*

Atkinson, P., Crossland, N., Thomson, G., Feeley, C. (2023). A narrative inquiry approach to understand how women from different socioeconomic backgrounds experience the revised UNICEF UK Baby Friendly Initiative (BFI) standards. *Oral Presentation/ Institute of Health Visiting Conference, 09/2023*

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Glossary of terms and abbreviations

For the purposes of my research, I have used the term 'health care professional' to describe a health care worker who adheres to a code of conduct to safeguard the health and well-being of a specific population group. In the context of this study, this includes midwives and health visitors.

To reflect the biology and identity of those who participated in my research I have used sexed language in this thesis i.e., 'women,' and 'mother.' As argued by Gribble et al. (2022) pregnancy, birth and early motherhood are fundamentally sexed issues. However, Bartick et al. (2021) highlights the need to use gender-inclusive language in many settings to be inclusive of all people. Therefore, I have used the terms 'birthing people' and 'chest feed' in addition to 'women' and 'breast feed' in my systematic review to consider different identities.

The term 'infant feeding communication' has been used in this thesis to refer to the one-to-one communication that occurs between a healthcare professional and a mother where infant feeding messages are being conveyed either verbally or non-verbally.

I use the term 'commercial milk formula' rather than 'formula milk,' 'artificial milk' or 'breast milk substitute' in line with recommendations from the 2023 Lancet Series on

Breastfeeding¹ to reflect the artificial and ultra-processed nature of this milk. Additionally, the words 'artificial' and 'substitute' have negative and inaccurate connotations. For example, the word 'substitute' conveys the notion of equivalence. Whilst infant formulas attempt to mimic the nutritional composition of breastmilk, the production of an identical product to breastmilk is not possible (Martin et al., 2016). This is because breastmilk contains immune cells, stem cells and other bioactive molecules which cannot be replicated. Additionally, the composition of human breast milk is dynamic and changes over time (Martin et al., 2016).

I have used the term 'breastfeeding' to refer to women who feed their babies at the breast. Whilst Rasmussen et al. (2017) suggests that the term 'feeding at the breast' is a more accurate way of distinguishing the way an infant obtains breast milk, I wanted to use terminology that was both clear and comparable to terminology currently used in infant feeding research. However, like Rasmussen et al. (2017) I have used the term 'expressed breast milk' to describe when breast milk is removed from the breast by hand or pump before it is fed to an infant.

The term 'mixed fed' has been used to describe babies who are fed both human milk and commercial milk formula.

¹ The 2023 Lancet Series on Breastfeeding is a three-paper series which explores both the value of breastfeeding and the negative influence of commercial interests on health and human rights (Mialon, 2023).

I have used the term ‘the introduction of solid foods’ to refer to the process when an infant is given solid food in addition to milk feeds at around six months of age.

Whilst I have used the terms ‘story’ and ‘narrative’ interchangeably throughout this thesis to reflect the available literature (Riley & Hawe, 2005), there is a subtle difference between these terms which is important to highlight. According to Merriam and Tisdell (2016) stories define the lives of the individual whereas narrative focuses on the individual’s lived experience. In contrast, Czarniawska (2004) explains stories are narratives that have been re-storied into a coherent whole. However, Connelly and Clandinin (1990) comment on the distinction between these terms by focusing on how in research people tell stories of their lives whereas narrative researchers collect and tell these stories by writing narratives of experience.

Abbreviations

BFHI: Baby Friendly Hospital Initiative

BFI: Baby Friendly Initiative

FAB: Family and Babies Team

NHS: National Health Service

NICE: National Institute for Health and Care Excellence

NIHR ARC NWC: National Institute for Health Research Applied Research
Collaboration Northwest Coast

PHE: Public Health England

SEM: Socio-Ecological Model

WHO: World Health Organization

UK: United Kingdom

US: United States

UNICEF: The United Nations Children's Fund

Chapter 1: Introduction

1.1 Introduction

In this thesis I use a narrative approach to explore how a diverse sample of women experience infant feeding care from UNICEF UK BFI Gold accredited maternity and health visiting services. In this chapter, I explain the importance of the first 1000 days in relation to nutrition, identify why infant feeding inequities related to socio-economic status matter, introduce the revised BFI standards (UNICEF UK BFI, 2017a²) as the focus of my research, identify my professional and personal infant feeding experiences which motivated me to undertake this doctoral study and provide a brief outline of each chapter.

1.2 The importance of the first 1000 days

The first 1000 days of life, which span from conception to two years of age have been identified as a critical period for early brain development (Hawkes et al., 2019). According to several studies appropriate nutrition and stimulation during this period is essential for positive social and emotional development through the life-course (Cooke et al., 2016; Groh et al., 2014; Groh et al., 2017; Pallini et al., 2014). As a result, in England, the NHS Long Term Plan (NHS, 2019) and PHE's guidance on 'giving every child the best start in life' (PHE, 2016) highlight the importance of positive early experiences to improve infant and maternal health and well-being

² Whilst the initial guide to the UNICEF UK BFI Standards was published in 2012, I have cited the second version of this document throughout this thesis which was published in 2017. This version of the standards was the one being used by health services (maternity and health visiting) during the time I was undertaking my research.

outcomes and reduce health inequalities across the life-course. The first 1000 days of life is relevant for this longitudinal study which covers the infant feeding care women received whilst pregnant until six months postnatal.

1.3 The importance of the first 1000 days and responsive parenting

Responsive parenting, which Black and Aboud (2011) explain, helps infants and their caregivers to learn to recognise and interpret both verbal and non-verbal communication signals from one another. This reciprocal process forms a basis for the development of secure attachments (Ainsworth, 1990; Bowlby, 2005) which are necessary to build the structural foundation necessary for healthy brain development (Winston & Chicot, 2016). Moreover, Black and Aboud (2011) suggest that responsive parenting which promotes reciprocity provides the theoretical basis for responsive feeding (which is discussed in the next section).

Responsive feeding

To date, several studies have examined the relationship between responsive feeding practices and child weight outcomes, highlighting the role responsive feeding plays in childhood obesity prevention (DiSantis et al., 2011; Matvienko-Sikar et al., 2018; Savage et al., 2018). According to a definition provided by Hodges et al. (2016) responsive feeding involves prompt, consistent and appropriate feeding interactions by caregivers to a child's hunger and satiety cues. Whilst responsive bottle-feeding practices are important for all infants to develop secure attachments (see section 1.3), previous research (Pérez-Escamilla et al., 2021; Ventura et al., 2022) highlights the significance of responsive bottle-feeding practices for infants who are fed commercial formula milk to reduce overfeeding and prevent rapid weight gain.

1.4 The importance of the first 1000 days and nutrition

Breastfeeding

Due to the importance of breastfeeding for short-term and long-term positive health, economic and environmental outcomes (Pérez-Escamilla et al., 2023; Renfrew et al., 2012a), both the WHO and UNICEF recommend exclusive breastfeeding until six months of age, with continued breastfeeding alongside complementary foods for two years or more (WHO, 2023a).

For infants, exclusive breastfeeding contributes to reduced risks of chronic conditions such as obesity (Rito et al., 2019); allergies (Boyle & Shamji, 2021) and diabetes (Horta & de Lima, 2019). Whilst improved cognitive and

neurodevelopmental outcomes have been associated with breastfeeding (Weerth et al., 2022), Pereyra-Elías et al. (2022) highlight that when improved cognitive development is adjusted for socio-economic position and maternal cognitive ability, only a modest effect of breastfeeding on cognitive development can be observed.

For mothers, epidemiological studies have shown that breastfeeding reduces the risk of hypertension (Tschiderer et al., 2022); cardiovascular disease risk factors (Nakada et al., 2023); type 2 diabetes (Morris, 2018); breast cancer (Brown et al., 2018), and ovarian cancer (Modugno et al., 2019). On the one hand current research suggests a bidirectional relationship between depression and breastfeeding with prenatal depression predicting lower likelihood of extended exclusive breastfeeding and exclusive breastfeeding being associated with lowered odds of later postpartum onset (Henshaw, 2023). On the other hand, Yuen et al. (2022) argue that breastfeeding challenges or a mismatch between a woman's feeding expectations and actual experience can have a negative effect on maternal mental health outcomes. Moreover, women who are unable to achieve their breastfeeding goals may experience guilt and shame, which can increase the risk of postpartum depression (Brown, 2018; Brown, 2019; Jackson et al., 2022; Russell et al., 2021; Thomson et al., 2015)

Commercial formula feeding

Whilst, in ancient times, breast milk was considered sacred and essential for the survival of the infant (Papastavrou et al., 2015), the use of formula has increased as women have had to juggle care and income earning responsibilities. When mothers began to work outside the home during the Industrial Revolution in the 19th century, commercial formula milk became the more practicable option (von Strandmann, 2013). Moreover, by the end of the First World War, powdered milk had become widely available, and the practice of bottle feeding had become accepted as easy, convenient, and affordable (Crowther et al., 2009). However, it is important that parents understand how to prepare feeds safely as pathogens found in milk powder can cause infection (Kent et al., 2015). Likewise, Boué et al. (2017) emphasise how infants are more susceptible to infections during the first few months of life.

Therefore, for those mothers who are unable to breastfeed or choose to give their babies commercial formula milk, being able to do so safely is essential.

Introducing solid foods

To date, several studies have shown how the age at which an infant is introduced to solid food influences health later in life (D'Hollander et al., 2022; Papoutsou et al., 2018). As a result, current UK guidance (NICE, 2025) recommends that babies should be introduced to solid food from around 6 months onwards, when showing

signs of developmental readiness³, alongside usual milk feeds (breast milk or commercial milk formula).

³ An infant is developmentally ready for solid food when they can sit up and hold their head steady, co-ordinate their eyes, hand and mouth to be able to look at food, pick it up and put it in their mouth and swallow food.

1.5 The current context

Most countries are still far from reaching the WHO's recently updated target for all countries to reach at least a prevalence of 70% of exclusively breastfed infants by 2030 (WHO, 2023a; UNICEF, 2019). Globally, 48% of infants under the age of six months are exclusively breastfed (WHO, 2023a). However, in the UK, where breastfeeding rates remain some of the lowest in the world (Victora et al., 2016), only 1% of infants under the age of six months are exclusively breastfed (WHO, 2017).

Data from the last UK-wide Infant Feeding Survey conducted in 2010⁴ found that in the UK, eight out of ten women stop breastfeeding before they are ready (McAndrew et al., 2012; UNICEF, 2017b). In relation to introducing solid food, an online survey of 1000 parents with children aged three to eighteen months in the UK found 40% of first-time mums introduced solid food before their babies were 5 months old (Office for Health Improvement and Disparities, 2022). Furthermore, this survey indicated that around 3 in 5 (59%) of first-time parents found the decision to start weaning confusing and 64% received conflicting advice on what age to start introducing solid foods.

In the next section I provide a brief introduction to the BFHI and the UNICEF UK BFI. I provide an in-depth background about the BFHI and BFI in the next chapter.

⁴ Results from the most recent infant feeding survey undertaken in 2023 are expected to be published in summer 2025.

1.6 The UNICEF UK BFI as the focus of my research.

The UNICEF UK BFI is based on the BFHI, a global accreditation programme which was introduced by UNICEF and the WHO to implement practices that protect, promote and support breastfeeding (WHO, 2009). Additionally, as this intervention is underpinned by the United Nations convention on the rights of the child (CRC)⁵, (UNICEF UK BFI, n.d. - a), it aims to protect the best interests of every child.

Implementation of the UNICEF UK BFI standards is now recommended as a minimal standard in numerous policy documents including NICE (2021a; 2021b; 2025) and the NHS Long Term Plan (NHS, 2019)⁶. Additionally, increasing the number of babies who are exclusively breastfed is integral to the Early Years High Impact Area 3: supporting breastfeeding (PHE, 2021). The UNICEF UK BFI works with health services with the aim of improving standards of care and support for families with feeding and parent infant relationships. Prior to 2012, to gain a Baby Friendly award, maternity services needed to demonstrate that they had implemented the Ten Steps to Successful Breastfeeding (see appendix 1) or for community health-care settings, the Seven Point Plan for the Protection, Promotion and Support of Breastfeeding in Community Health Care Settings (see appendix 2). Whilst the revised standards continue to embed the original standards (Ten Steps and Seven Points), they were expanded to include neonatal units, children's centres, and universities. Moreover,

⁵ The UN Convention on Rights of a Child, which was adopted in 1989, is a legally binding treaty (Galtry, 2015).

⁶ UNICEF UK BFI are currently working with the University of Lancashire to review the evidence and rationale for the UNICEF UK BFI standards (Entwistle, 2013). The BFI is currently recommended in advance of this review.

these standards provided an increased focus on supporting all mothers with feeding, irrespective of infant feeding method and recognised the importance of supporting all mothers to develop close and loving relationships with their infants. See section 2.4 where the revised standards are discussed further.

1.7 How socio-economic deprivation can affect health.

The association between socio-economic status, determined by level of income and access to resources, and health and well-being is well established (Weightman et al., 2012). The WHO (2018a) discusses how the lower an individual's socio-economic status the higher their risk of poor health. These disparities exist because living on a low income means an individual is more likely to receive less care relative to their needs or receive inappropriate care which often leads to poorer experiences and quality of care (Buck et al., 2018; Kings Fund, 2024). Julian Hart (1971, p.405) coined the phrase 'inverse care law' to the observation that disadvantaged populations need more health care than advantaged populations but receive less. The inverse care law is primarily about inequity in health care that results from unfair social inequalities in health (Cookson et al., 2021). Addressing the wider determinants of health has a key role in promoting health and social equity (Marmot et al., 2020; WHO, 2023b). This is because health inequalities which begin at an early age influence health throughout the life-course (Parbery-Clark, 2024; PHE, 2018).

Whilst the Marmot Review 10 years on (Marmot et al., 2020) highlights the increase in health inequalities in England, there has been a further upward trend in food

insecurity since the COVID-19 pandemic and the cost-of-living crisis, which has led to worsening poverty, further amplifying inequalities in health (Department of Health & Social Care, 2024). Moreover, the latest data now shows that 36% of children in families where the youngest child was aged under five currently live in poverty (Joseph Rowntree Foundation, 2025). Children in families with lower income and who have mothers with lower levels of education have worse health on average than those with greater socio-economic advantage (Allin & Stabile, 2012).

Women of a lower socio-economic status are also more likely to experience perinatal mental health illness than women of a higher socio-economic status, after adjusting for other sociodemographic factors (Ban et al., 2012). Chronic stress in early childhood whether caused by severe maternal depression or extreme poverty affects all aspects of a child's development both in the short and long term (Marmot et al., 2020). Maternal well-being is crucial in the healthy development of early attachment relationships and responsive parenting (Higgins et al., 2013). Since a mother who has poor mental health is less likely to respond effectively to her infant's attachment needs and facilitate the development of secure attachments (Risi et al., 2021), stress and mental health issues can make it harder for parents to bond with their children and adopt positive parenting practices (PHE, 2014). Additionally, women who have had negative experiences of being parented may also struggle to parent responsively thereby illustrating intergenerational impacts (Iyengar et al., 2014).

Socio-economic status and breastfeeding

In the UK, Goncalves (2017) suggests the context in which mothers' live influences how they feed their babies. According to Dowling et al. (2018), there is a clear relationship between socio-economic status and breastfeeding, with significantly lower rates seen in the most deprived areas. The study by Peregrino et al. (2018) which explored whether breastfeeding was associated with neighbourhood context measured by neighbourhood deprivation in the UK highlights that mothers living in the most deprived areas are 40% less likely to initiate breastfeeding when compared with those living in the least deprived areas. Due to the evidenced-based benefits of breastfeeding (see section 1.4), many authors have recognised the importance of enabling women to breastfeed to reduce health inequity (Entwistle, 2013; Skouteris et al., 2020; Vilar-Compte et al., 2022). However, Dowling et al. (2018) explain the reasons for breastfeeding inequities in the UK are complicated and multifaceted. Please see chapter 2, where the multi-system level factors which influence how women feed their babies in the UK are discussed.

1.8 Socio- ecological models

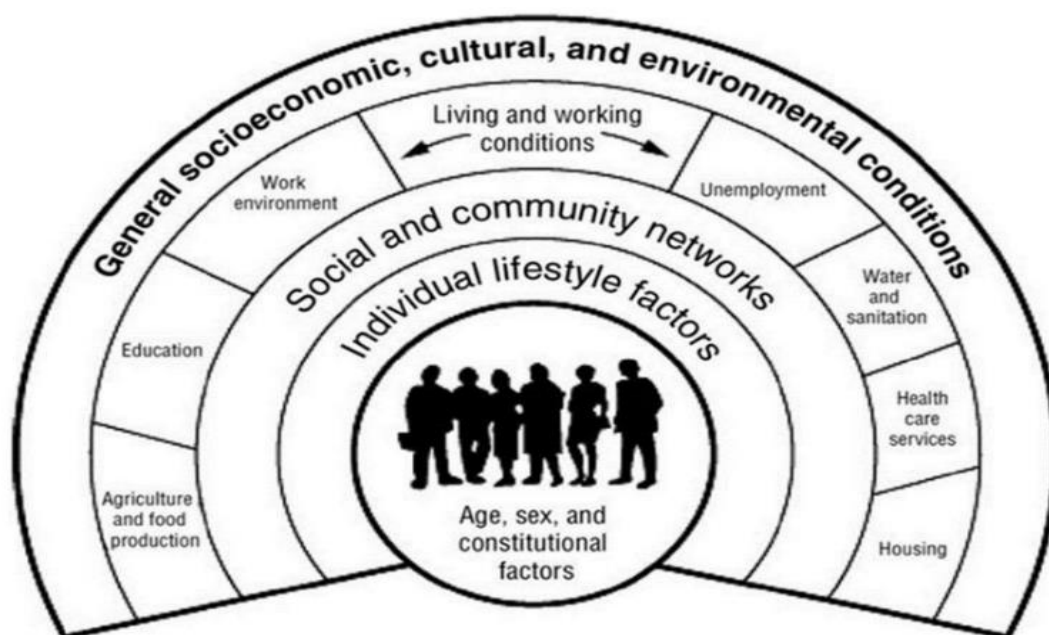
Both Dahlgren and Whitehead's Model of the Social Determinants of Health (Dahlgren & Whitehead, 1991) and Bronfenbrenner's Ecological Systems Theory (Bronfenbrenner 1977) provide socio-ecological frameworks to understand the complex interplay between individuals and their environments. As shown in Figure 1, Dahlgren and Whitehead's Model of the Social Determinants of Health (Dahlgren & Whitehead, 1991), uses concentric circles to both represent different levels of

influence and to highlight the importance of the key determinants of health in determining health outcomes. Jahnel et al. (2022) discuss how an unequal distribution of 'positive health factors', 'protective factors' and 'risk factors' on these hierarchical levels can demonstrate health inequity. However, Dahlgren and Whitehead when reflecting on their model in 2021 identify that the model fails to illustrate the links between the social, economic, and cultural determinants of health and thereby places blame on the individual for their lifestyle choices. Similarly, Wilderink et al. (2022) criticize the model of the Social Determinants of Health for not sufficiently highlighting the interaction between different determinants. Moreover, the 'Call to Action'⁷ (UNICEF UK BFI, 2016) and Rollins et al. (2016)⁸ advocate for approaches which shift responsibility for infant feeding away from the individual.

⁷ The Call to Action was a campaign introduced by UNICEF UK BFI in 2016. This campaign requested the UK government to take steps to support and promote breastfeeding and protect all babies from commercial interests (UNICEF UK BFI, 2016).

⁸ This paper was included in the 2016 Lancet Series on Breastfeeding.

Figure 1: Dahlgren and Whitehead's Model of the Social Determinants of Health



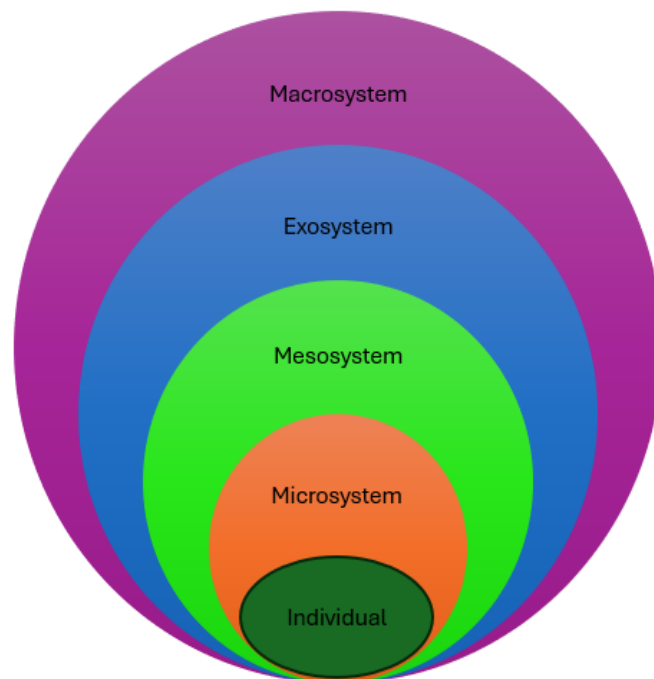
Source: Dahlgren and Whitehead (1991)

Bronfenbrenner's Ecological Systems Theory, which is also commonly referred to as the Socio-Ecological Model (SEM)⁹ (Bronfenbrenner, 1977) considers individuals as inherently linked to, and interacting with, a complex array of 'systems' that impact human development. Although this theoretical model has been adapted over time (Tudge et al., 2009), the earliest version of this model identifies four levels or 'systems' within the social environment which serve as the context for an individual's

⁹ In accordance with the studies by Munn et al. (2016) and Snyder et al. (2021), I use the term 'Socio-Ecological Model (SEM)', throughout this thesis, to refer to Bronfenbrenner's Ecological Systems Theory.

development. These systems which are typically presented as a series of concentric circles (Figure 2) represent influences which are directly and indirectly related to the individual, with the system closest to the individual (the microsystem) considered to be the most influential level (Sallis et al., 2015).

Figure 2: Bronfenbrenner's Socio-Ecological Model (Bronfenbrenner, 1977)



Jennings (2017), supports the use of Bronfenbrenner's Ecological Systems Theory to map both individual experience in context and consider how social systems and social characteristics interact to produce social inequalities. Moreover, Cutts and

Cochrane (2016) argue the importance of shifting thinking away from linear cause-effect to look for interrelationships. Likewise, in relation to breastfeeding, Carter (1995) suggests the importance of recognising the ways health is affected by factors beyond the control of individuals. Therefore, for my research, the ability to both identify the factors and emphasise the systems, which Rutter et al. (2017) propose is possible with the SEM, was necessary to understand how socio-economic status influences women's outcomes and experiences and to identify any inequities.

Several authors have identified how interacting factors in the socio-cultural environment influence infant feeding decision making (Hernández-Cordero & Pérez-Escamilla, 2022; Pérez-Escamilla et al., 2017; Roll & Cheater, 2016; Rollins et al., 2016). Thus, previous studies have used the SEM to identify how factors at each level interact to influence breastfeeding behaviour (Bookhart et al., 2021; Jackson et al., 2022a; Roll & Cheater, 2016; Snyder et al., 2021; Thomson et al., 2022; Trickey, 2018). Using this approach ensures that any responsibility for infant feeding is shifted away from the individual, as advocated by Rollins et al. (2016). The importance of considering how context interacts with an individual's circumstances is emphasised in the SEM, thus aligning with the social constructionist epistemological underpinning of my research. This was essential for this research to understand any variations in infant feeding care experiences and perceptions amongst a diverse sample of women throughout their infant feeding journey.

1.9 Intersectionality

This research aimed to explore how a diverse sample of women experienced infant feeding care from Gold accredited health services (maternity and community) and identify any variations in experience. Considering intersectionality was important for my research in relation to the social characteristics gender and socio-economic status to understand the relationship between breastfeeding and health inequalities. Similarly, Pérez-Escamilla and Sellen (2015) make the case for considering intersectionality to understand the power structures that are responsible for the infant feeding realities of low-income women. The use of intersectionality theory is a well-established approach in public health to facilitate the analysis of complex life experiences from an ecological perspective (Bowleg, 2012; Schoon & Krumwiede, 2022). Supporting this view, Ruiz et al. (2021) suggests using intersectionality theory in nursing to aid the holistic analysis of the interacting factors which impact health to address health inequalities. Likewise, Bauer (2014) argues the importance of using intersectional frameworks in research to understand how socially defined characteristics shape health. Moreover, intersectionality theory recognises that individuals categorised by any given social characteristic (e.g., gender, race, age, socioeconomic status, disability, religion, sexuality) are not part of a homogenous group (Bond, 2021). Commenting on intersectionality, Davis (2019) argues that race and gender along with other characteristics, for example, socio-economic status work together and determine health status and reproductive outcomes. Thus, Jones et al. (2015) used intersectionality theory to explain how intersecting layers of identity influence participation in breastfeeding.

To understand the causes of health inequality, in the next chapter I have used both intersectionality theory and Bronfenbrenner's SEM (Bronfenbrenner, 1977) to explore the multi-level factors which influence how women feed their babies in the UK. I believe that combining these approaches was vital to understand how the specific social context in which a mother breastfeeds in the UK is shaped by multiple interacting factors which include gender and socio-economic status.

1.10 Positioning myself within my research

Several authors have discussed how reflexivity is important within qualitative research for the researcher to acknowledge the way they affect both the research process and research outcomes (Haynes, 2012; Probst & Berenson, 2014).

Additionally, reflexivity is important within my chosen methodology, narrative inquiry, where stories are co-produced between the researcher and research participant (Colombo, 2003). This will be explored in more detail in section 5.9.1.

Therefore, as suggested by Lear et al. (2018), at the beginning of my research journey, I completed a reflexive interview with my Director of Studies. This enabled me to reflect on my personal and professional experiences of infant feeding, identify how my experiences influenced my infant feeding values and beliefs and reveal any biases.

By telling my own infant feeding stories I was able to explore and understand the personal and cultural context in which my own infant feeding experiences were

constructed. In addition, it enabled me to become aware of my own assumptions and consider how these were situated within my research. This helped me to identify my misconception about women of a lower socio-economic status not breastfeeding and understand how my experiences as a newly qualified health visitor had contributed to this. Furthermore, telling my own story provided me with a meaningful way to start this thesis. It felt important for me to share my own story before I shared the stories of the women who participated in my research. I have accepted the feelings I had during my early breastfeeding experiences and now feel comfortable articulating these. I have divided my stories into sections to identify and discuss the different parts of my personal and professional infant feeding journey to date: 'My identity', 'Breastfeeding is important to me', 'Pippa do it' and 'A therapeutic relationship is important'

My identity

Professionally I identify as a health professional, both as a registered nurse and a specialist public health practitioner – health visitor. I have obtained these identities through professional education and subsequent registration with the Nursing and Midwifery Council (NMC). I believe this identity has positively influenced my self-esteem and confidence in relation to infant feeding. As a health visitor, I have delivered the Healthy Child Programme (Office for Health Improvements and Disparities, 2023) which is a programme based on a model of proportionate universalism to focus on prevention and early intervention. I concur with Morton (2024) that I have a crucial role in supporting better physical and mental health outcomes for babies, children up to five years and adults. This focus is part of who I

am as a health visitor and has enabled me to enhance health and reduce health inequalities for children aged 0-5 years for the past twenty years.

I have no experience of living in poverty. My current state of health embodies my advantaged childhood. My father was employed as a General Practitioner, and my mother was a Registered Nurse, although she did not work during my early years. My brother and I had everything we needed during our childhood to meet our social, emotional, and educational needs. Reflecting on this at the start of my PhD enabled me to understand how our family's socio-economic status shaped my childhood experiences.

Breastfeeding is important to me

I have three children of my own and I exclusively breastfed all three of them. My eldest for a year, my middle child for 18 months and my youngest for 16 months. However, my infant feeding journey began before the birth of my eldest child. I undertook UNICEF UK BFI's two-day Breastfeeding Management Course during my health visiting training which enabled me to understand the health benefits of breast milk. My first job as a newly qualified health visitor was on a housing estate in one of the most deprived estates in Bradford. Breastfeeding rates on the housing estate were low, with most women on the estate choosing to commercially formula feed their babies. I could not use any of the knowledge or practical skills I had learnt during my health visiting training. I was practicing at a novice level in all aspects of my practice. However, it was only when reflecting on this experience that I could appreciate how my lack of experience meant I lacked the practical expertise to support women to breastfeed.

I became pregnant a year after qualifying as a health visitor. However, I was only provided with minimal information about breastfeeding during my pregnancy. I was unaware of the realities of what feeding would be like, which left me unprepared for the early challenges I faced. I also was not provided with any practical skills as part of my antenatal care, which meant that I was unprepared for the act of breastfeeding itself.

Although my knowledge about the practicalities of breastfeeding was minimal, I was aware of the health benefits of breast milk. It was these benefits which positively

shaped my perceptions about breastfeeding and motivated me to exclusively breastfeed my babies.

I never perceived any pressure to breastfeed although I was clear antenatally that I wanted to breastfeed which reflected the goals of the health professionals who supported me. To me, breastfeeding meant that I was doing my best for my baby. I can now understand and appreciate how important breastfeeding is to me and how I associated this with being the best mother I could be.

In my family breastfeeding is the norm. I was breastfed and so was my mum. I was lucky that when I experienced challenges, I received the support I needed from my family which enabled me to continue. It is likely that without this timely support I would have had difficulty in overcoming these challenges which could have led to the end of my feeding journey.

I have two clear memories of my dad supporting me with feeding. The first occasion was when I was unable to effectively attach my daughter to my breast, and my nipples were damaged. I had been provided with an electric breast pump to collect my colostrum but had not been shown how to use it. The pump had been on the wrong speed, and my nipples had become further damaged. It was my dad, who encouraged me to stop using the pump and to have another go at attaching my daughter to my breast. The other occasion was when I had mastitis. I can remember even now the pain I was in and how awful the infection was making me feel. I was staying with my parents at the time, and I am certain that the encouragement they

gave me, telling me I would be in more pain if I stopped feeding, enabled me to continue. However, I do appreciate that many women do not have the intergenerational support to help them shape their decisions about how they want to feed their babies and to provide them with the ongoing support they need to enable them to breastfeed long term.

Pippa do it

My first baby was jittery after birth and the midwife who was looking after me told me this was because her blood sugar levels were low and that I should give her a bottle of commercial milk formula. I can remember thinking that it was unlikely that she would have low blood sugar levels. I was adamant that I did not want her to have any formula unless it was clinically indicated as I really wanted to breastfeed.

However, I felt forced to give my consent for the midwife to give my baby commercial milk formula. I was told that I was putting my desire to breastfeed before the safety of my newborn baby. I made the mistake of reading my midwifery records in which the midwife's perception that I had been unable to put the needs of my baby above my own had been recorded. My daughter vomited shortly after being fed this bottle of milk and did not receive any further bottles. I should have felt vindicated, but this experience had negatively shaped my early confidence in my abilities as a mother. If I had relied on the midwife's belief that there was a medical reason my daughter should be given commercial milk formula, I may have continued to bottle feed and would never have achieved my goal of exclusively breastfeeding.

My first baby was slow to gain weight. As I found it difficult to interpret her cues, I fed her constantly. I was told by my health visitor during a scheduled home visit to review her weight, if she did not have a significant weight gain the following week, I would need to top her up with commercial milk formula. Whilst I understood that my baby had not gained weight as expected, I failed to understand that I was still learning to breastfeed. I felt deflated and doubted my ability to be able to feed her effectively. However, I was adamant that I would feed my baby and that she would gain weight. I had a positive outlook and was determined that she would not need 'the top ups' mentioned during the home visit. I was not giving up. I was going to do it!

Being able to breastfeed was fundamental to my definition of motherhood. If I could breastfeed effectively, I was succeeding in my new mothering role. However, I appreciate that I required positive feedback that validated my ability to feed effectively or at least continued support and encouragement while I was still learning.

It was my perseverance and self-confidence despite the circumstances I found myself in, that enabled me to continue to breastfeed and for my baby to gain weight. I recognise my ability to view this experience as a challenge rather than as a hurdle illustrative of my resilience and self-efficacy. I had a sense of what was expected of me which was crucial.

Blixt et al. (2019) highlights the importance of preparing expectant parents for breastfeeding by providing realistic and practical information. My experience provides some contrast to this. Maybe the midwife and health visitor who visited me

antenatally assumed that being a health visitor meant I was knowledgeable about feeding. It was also possible that they assumed that, as an educated woman, there was a higher probability that I would breastfeed, as suggested by Victora et al. (2016) and any further discussion was therefore unnecessary. Additionally, the health professionals who supported me may not have possessed the experience or knowledge to provide this information and support.

A therapeutic relationship is important

Wilson et al. (2012) suggest that it is the connection with a health professional which provides the confidence and resolve for a mother to overcome breastfeeding challenges. However, I believe I had been unable to develop a therapeutic relationship with the health visitor providing my care and was not able to use the opportunities available to me to obtain the help I required (McFadden et al., 2017). Additionally, I felt I should have been able to solve my problems. I did not recognise that I lacked the skills and knowledge I needed, despite undertaking breastfeeding management training. I also did not recognise how my first-time motherhood status meant that I had no personal experience of breastfeeding to draw on.

I became a Specialist Health Visitor and Infant Feeding Lead in 2012. My role was to lead on the implementation of UNICEF's UK Baby Friendly Standards and enable the health visiting service and Children's Centres in Nottingham City to become accredited as Baby Friendly. I was responsible for staff training and setting up and managing a peer support service for women aged under 25-years. I also provided specialist support for mothers experiencing complex challenges in accordance with

the revised UNICEF UK BFI standards. It was this experience which motivated me to explore how infant feeding care provided to mothers employed by organisations accredited as Gold meets their emotional and practical needs and whether there were any variations in experience between a diverse sample of women. Please see section 1.5 where I will discuss the UNICEF UK BFI standards further.

The infant feeding support I provided to mothers benefited from the infant feeding education I undertook during this time. I obtained the Breastfeeding Specialist diploma in 2015 and went on to become an International Board-Certified Lactation Consultant (IBCLC) in 2017. I believe my training as an IBCLC and development of 'expert' practice as a Specialist Health Visitor enabled me to really listen to mothers and encourage them to both talk about their infant feeding experiences and support them to reach their personal infant feeding goals where possible. I can now recognise the value of being able to provide expert professional support to mothers and have seen how this has enabled women to overcome difficulties and find confidence in their own abilities.

My understanding of the Baby Friendly standards helped me support the University of Lancashire to achieve the Gold Award for universities in March 2021. The University of Lancashire was the first higher education institution to achieve this recognition for midwifery and health visiting programmes simultaneously. I felt immensely proud being part of the team achieving this award, especially when the lead assessor commented she had never assessed a university where the values of the team were so much in line with those of the UNICEF UK BFI, particularly in

relation to kindness and compassion. I now continue to use my infant feeding knowledge and skills in my role as the BFI lead for the Health Visiting programme. I believe that the value I place on understanding infant feeding from the point of view of women and developing supportive relationships to enable women to share their stories led me to use a narrative inquiry approach in my empirical research. I discuss this further in chapter 4. Moreover, I have often reflected on the conversation I had with my health visitor when she shared her concerns about my baby's insufficient weight gain. Although I am unable to remember the specific words she used, I have never forgotten how they made me feel. This experience motivated me to explore what women want from their infant feeding communication in my systematic review.

1.11 Research funding

This research was independently funded by a NIHR ARC NWC doctoral studentship. However, the views expressed in this thesis are my own views and not necessarily those of the National Institute for Health Research or the Department of Health and Social Care. I also obtained funding from the Institute for Relational Research (INTERRELATE) at The University of Lancashire to create a professionally designed visual image (see chapter 8) to represent my research findings.

1.12 Embedding an equity lens throughout my research

To ensure I embedded an intersectional equity lens throughout my research I used the Health Inequalities Assessment Tool (HIAT). Using the HIAT is a requirement of NIHR ARC NWC to ensure work undertaken is equitable. This tool was initially designed to support researchers to integrate a health equity focus into research and

to maximise the relevance of findings for practice and policy to reduce inequalities (Porroche-Escudero & Popay, 2021). The HIAT questions can be found in appendix 3.

1.13 Ensuring co-production and public involvement in my research

Since co-production and public involvement is central to NIHR ARC NWC's vision and strategies (NIHR ARC NWC, 2021), I recruited¹⁰ two mothers who lived in the study area into the role of public advisor. These mothers had varied lived experience relevant to my research. These experiences included lived experience of breastfeeding, commercial formula feeding, living on a low income and infant feeding within different cultural backgrounds. This helped me both identify dimensions of inequalities relevant to my study and conduct research sensitive to inequalities.

I met with the public advisors on nine occasions during the research. First, I met with them to discuss the wording of the supporting documents for my Integrated Research Application System (IRAS) application to ensure they were sensitively worded. Their feedback resulted in the inclusion of an explanation on the questionnaire I used to collect the participant's demographic information as to why specific information was being requested (see section 5.4 where I discuss this questionnaire further). Second, they trialled and provided feedback on the use of the

¹⁰ The public advisors were recruited following an open meeting and an opportunity to recruit. This involved creating a role description, which was shared with existing public advisors on the NIHR ARC NWC database. However, only one of the public advisors recruited was an existing public advisor. The other became a public advisor after seeing the role description.

OneNote notebook to collect diary data and discussed how the women who would participate in the study should be orientated to their OneNote notebook.

When undertaking my systematic review, we discussed the question and search terms that I would use (see section 3.4). I also requested their feedback about the conceptual categories and the conceptual framework I developed (see section 3.4).

During data analysis, the public advisors listened to the reading of two of the full stories and made suggestions about the wording of the meta-narratives. Finally, the public advisors contributed to the design of the visual metaphor which illustrates the research findings (see chapter 8).

I supported the public advisors to use journalling three times during the study. First to reflect on the public advisor role and what this meant to them. Second, to undertake a journaling activity after listening to the participant stories to reflect on their own infant feeding experiences. Finally, at the end of the study, to reflect on their involvement in the research and how being part of the research had influenced them.

Whilst I was undertaking my initial HIAT, I also convened a study advisory group of key partners (the Professional Officer for Policy and Advocacy at UNICEF UK BFI (now retired)) and local stakeholders (Maternity and Health Visiting Baby Friendly Leads who worked in the study area) and an academic researcher with expertise in infant feeding and the experiences of women in a range of contexts but with no

connections or current role with UNICEF UK BFI. This helped me to seek perspectives from both those with current clinical involvement with the BFI and obtain perspectives from an unaffiliated 'critical friend' to help with my reflexivity. Please see section 5.9 where I provide further details about the role of my advisory group in my research.

1.14 Introducing the chapters

The next chapter (Chapter 2, Background Chapter) is subdivided into three sections. In the first section I use Bronfenbrenner's SEM and intersectionality theory to explore the multi-system level factors which influence how women feed their babies in the UK and explore why breastfeeding rates are lower in women of lower socio-economic status. The second section provides a history of both the global BFHI and UNICEF UK BFI to provide context to my research. The last section gives a brief review of current research which focuses on both the BFHI and UNICEF UK BFI to introduce and provide the rationale for the aims and objectives of my research.

In chapter 3, I present my meta-ethnography which explores what women and birthing people want from infant feeding communication.

In chapter 4, I justify the epistemology, ontology and theoretical framework underpinning my research. I also describe the narrative methodology approach I have used.

In chapter 5, I describe the methods I used to collect women's stories which included diaries and interviews. I also consider how I addressed ethical issues and ensured quality.

In chapter 6, I begin by introducing my research findings. I provide demographic information about the women who participated in the research and the adapted

version of the SEM I used to both analyse and present my findings. I conclude this chapter with an overview of the meta-narratives which will be discussed in the next chapter.

In chapter 7, I present the meta-narratives. For each meta-narrative I provide case studies, a table of key findings and a critical summary. When concluding this chapter, I present the main constructs that arose from the meta-narratives.

In chapter 8, I consider the women's stories in relation to the UNICEF UK BFI standards to identify where the women's stories provide evidence of the standards. I also identify variations in the women's experiences due to their socio-economic status.

In chapter 9, I summarise my findings and discuss them in relation to the wider literature. I identify the strengths and limitations of my research as well as the implications of my research for research, policy, and practice. I identify my unique contribution to knowledge before concluding my thesis with a reflection.

Chapter 2: Background chapter

2.1 Introduction

In the previous chapter, I explained the importance of the first 1001 days in relation to nutrition and nurture, identified why infant feeding inequities relating to socio-economic status matter, introduced the revised BFI standards as the focus of my research, explored how my professional and personal infant feeding experiences motivated me to undertake this doctoral study and provided a brief outline of each chapter. In this chapter I first use Bronfenbrenner's SEM (Bronfenbrenner, 1977) to discuss the multi-level factors which influence how women feed their babies in the UK and explore the reasons why breastfeeding rates are lower amongst women of lower socio-economic backgrounds. I then provide a history of the BFHI and UNICEF UK BFI and introduce the BFI standards as the focus of my research. This chapter concludes with a discussion of current research into the BFHI and UNICEF UK BFI. Within this discussion I both identify the lack of research which explores the UNICEF UK BFI standards and justify the aims and objectives for my research.

In the next section I use Bronfenbrenner's SEM to explore the factors which influence how women feed and care for their babies in the UK. I present the evidence in this section with a particular consideration about socio-economic status as this is the focus of my research.

2.2 The factors which influence how women feed and care for their babies in the UK.

2.2.1 Individual level of the SEM

The individual is placed at the centre of Bronfenbrenner's SEM (Bronfenbrenner, 1977) to illustrate how interrelated systems influence the individual but also to demonstrate how the individual themselves impacts on these systems (Bronfenbrenner & Ceci, 1994). To date, several authors (Jackson et al., 2022a; Synder et al., 2021; Thomson et al., 2022) have classified the individual level factors which influence infant feeding decision making and women's experiences. Both Thomson et al. (2022) and Jackson et al. (2022a) use certain socio-demographic characteristics of individuals such as age, parity¹¹, ethnicity, and employment to explain why certain mothers breastfeed. However, to explain how intersecting layers of identity (see section 1.7) influence participation in breastfeeding the following section will focus on the individual level factors race and socio-economic status which, Vilar-Compte et al. (2022) suggest, are more likely to result in breastfeeding inequities.

¹¹ The term parity is used here to refer to the number of times a woman has given birth.

Ethnicity

Data from the Infant Feeding Survey undertaken in 2012 in the UK (McAndrew et al., 2012) demonstrates how white women are less likely to breast feed longer-term than women from other ethnic groups. Likewise, the study undertaken by Oakley et al. (2013) to identify the sociodemographic factors associated with variation in area-based breastfeeding in England found that there was considerable variation in breastfeeding across Primary Care Trusts. This study found that outside London, the proportion of the local population from a Black and Minority ethnic background compared with those from a White British background was associated with higher breastfeeding whereas area-based deprivation was associated with reduced breastfeeding rates. Similarly, Santorelli et al. (2013) in their multi-ethnic longitudinal cohort study 'Born in Bradford' showed that women from other ethnic groups were significantly more likely to initiate breastfeeding and continue any breastfeeding at four months compared with white British women. However, the rates of exclusive breastfeeding at four months were not significantly different once socio-economic, lifestyle and birth factors were accounted for.

Socio-economic status

As previously stated, (see section 1.6) women of lower socio-economic status are less likely to breastfeed. Since time spent breastfeeding takes away from time that could be spent earning, returning to work is one of the most frequently cited reasons as to why women of a lower socio-economic status introduce commercial milk formula (Fisher & Olson, 2014; Raisler, 2000). Similarly, the scoping review by Brugaillères et al. (2024) which overviews research on the maternal employment characteristics that support breastfeeding continuation after return to work in the

European Region found that adverse work-related factors such as being self-employed and working in a non-manual profession influenced whether women were able to continue to breastfeed on their return to work. Although this review only included two studies undertaken in the UK, writers, including Carter (1995) and Gribble et al. (2023) have questioned whether women who need to return to work early really can choose whether to breastfeed due to the demands that life places on them.

Thomson et al. (2021) in their systematic review to explore socioeconomic inequalities and adverse pregnancy outcomes in the UK and Ireland highlight how women and families of lower socio-economic status experience worse pregnancy outcomes compared with women of a higher socio-economic status. This is significant because complications such as an intervention based, or traumatic birth can influence women's infant feeding experiences (Beck & Watson, 2008). Similarly, Cohen et al. (2018) in their meta-analysis to identify factors associated with breastfeeding initiation and continuation found mode of delivery at birth was associated with postnatal challenges. Supporting this view, Liu et al. (2024) in their retrospective cohort study of breastfeeding success after vaginal delivery and caesarean section found that women who deliver by caesarian section are less likely to maintain exclusive breastfeeding postpartum and are more likely to supplement their babies with commercial milk formula. These findings are significant because women living in areas with the highest levels of poverty in the UK are more likely to experience increased rates of caesarean section and poor maternal and neonatal outcomes (Lindquist et al., 2015). This evidence supports the focus on socio-

economic status within my research rather than other characteristics such as ethnicity.

The following section discusses how key psychological factors such as breastfeeding self-efficacy and attitudes (motivation or intention) at the individual level influence breastfeeding.

Self-efficacy

Dennis (1999) uses the term 'breastfeeding self-efficacy' to refer to the self-belief and confidence a woman has in her perceived ability to breastfeed versus her actual ability to breastfeed. Prior studies have noted the importance of self-efficacy in relation to breastfeeding behaviour (Radzyminski & Callister, 2016; Snyder et al., 2021; Susiloretni et al., 2015). According to the systematic review by Sanchez et al. (2024) exclusive breastfeeding rates are maintained in the early postpartum period and at one month after birth when breastfeeding self-efficacy levels are high. Similarly, the critical incident study undertaken in Sweden by Jacobzon et al. (2022) found that positive breastfeeding experiences positively influence a mother's self-efficacy. Whereas Nilsson et al. (2020) in their prospective longitudinal study undertaken in Denmark, showed that low breastfeeding self-efficacy was associated with negative breastfeeding experiences in the first week postpartum. This is significant because low maternal self-efficacy is associated with increased perception of insufficient milk. Moreover, self-reported insufficient milk supply is one of the main reasons women give for stopping breastfeeding (Hernández-Cordero & Pérez-Escamilla, 2022). Data from current studies (Entwistle et al., 2010; Swanson

& Hannula, 2022) suggest that women of a lower socio-economic status in the UK experience lower breastfeeding self-efficacy levels. Entwistle et al. (2010) who explored the experiences of women from low-income groups in the UK suggested that although women were often knowledgeable about breastfeeding, they lacked the self-confidence to breastfeed. Similarly, most of the adolescents interviewed in the study by Dykes et al. (2003) undertaken in the Northwest of England felt a lack of confidence in both their ability to breastfeed and whether they would produce enough milk. Swanson and Hannula (2022) call our attention to the role of breastfeeding stress, self-efficacy, and social support as predictors of stress and role strain for new mothers. In their study which compared two countries with different parenting contexts (Finland and the UK), they suggest that mothers who experience more parenting stress and role strain related to their living circumstances find it harder to cope with breastfeeding and any breastfeeding challenges.

Infant feeding attitudes

Previous research has established that breastfeeding intention is one of the most significant modifiable predictors of breastfeeding behaviour. In the study by Norman et al. (2022), which investigated factors that influenced breastfeeding behaviour in the UK, knowledge was found to be an important influencing factor as to whether women chose to initiate and continue with breastfeeding. Additionally, participants who were more knowledgeable about the health benefits of breastfeeding were more likely to persevere long term. However, this research fails to consider the views of women from lower socio-economic backgrounds as most of the women who participated in this research were from higher socio-economic backgrounds. Fisher and Olson's 2014 study is particularly helpful owing to its exploration of infant

feeding decisions in relation to both race and socio-economic status. Whilst this study was undertaken in the US, most of the women of lower socio-economic status interviewed expected breastfeeding to be difficult. This attitude meant that these women would try breastfeeding but not fully commit in case they experienced difficulties.

2.2.2 Microsystem level of the SEM

The micro-system level (Bronfenbrenner, 1977) is the innermost layer of the SEM. Within this level, elements which are directly connected to the individual are considered. Common to those studies which have used the SEM to consider factors which influence breastfeeding (Roll & Cheater, 2016; Synder et al., 2021) the microsystem in relation to breastfeeding refers to those individuals that have the potential to directly influence the mother's infant feeding journey.

Significant others

Available literature identifies how significant others, including partners and family and friends influence infant feeding decision making. Most of the women who participated in the study by Norman (2022) which explored the factors that influence breastfeeding behaviour in the UK, felt that the attitudes of others influenced their views about considering, initiating, and continuing to breastfeed. Furthermore, participants highlighted that exposure to other mothers breastfeeding, particularly within their own friendship groups or family increased their likelihood to want to breastfeed themselves and to initiate breastfeeding at birth. In addition, family and friends' knowledge and attitudes about breastfeeding influenced the factual knowledge participants felt they had about breastfeeding. Additionally, most of the

first-time mothers interviewed in the study by Radzylinski and Callister (2016) stated that they obtained information from family and friends prior to making infant feeding decisions. Similarly, Davidson and Ollerton (2020) in their integrative review and Roll and Cheater (2016) in their systematic review highlight how partners may influence breastfeeding initiation through their own knowledge and attitudes about breastfeeding, and their provision of practical support. In the cohort study by Cox et al. (2015) included in the integrative review by Matriano et al. (2022), women who felt that their partner was ambivalent towards the use of formula were more likely to stop breastfeeding. Whereas some mothers interviewed in the study by Radzylinski and Callister (2016) explained how their husbands had influenced their decision to either breast or bottle feed. Moreover, in the critical incident study by Jacobzon et al. (2022) undertaken in Northern Sweden, mothers described the significance of getting support from family for having a positive breastfeeding experience. The systematic review by Negin et al. (2016) which examined the influence of grandmothers on breastfeeding rates found that grandmothers had a significant positive impact on breastfeeding when they had breastfed themselves or held positive attitudes towards breastfeeding.

In the study by Murimi et al. (2010) which explored the factors that influence breastfeeding decisions amongst women who were participating in the Special Supplemental Nutrition Programme for Women, Infants and Children (WIC)¹² in Central Louisiana, participants who were breastfed as a child were significantly more

¹² The Special Supplemental Nutrition Programme for Women, Infants and Children (WIC) is a public health nutrition programme for low-income pregnant and postpartum women, infants, and children up to age 5 in the US (National WIC Association, 2025).

likely to breastfeed their children than those who were not breastfed as a child. Additionally in a literature review by Emmanuel (2015) which examined the factors that influence breastfeeding, knowledge of individuals' feeding as babies was highlighted as a factor which influenced duration of exclusive breastfeeding. The randomised controlled trial by Forster et al. (2006) included in this review identified how women who had been breastfed themselves as a baby were more likely to be feeding their babies breastmilk at six months.

2.2.3 Mesosystem level of the SEM

The third level of Bronfenbrenner's systems theory, the mesosystem (Bronfenbrenner, 1977) refers to the wider social structures in which women interact directly. Whilst Roll and Cheater (2016) and Synder et al. (2021) consider the provision of information and support by health services at the exosystem level, I consider the infant feeding care women receive at this level since women's interactions with health professionals directly influence their infant feeding outcomes and experiences.

According to Page et al. (2021) it is important to separate out helpful support from unhelpful support to ensure mothers receive infant feeding support which meets their needs. This is particularly important in the UK where women's infant feeding care experiences vary (McAndrew et al., 2012). The systematic review by Schmied et al. (2011) which examines women's perceptions and experiences of breastfeeding support suggests that support for breastfeeding occurs along a continuum from

effective support at one end to ineffective support at the other. Using retrospective data from an online survey, Emmott et al. (2020) explored the types of postnatal support received by mothers in the UK and identified three distinct types of postnatal support. Extensive support, where mothers received support from a wide range of supporters including health professionals. Family support where mothers received support from partners, maternal grandmothers and friends but were less likely to receive support from health professionals. Low support where mothers primarily received support from partners.

In 2010, Marmot proposed the principle of proportionate universalism as a solution to reduce inequalities where actions are provided universally, but with an intensity and scale proportionate to the level of disadvantage. However, Carey et al. (2015) suggest that due to a lack of guidance for policy makers and practitioners the application of 'proportionate universalism' in practice has been limited. Furthermore, Francis-Oliviero et al. (2020) highlight that before interventions can be adapted in proportion to the level of disadvantage or need, it is necessary to determine what the needs are. Data from several studies suggest the importance of infant feeding care being tailored to a mother's individual needs (Blixt et al., 2019; Bengough et al., 2022). Similarly, the meta-synthesis by MacVicar et al. (2015) which explored the perception of low-income and teenage mothers on their experience of breastfeeding support interventions stresses the importance of tailoring interventions to the specific support needs of disadvantaged mothers. Moreover, several studies have examined the extent to which a woman's socio-economic status influences the effectiveness of infant feeding care and whether this is perceived as supportive (Cook et al., 2021; Entwistle et al., 2010). As argued by Groleau et al. (2016), being able to access

appropriate support for breastfeeding and strategies to overcome potential barriers is crucial for women from lower socio-economic groups. However, Entwistle et al. (2010) propose that women from lower socio-economic groups are less likely to seek appropriate opportunities to discuss infant feeding and access support even when they know about it, for fear of failure and a lack of self-confidence.

Several lines of evidence suggest that health professionals should provide infant feeding care across the antenatal and postnatal period. Wong et al. (2021) in their systematic review to examine the effects of different approaches to help women sustain breastfeeding and improve breastfeeding self-efficacy suggest that multi-component breastfeeding support interventions delivered across the antenatal and postnatal period are the best way to improve exclusive breastfeeding, partial breastfeeding and breastfeeding self-efficacy among first-time mothers. This systematic review included a longitudinal study by Chan and Choi (2016) and a randomised control trial by Prasitwattanaseree et al. (2019) which found that interventions implemented in both the antenatal and postnatal period had 3-folds increase on exclusive breastfeeding rates. Moreover, most of the women interviewed in a study by Cook et al. (2021) felt that health professionals should provide breastfeeding help and support throughout the breastfeeding journey.

The following sections discuss interventions to support infant feeding in the antenatal and postnatal period.

Supporting breastfeeding during pregnancy

Previous studies have shown that antenatal education can improve breastfeeding self-efficacy (Brockway et al., 2017) and prevent the unnecessary introduction of commercial milk formula (Hernández-Cordero & Pérez-Escamilla, 2022). Smith (2018) suggests that antenatal education should both encourage breastfeeding and alter maternal perceptions, by normalising the activity. To be effective, Oggero et al. (2024) explain that antenatal education should contain a psychological component. In their systematic review which explored the effects of prenatal breastfeeding education on breastfeeding duration, they highlight the importance of helping women to develop coping skills for common breastfeeding challenges. Supporting this, in the study by Jacobzon et al. (2022) mothers described the importance of acquiring knowledge about breastfeeding so that they could react appropriately if breastfeeding challenges occurred. The study by Roberts et al. (2023) which explored the infant feeding experiences of formula feeding mothers in the UK highlighted the importance of more comprehensive and tailored antenatal breastfeeding education to ensure mothers develop the practical skills necessary to breastfeed. According to McFadden and Toole (2006) whose qualitative research was undertaken in an area with high levels of socio-economic deprivation, whilst most mothers seemed to have awareness that breastfeeding was better for the baby, they had little knowledge of the specific benefits. Moreover Brown (2016) highlights the importance of mothers receiving both sufficient and realistic information antenatally because conflicting information or information which pushes breastfeeding can be unhelpful and even harmful. In the study by Punduk Yilmaz et al. (2024) which compared whether video or face-to-face education differed in affecting breastfeeding self-efficacy, mothers who received face-to-face education

had higher breastfeeding self-efficacy scores than those who received video-based education. Gadeberg et al. (2025) in their realist evaluation of a Danish breastfeeding support intervention investigated whether a home visit by a health visitor during pregnancy could prolong breastfeeding and reduce social inequalities. Most of the mothers interviewed in this study felt that the antenatal visit had helped them to develop a relationship with their health visitor which had facilitated a positive breastfeeding experience. Additionally, the health visitors interviewed in this study felt that the antenatal home visit provided the opportunity to understand the individual needs of the family which subsequently helped them to tailor breastfeeding support in the postnatal period.

Support to get breastfeeding established after birth

The systematic review by Segura-Pérez et al. (2022) highlights how maternity practices aligned with the BFHI, such as timely breastfeeding initiation, avoiding in-hospital supplementation with a breast-milk substitute and breastfeeding counselling support decrease the risk of both delayed onset of lactation (DOL) and self-reported insufficient milk (SRIM). However, this systematic review also identified how factors indicative of lower socioeconomic status increased the risk of both DOL and SRIM. Likewise, Tomori and colleagues when updating the evidence of what works to protect, promote, and support breastfeeding on a large scale in 2022 highlight the importance of effective maternity interventions aligned with the BFHI such as skin to skin. Moreover, the study by Vehling et al. (2018) which studied women and infants in the Canadian Healthy Infant Longitudinal Development (CHILD) study illustrates the importance of women of lower socio-economic status receiving the help they need to get breastfeeding off to a good start. In their study, they found exclusive breastfeeding in hospital was associated with longer breastfeeding duration

particularly among women of lower socio-economic status. However, the meta-synthesis by MacVicar et al. (2015) which explored the perception of women from disadvantaged groups of in-hospital and professionally led interventions to support the establishment of breastfeeding identified a lack of practical skills among low-income women to successfully establish breastfeeding. Some of the women interviewed in a study by Spear (2006) which was included in this meta-synthesis, identified how they valued practical support which enabled them to get their baby attached to the breast. Similarly, most of the low-income mothers interviewed in the study by Cook et al. (2021) wanted practical advice and support to overcome the struggles they had at the beginning with latching problems. Whilst the process evaluation of a breastfeeding support intervention to promote exclusive breastfeeding and reduce social inequity in Denmark by Rossau et al. (2024) included both health visitors and families, findings suggest that providing clear and simple, evidence-based support for effective positioning for breastfeeding strengthened parents' confidence to breastfeed exclusively.

Support to continue to breastfeed

Many authors (Cook et al., 2021; Garner et al., 2016; Tomori et al., 2022) have identified the importance of continuity of breastfeeding care and support across health services to help mothers to breastfeed long term. The results of the randomised control trial by Rodríguez-Gallego et al. (2024) suggests that breastfeeding support groups can be effective at maintaining exclusive breastfeeding at six months postpartum where both peer supporters and health professionals provide counselling. However, several studies (Blixt et al., 2019; Lawlor et al., 2023; Theodorah & Mc'Deline, 2021) have highlighted how individualised interventions, particularly those delivered face-to-face produce better outcomes.

The systematic review by McFadden et al. (2019) found that breastfeeding counselling¹³ can increase the rates of any and exclusive breastfeeding up to six months. This review indicated that counselling delivered at least four times in the postnatal period and face to face was more effective than telephone counselling. However, there were mixed findings in terms of who provides the counselling, but the largest effects were for lay or combined lay and non-lay providers on exclusive breastfeeding at 4-6 weeks postpartum.

Peer support¹⁴ is recommended by both the WHO in the Global Strategy for Infant and Young Child Feeding (2003) and in NICE guidance on maternal and child

¹³ Breastfeeding counselling is not a term often used in the UK. In the review by McFadden et al. (2019) counselling interventions were defined as those interventions that were delivered directly to women and supported them with their decision making.

¹⁴ A breastfeeding peer supporter is a person with lived experience of breastfeeding who has completed appropriate training to support others to breastfeed.

nutrition (NICE, 2025) to provide additional support for breastfeeding continuation. Whilst a Cochrane review of support interventions for breastfeeding mothers by McFadden et al. (2017) found that additional lay and professional support improved breastfeeding rates, there is a lack of current knowledge about how breastfeeding peer support mitigates health inequalities. The review by Trickey et al. (2017) identified a chain of mechanisms relevant to one-to-one breastfeeding support to increase effectiveness of peer support including a consideration of the needs of local mothers. Similarly, Hunt et al. (2021) in their interpretive study, which used case study methodology to explore how and why two breastfeeding peer support services developed their services in socio-economically deprived contexts in the UK, highlighted the importance of using knowledge about women's lives to develop services which focus on women's needs.

Similarly, whilst the systematic review by Yang et al. (2024) found that mothers perceived that peer support had a positive impact on breastfeeding, only six out of the fifteen studies including in this review were undertaken in the UK. This is important because Grant et al. (2018) in their cross-sectional study of breastfeeding support in the UK suggests that there is poor integration of breastfeeding peer support services with NHS services in many areas and women from areas of socio-economic deprivation experience poor access. More recently in 2024, the World Breastfeeding Trends Initiative UK (WBTi UK) identified the variation in equity of provision and access to integrated services including peer support in the UK.

The study by Chambers et al. (2023) which explored emotional and informational social support from health visitors and breastfeeding outcomes in the UK highlighted the importance of health visitors providing emotional support in addition to informational support for both breastfeeding continuation and to encourage a positive subjective experience of infant feeding. Whilst this study included predominantly affluent mothers who are likely to breastfeed for longer, findings support those of Gavine et al. (2022) who propose that the support and guidance a health professional can provide is of major importance for some mothers to achieve their breastfeeding goals. Similarly, Entwistle et al. (2010) suggest the importance of health professionals providing women from lower socio-economic groups with the strategies they need to cope with breastfeeding difficulties and empower them to continue.

[Support for mothers who choose to commercially formula feed](#)

Mothers who cannot or choose not to breastfeed need accurate guidance and support to enable safe feeding practices and prevent negative infant feeding outcomes (Jackson et al., 2022b; Moss-Racusin et al., 2020). Previous research by Appleton et al. (2018) and Tarrant et al. (2013) highlights that mothers who bottle feed report a lack of sufficient information and support about safe and responsive bottle feeding. Along the same lines Ellison et al. (2017) and Hvatum and Glavin (2017) suggest that this lack of information contributes to mothers feeling uncertain and unsafe in their practice when they first start using formula. Moreover, research suggests that many parents who formula feed do not get the information they need from health professionals and rely on other information sources such as family (Fallon et al., 2016) or information on the commercial formula milk tin (Appleton et

al., 2020) instead. According to the secondary analysis of data from an Australian longitudinal cohort study (Baby's First foods) by Appleton et al. (2020), a fifth of mothers' formula feeding reported, receiving no advice from any professional sources and almost all reported that the tin of formula was the predominant source of advice. This finding is significant because, Piwoz and Huffman (2015) argue that the information on a tin of commercial formula milk is classed as formula marketing which aims to both influence attitudes and promote the use of their products and is therefore less trustworthy than health professional advice.

Support to help families introduce solid foods

In section 1.4 I identified the importance of introducing babies to solid foods around six months when they are developmentally ready. However, Brown and Rowan (2016) highlight how many mothers introduce solid foods before this time and for a wide variety of reasons. Likewise, Harrison et al. (2017) suggest in their systematic review that many parents, particularly first-time parents, struggle to identify the optimal approach for introducing solid foods. Begley et al. (2019) makes a similar point in their qualitative study which explored Australian mothers' understanding of infant feeding guidelines and their associated practices. As most of the mothers interviewed appeared to be unsure of the signs of readiness, they suggested that health professionals should consider how to communicate guidelines to parents to empower them to understand their baby's development signs which indicate readiness and avoid the early introduction of solid food. Additionally, their study also highlighted how conflicting sources of information can make it difficult for mothers to introduce solid foods in line with current guidance. This view is also supported by Norlyk et al. (2019) who explored first-time parents' lived experiences of their infant's

transition from milk to solid foods. Some of the mothers interviewed in their study found it difficult to identify whether available information was reliable due to the information containing conflicting advice. Similarly, most of the mothers who completed an online survey in the research undertaken by Moore et al. (2014) to assess UK parents understanding of current introduction of solid food guidelines, felt that they had received conflicting advice which had left them feeling confused. This finding is important because being confused was associated with early weaning. Moreover, their study suggested that understanding of the guidelines was a more reliable predictor of weaning behaviour than educational attainment or being in receipt of benefits.

2.2.4 Exosystem level of the SEM

The exosystem (Bronfenbrenner, 1977), refers to the socio-cultural context or the formal and informal structures at the community level which influence women's infant feeding experiences indirectly. There is consensus in previous studies (e.g. Radzimirski & Callister, 2016) that societal attitudes affect a mother's decision to breast or bottle feed. Moreover, Sriraman and Kellams (2016) highlight how many families in low-income communities bottle feed. This is important as vicarious experience of bottle feeding has been associated with a more positive attitude towards bottle feeding (Bartle & Harvey, 2017). Some of the women interviewed in a qualitative study by Isherwood et al. (2019) who lived in an area with low breastfeeding rates felt that breastfeeding was something a minority of mothers did as this was based on what they saw around them.

Some of the women interviewed in the study by Radzynski and Callister (2016) described how their socio-cultural context had influenced their decision to breast or bottle feed. Data from several studies suggest that negative perceptions of breastfeeding which have been attributed to the sexualisation of women's breasts (Jamie et al., 2020; Roll & Cheater, 2016; Zamora et al., 2015) can lead to women feeling embarrassed about breastfeeding in public or in the presence of peers and family members (Cook et al., 2021; Leahy-Warren et al., 2017). This is important because Smith (2018) explains this can result in breastmilk and breastfeeding being viewed as dirty and disgusting. In the qualitative study undertaken by Cook et al. (2021) in deprived wards in Luton UK the main barrier to breastfeeding was the embarrassment and stigma associated with breastfeeding. Whilst some of the mothers in this study acknowledged that breastfeeding was better for the baby, many mothers found formula feeding to be the more convenient option. In addition, embarrassment, and feelings of shame towards breastfeeding can be compounded in areas of high formula feeding (McFadden et al., 2017). Furthermore, when women are not exposed to breastfeeding, this can result in misinformation and a belief that women do not produce enough milk for exclusive breastfeeding (Zamora et al., 2015). Support is therefore even more necessary in areas where breastfeeding is not the norm to increase a woman's belief in breastfeeding and provide her with the confidence to continue (McFadden et al., 2017).

2.2.5 Macrosystem level of the SEM

The outer level of Bronfenbrenner's theory, the macrosystem (Bronfenbrenner, 1977), which Synder et al. (2021) explain, relates to the structures in an individual's environment at the national and global level that can influence resource allocation

and access to support for infant feeding. This level focuses on the importance of investment in health services, population level health promotion, supporting maternal legal rights, protection of maternal well-being and reducing the reach of the breastmilk substitute industry to illustrate barriers at the societal level which influence breastfeeding, but as Brown (2017) argues are outside a mother's control.

2.2.5.1 Investing in infant feeding

Although Merritt et al. (2023) suggest that infant feeding care can be the most accessible and cost-effective action to improve public health, information obtained by the WBTi UK (2024) suggests the English government does not sufficiently recognise the importance of infant feeding. According to the WBTi UK (2024) there is neither a national infant feeding strategy to implement the WHO recommendations to protect, promote and support breastfeeding in England nor national sustainable leadership for infant feeding. However, the WBTi UK (2024) maintain there is both leadership and commitment to breastfeeding in three of the four UK nations. First, Northern Ireland has a national strategy and a lead in place to oversee the strategy. Second, Brown et al. (2022) highlight in their findings from the Becoming Breastfeeding-Friendly process in Wales the nation's strong commitment to the promotion, protection, and support of breastfeeding, including investment in the UNICEF UK BFI across Wales and funding of breastfeeding programmes to 2025. The review by the Scottish Becoming Breastfeeding Friendly committee (McFadden et al., 2022) highlights the nation's strong political commitment and scaling-up environment for the promotion, protection, and support of breastfeeding, evidenced by its effective leadership, strong infant feeding policies and investment in implementing the UNICEF UK BFI standards in services across the country.

More recently, the report from First Steps Nutrition Trust (2024) identifies key actions needed to protect children from overweight and obesity in the first 1001 days of life including requiring services to become Baby Friendly Accredited. This report identifies 18 key actions needed to promote a healthy weight in the early years, including increasing investment in universal breastfeeding support, closing existing legal loopholes to protect families from the misleading marketing that undermines breastfeeding and safe and appropriate formula feeding and align with the International Code of Marketing of Breast-milk substitutes (see section 2.2.5.4) and offering greater support for families to practice age-appropriate introduction of solids and responsive feeding.

A considerable amount of published literature identifies the benefits of investing in breastfeeding (Renfrew et al., 2012a; Rollins et al., 2016). However, a lack of investment in infant feeding in the UK and prioritisation of funding to support breastfeeding have limited a health professional's capacity to support infant feeding. Whilst additional funding has been allocated to local authorities with high levels of deprivation to improve infant feeding services and provide support with breastfeeding (Department of Health and Social Care & Department for Education, 2025), the midwifery and health visitor workforce continue to be under immense pressure and there are significant disparities in service provision (Hunter, 2023; Institute of Health Visiting, 2025). Additionally, many areas have lost Children's Centres and only half of local authorities have funding for Family Hubs.¹⁵ Greater investment is therefore

¹⁵ Family hubs have been designed as 'one-stop-shops' for families to access support to both reduce inequalities in health and improve health and education outcomes (Department of Health & Social Care, 2023a).

needed for breastfeeding support to prevent difficulties arising and to support new mothers. Moreover, Brown and Shenker (2021) explain how changes to service delivery during the COVID-19 pandemic and redeployment of staff in some areas prevented some women and families from accessing the help they needed, and some mothers stopped breastfeeding before they were ready. Likewise, research undertaken by Quigley et al. (2023) which explored the sources of support breastfeeding women used during the COVID-19 pandemic found that breastfeeding support did not meet the needs of many women during the pandemic. They suggest that a possible explanation for this might be the increased use of remote breastfeeding support during the pandemic. However, their most important result was that younger mothers who had left full-time education and lived in the poorest areas were less likely to access support via video call. Similarly, Vazquez-Vazquez et al. (2021) in their study which explored maternal experiences in relation to infant feeding during the UK lockdown highlighted how breastfeeding support had predominantly been provided online or by phone. Moreover, UNICEF UK BFI (2021) suggest that for those mothers and families with no or limited access to Wi-Fi, virtual support during the pandemic was not an adequate substitute for face-to-face support, further influencing ability to access care.

2.2.5.2 Population level health promotion

It is now well established that the way in which breastfeeding is promoted has a strong influence on infant feeding decision-making (Rollins et al., 2016; Susiloretni et al., 2015). In her qualitative study of the factors which affect the initiation of breastfeeding in the UK, Earle (2002) suggests that health promotion campaigns in the UK have been influential in their ability to educate women about breastfeeding.

However, several authors (Brown, 2016; Martucci & Barnhill, 2018; Smyth & Hyde, 2020), caution against health promotion which promotes breastfeeding as the ‘best’ or ‘natural’ way to feed an infant. The study by Brookes et al. (2016) compared the texts from leaflets used in the Better Health Start for Life¹⁶ campaign to provide information about breastfeeding and formula feeding to parents in the UK. They found that the texts which promoted breastfeeding as desirable or natural failed to consider the structural constraints that affect the ‘ideal’ of breastfeeding and could have negative consequences on the health and well-being of both mother and baby.

Adopting a similar position, Burchell (1996) suggests health promotion campaigns in the UK encourage individual responsibility to make health-related behaviour choices to prevent health risks. However, Rollins et al. (2016) calls our attention to how the UK’s low breastfeeding rates are not the responsibility of individual women. Similarly, mothers in the study by Brown (2016) which explored new mothers’ attitudes toward breastfeeding, education, and promotion, highlight the need for promotion to target family members and wider society rather than mothers themselves. Interestingly, Brown (2017) in her narrative review which examined the barriers to breastfeeding which occur at the social, cultural, and political level referred to a series of breastfeeding adverts used in Australia to promote acceptance and knowledge of breastfeeding as normal and part of life. Along the same lines, the initiative ‘Human Milk, Tailor-made for Tiny Humans’ created a breastfeeding advert in 2017 to make information about the science of human milk and breastfeeding common knowledge

¹⁶ The Start for Life campaign provides a range of leaflets and digital resources to provide information to parents on breastfeeding, bottle feeding and introducing solid foods (Department of Health & Social Care, 2023b).

(Burst Pictures, 2017). Supporting the use of adverts to provide information about breastfeeding to both mothers and wider society, mothers in the study by Brown (2016) suggested the use of promotional campaigns such as TV adverts. Similarly, Marcon et al. (2018) in their study which explored how breastfeeding is promoted and supported on Instagram, suggested that Instagram was a useful platform for sharing breastfeeding related content and could be used to promote, protect, and support breastfeeding.

2.2.5.3 Policy and law to protect breastfeeding mothers

Whilst mothers in the UK are protected by law to breastfeed their babies in public places¹⁷, Brown (2017) highlights the importance of approaches such as the Breastfeeding Welcome Scheme where public places sign up to support breastfeeding. Boyer (2012) makes a similar point in her study which asked women to reflect on their experience of breastfeeding in public found that 49% of the women interviewed reported some kind of negative experience.

Galtry (2015) explains how a woman's right to breastfeed and a child's right to receive breast milk underscores relevant international human rights treaties which include the International Labour Organization's Maternity Protection Convention (MPC), which is discussed below and the United Nations Convention on the Rights of the Child (discussed in section 1.6).

¹⁷ Part 3 and Part 4 of the Equality Act 2010 identifies that mothers are legally allowed to breastfeed anywhere.

Evidence indicates a dose-dependent relationship between maternity protection measures and breastfeeding prevalence and duration. Poor maternity protection legislation and the absence of paid maternity leave have been shown to interfere with the ability to breastfeed (Hernández-Cordero & Pérez-Escamilla, 2022).

Moreover, insufficient investment in maternity protection has been shown to underpin the growth of commercial milk formula markets. This is because without paid maternity leave women must return to paid employment which increases reliance on commercial milk formula (Tomori, 2022). The gender equality International Labour Organization's MPC establishes the right of women to a minimum of 14 weeks of maternity leave, and the right to paid lactation breaks and appropriate nursing facilities upon return to work, with a further recommendation to extend this to 18 weeks at full previous earnings (UNICEF & WHO, 2019). However, just half of countries have enacted laws that meet the minimum MPC standard, and the standard itself is currently below WHO's recommended 26-week duration of exclusive breastfeeding. Significantly in the UK, whilst most employed women rely on statutory maternity pay, this drops to less than a third of women's average full-time earnings after six weeks (Dennis, 2024). Therefore, many women, particularly if they are the main wage earner, return to work for financial reasons when they are still breastfeeding or make the decision to stop (Mirkovic et al., 2016).

According to a study of infant formula and follow-on formula in the UK by the Competition and Markets Authority (CMA) in 2025, the increasing cost of commercial milk formula and reduced household resources continues to contribute to high food insecurity. As breastfeeding can be a secure food for most infants, Frank (2015) and Salmon (2015) suggest that increasing breastfeeding rates is key to improving food

security and reducing poverty. However, Dinour et al. (2020) indicate in their cross-sectional study to examine the role of prenatal food insecurity on breastfeeding behaviour, that food secure women are more likely to initiate breastfeeding than food insecure women. Shepherd-Banigan and Bell (2014) suggest that the reason for this is due to inadequate maternity leave, particularly for low-income mothers, who must return to work soon after birth. Therefore, Galtry (2015) argues that to achieve sustainable food systems, it is essential to protect the breastfeeding rights of working women. However, it is unclear why this has not been included in the recent Food Strategy (Department for Environment, Food & Rural Affairs, 2022).¹⁸

2.2.5.4 Reducing the reach of the breastmilk substitute industry.

Many authors have argued that aggressive marketing and the widespread promotion of commercial milk formula by the milk industry has undermined breastfeeding and increased the prevalence of bottle feeding (Piwoz & Huffman, 2015; WHO, 2022). However, Palmer (2015) maintains that monitoring the marketing of breast milk substitutes and implementing interventions, such as the International Code of the Marketing of Breastmilk Substitutes (WHO, 1981) can stop the inappropriate marketing of breast milk substitutes and help meet the global standards for breastfeeding. This is because the International Code of the Marketing of Breastmilk Substitutes aims to regulate the marketing and promotion of all breastmilk substitutes, and any product marketed for baby feeding which may undermine

¹⁸ Perhaps because of the power imbalances which exist between private commercial interests and those with duty and mandate to protect the rights and needs of children and mothers.

breastfeeding. It also aims to provide evidence-based information about infant and young child feeding for parents, carers, and health workers (Palmer, 2015).

Whilst the International Code of Marketing of Breast Milk Substitutes aims to regulate the marketing of breastmilk substitutes, set standards for the labelling and quality of products, and prevent the advertising or promotion of any breastmilk substitute, feeding bottle or teat through healthcare facilities (WHO, 2000) unethical marketing of breastmilk substitutes continues (WHO, 2024b). In the UK current regulations governing the labelling and marketing of commercial milk formula are inadequate (Kamata et al., 2025). Similarly, Conway et al. (2023) have identified widespread marketing practices not covered by current UK legislation such as advertising which focuses on toddler milks. This is important because Berry et al. (2011) in their study which explored what Australian mothers, and those who influence them, know about formula products, suggest that it may be difficult for mothers to access independent information. Moreover, Becker et al. (2022) conducted a systematic scoping review to examine research evidence on the nature and extent of exposure to the code from 1981 to August 2021. This review identified how companies' market directly and indirectly to caregivers across settings and environments, highlighting legal loopholes which are currently being exploited to market products. Therefore, the importance of greater enforcement of the International Code of Marketing of Breastmilk Substitutes (the Code) and increased interventions to promote, protect and support breastfeeding has been highlighted (Hernández-Cordero & Pérez-Escamilla, 2022).

This section has used Bronfenbrenner's SEM (Bronfenbrenner, 1977) to discuss the multi-level factors which influence how women feed their babies in the UK. This section has highlighted how interacting factors at the different levels of the SEM such as socio-economic status at the individual level; influence of significant others at the microsystem level; a lack of tailored interventions at the mesosystem level to help women continue to breastfeed, negative cultural perceptions of breastfeeding at the exosystem level and a lack of policy and funding to protect breastfeeding at the macrosystem level contribute to the lower breastfeeding rates currently observed amongst women of a lower socio-economic background in the UK.

The following section provides an overview and history of the BFHI and BFI.

2.3 The Baby Friendly Hospital Initiative

The BFHI was launched in 1991 as a global programme by the WHO/UNICEF to influence maternity services throughout the world. The aim was to both re-establish optimal maternity care for new mothers and their infants worldwide and help effectively protect, promote, and support breastfeeding (Bilson & Dykes, 2009).

Infant feeding care globally has been significantly shaped by the 'Ten Steps to successful breastfeeding;' globally recognised standards for appropriate care for all newborns (WHO, 2017). The 'Ten Steps' (see appendix 1) were developed by WHO and UNICEF in 1989 to highlight the importance of policies for breastfeeding, staff training and community support for breastfeeding, as well as summarise the evidenced-based maternity practices necessary to support breastfeeding (Bilson & Dykes, 2009; Vallenias et al., 1998; WHO & UNICEF, 1989; WHO, 1998). Moreover, the 'Ten Steps' aimed to remove the constraints such as separating mothers and babies, controlling feeding schedules and clinical routines which involved babies being fed breast milk substitutes which interfered with successful breastfeeding (Dykes, 2006; UNICEF UK BFI, 2008; WHO/UNICEF, 1989).

In 1990 the Innocenti Declaration was produced and adopted by participants at the WHO/UNICEF policymakers meeting 'Breastfeeding in the 1990s: A Global Initiative' (World Alliance for Breastfeeding Action (WABA), 1990). This declaration recommended that all governments ensured that every hospital providing maternity services adopted all the 'Ten Steps to Successful Breastfeeding.' Additionally, this

document placed emphasis on the significance of taking action to adhere to all articles of the International Code of Marketing of Breast-milk Substitutes (WABA, 1990).

The Baby-Friendly Community Initiative (BFHI) is an extension of the BHFI's 10th step of the Ten Steps to Successful Breastfeeding and of the BFHI overall (Kavle et al., 2019). Its focus is on community-based breastfeeding support for women beyond the initial days of giving birth.

In 2017 the WHO published evidence-based guidelines on breastfeeding support for maternity care services (WHO, 2017). These guidelines provided global evidence of the importance of health services scaling up the implementation of the 'Ten Steps' to achieve the Sustainable Development Goals and Global Targets for maternal, infant, and young¹⁹ child nutrition (WHO, 2017). In line with these guidelines, one year later, WHO issued an updated version of the 'Ten Steps' (WHO, 2018b). Pramono et al. (2019) identify several differences between the old and the new versions of the 'Ten Steps'. They argue that there is a stronger focus on helping a mother to breastfeed in the 2018 version. The importance of uninterrupted skin to skin contact as soon as possible after birth is also recognised²⁰. Additionally, using the term 'infant feeding' in

¹⁹Sustainable Development Goals and Global Targets for maternal, infant, and young child nutrition for 2025

Breastfeeding target: Increase the rate of exclusive breastfeeding in the first six months up to at least 50%.

Childhood overweight target: No increase in childhood overweight.

These are outlined in both the Global Strategy for Women's, Children's, and Adolescent's health (2016-2030) and the Global Strategy for Infant and Young Child Feeding (WHO, 2017).

²⁰ The systematic review by Karimi et al. (2020) which included randomised controlled trials found that mother-infant skin to skin increased the rate of exclusive breastfeeding.

the 2018 version suggested that hospitals should also provide mothers and families with information about safe commercial formula feeding practices. Moreover, changes to step 10 had implications for breastfeeding support following discharge from hospital. For the first time the responsibility for community support (for example breastfeeding support groups) for breastfeeding was no longer the hospital's responsibility (Pramono et al., 2019).

Hospital and other maternity services that adhere to each of the 'Ten Steps' as well as comply with the International Code of Marketing of Breastmilk Substitutes can be designated a 'Baby Friendly Hospital' (WHO, 2017; WHO, 2018b). A clear assessment process to identify the specific application of each of the 'Ten Steps' was developed by WHO and UNICEF and is used to evaluate the performance of maternity services (WHO, 2017).

Numerous global policy documents have emphasised the importance of implementing the 'Ten Steps' and the BFHI. In 1992, the World Health Assembly (WHA) called upon all member states to encourage and support all health services providing maternity services to become Baby Friendly. The 2002 Global Strategy on Infant and Young Child Feeding (WHO, 2003) reiterated the Innocenti Declaration call for maternity services worldwide to practice all the 'Ten Steps' (WHO, 2017). More recently, an indicator on the coverage of baby-friendly hospitals has been included in the Global Nutrition Monitoring Framework adopted by the 2015 World Health Assembly (WHO, 2017).

There is now a plethora of available evidence which examines the impact of each of the ‘Ten Steps.’ The seminal systematic review undertaken by Pérez- Escamilla et al. (2016) found a dose-response relationship between the number of steps women are exposed to and the likelihood of improved breastfeeding outcomes. Moreover, this review identified the importance of community support for improving breastfeeding continuation beyond the hospital setting. More recently, the review by Tomori et al. (2022) provides further evidence to suggest implementation of the BFHI is an effective, evidence-based intervention for protecting, promoting, and supporting breastfeeding on a large scale.

Whilst the importance of implementing the ‘Ten Steps’ continues globally, global coverage of BFHI remains around 10% (Fair et al., 2024) and only 10% of babies are born in services designated as ‘Baby-Friendly’ (WHO, 2017).

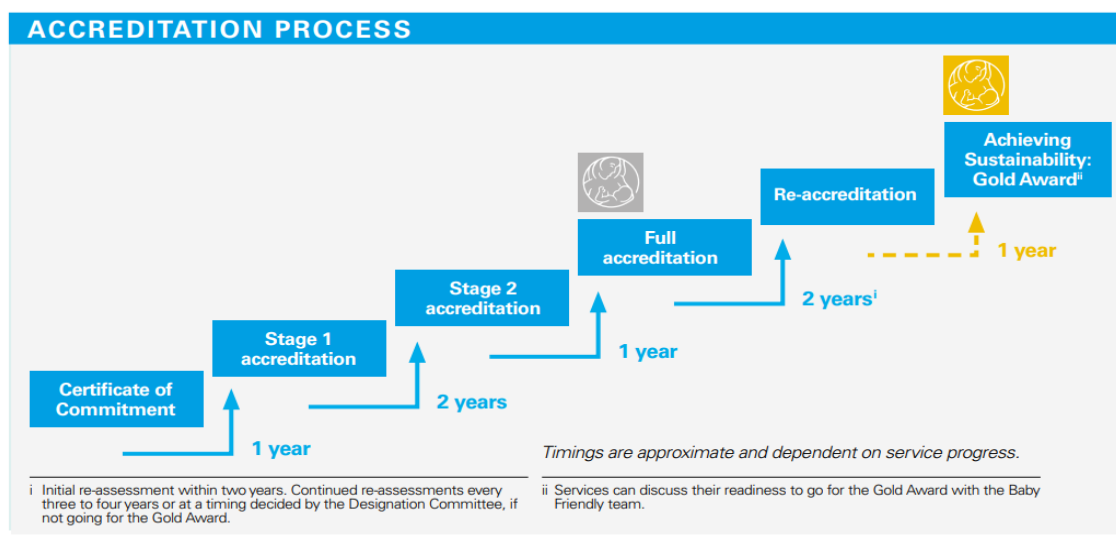
2.4 The UNICEF UK Baby Friendly Initiative

When the BFHI was adopted in the UK in 1994, it was renamed the ‘Baby Friendly Initiative’ to reflect the UK context where most of antenatal and postnatal care takes place outside of the hospital setting (UNICEF UK BFI, 2008). Additionally, to emphasise the importance of supporting mothers receiving antenatal and postnatal care in the community, in 1998, UNICEF UK BFI expanded the ‘Ten Steps’ and introduced the ‘Seven Point Plan for the Protection, Promotion and Support of Breastfeeding in Community Health Settings’ (UNICEF UK BFI, 2008). In 2005 standards were introduced for universities with midwifery and health visiting programmes. The ‘Seven-Point Plan’ was renamed ‘The Seven Point Plan for Sustaining Breastfeeding in the Community’ in 2008 to incorporate new evidence into

the ways breastfeeding initiation, duration and exclusivity could be enhanced (UNICEF UK BFI, 2008) (see appendix 2).

To become accredited as Baby Friendly in the UK, a service or organisation must implement the standards in stages (illustrated in the diagram below) and be externally assessed at each stage by UNICEF UK BFI. Most recent figures (UNICEF UK BFI, n.d.- b) indicate that 44% of maternity services and 69% of health visiting services have full Baby Friendly accreditation. Additionally, 40% of midwifery courses and 21% of health visiting courses are fully accredited as Baby Friendly.

Figure 3 illustrates the UNICEF UK BFI Accreditation Process (UNICEF UK BFI, 2024a, p. 23)



The first award given by UNICEF UK BFI is the Certificate of Commitment. This certificate recognises that the service/organisation has completed an action plan, adopted an infant feeding policy that covers all the Baby Friendly standards and is committed to implementing the plan. Commitment to implementing the plan is demonstrated by completing an application form for the Certificate of Commitment which is then signed by the Chief Executive.

To be successful at Stage 1 assessment, organisations need to demonstrate that they have built a firm foundation for the implementation of the BFI standards. This involves developing written policies supporting the implementation of the BFI standards, planning an education programme for staff and establishing processes for auditing and evaluating the standards to enable services to monitor their progress and adhere to the International Code of Breastmilk Substitutes (UNICEF UK BFI, 2017a).

To be successful at Stage 2 assessment the service/organisation needs to demonstrate that staff have been educated appropriately to implement the standards according to their role and the service provided. During the third and final stage, which leads to full BFI accreditation, evidence is gathered via interviews with mothers and key senior staff, and documentary evidence is reviewed (including internal audit results) to determine whether the Baby Friendly standards are being met (UNICEF UK BFI, 2017a).

Following a major review of the standards, in 2012 UNICEF UK BFI developed a new set of Baby Friendly standards (Entwistle & Dykes, 2018; UNICEF UK BFI, 2017a). A key aim of these standards was to focus on supporting all parents irrespective of how they decided to feed their baby to build close and loving relationships with their infants, emphasising strategies that promote early brain development, emotional attachment and positive parenting interactions such as responsive feeding to facilitate mother's capacities to respond to their babies' cues (Entwistle, 2013). Whilst these new standards continued to both embed the original standards (based on the 'Ten Steps' and 'Seven Points') to improve breastfeeding rates and experiences, the revised UK BFI standards proposed a broader approach to improve the health and wellbeing outcomes for all women and their infants, irrespective of infant feeding method (UNICEF UK BFI, 2017a). As such the revised standards also emphasise the importance of supporting parents who choose to commercially formula feed their babies to do so as safely as possible. Additionally, the revised BFI standards, for the first time, provided specific standards for maternity, health visiting and Children's Centres. These revised standards were expanded to incorporate neonatal units in 2015 and in 2022 specific standards were introduced for Children's Hospital Settings.

Moreover, these revised standards provided a framework for sensitive, mother-centred conversations from pregnancy through to the early years to provide mothers with opportunities to discuss infant feeding and relationship building and receive information relevant to their needs (UNICEF UK BFI, 2017a). Building on this the UNICEF UK BFI introduced signature sheets for antenatal and postnatal

conversations in 2018 to enable staff to have more meaningful conversations with mothers (UNICEF UK BFI, n.d. - c).

Table 1: The revised UNICEF UK BFI standards for maternity, neonatal, health visiting and Children’s Centres (UNICEF UK BFI, 2017a):

Maternity	Neonatal	Health Visiting	Children Centres
1.Support pregnant women to recognise the importance of breastfeeding and early relationships for the health and well-being of their baby	1.Support parents to have a close and loving relationship with their baby	1.Support pregnant women to recognise the importance of breastfeeding and early relationships for the health and well-being of their baby	1.Support pregnant women to recognise the importance of breastfeeding and early relationships for the health and well-being of their baby
2.Support all mothers and babies to initiate a close and loving relationship and feeding soon after birth	2. Enable babies to receive breastmilk and to breastfeed when possible	2.Enable mothers to continue to breastfeed for as long as they wish	2.Protect and support breastfeeding in all areas of the service
3.Enable mothers to get breastfeeding off to a good start	3.View parents as partners in care	3.Support mothers to make informed decisions regarding the introduction of food or fluids other than breastmilk	3.Support parents to have a close and loving relationship with their baby
4.Support mothers to make informed decisions regarding the introduction of food or fluids other than breastmilk		4.Support parents to have a close and loving relationship with their baby	
5.Support parents to have a close and loving relationship with their baby.			

As UNICEF UK BFI recognised that it would take time for health services to implement the revised Baby Friendly standards, services were able to implement the revised standards in a staged approach between 2012 and 2017 (UNICEF UK BFI, 2015). This ensured that the momentum for implementing BFI in the UK continued whilst also encouraging health services to focus on supporting all mothers to build a close and loving relationship with their baby at birth and long term (Entwistle, 2013).

Following on from the major review of the Baby Friendly standards in 2012 which suggested that the Baby Friendly standards were hard to maintain in the long-term UNICEF UK BFI decided that achieving sustainability should be part of the revised standards from the beginning and a new award was introduced in 2016 (UNICEF UK BFI, 2018). This award is aimed at sustainability after the initial accreditation: Baby Friendly Accreditation with Sustainability (Gold Award) to help services embed high quality care. In 2017, East Lancashire Hospitals NHS Trust was the first maternity service to be accredited with a Gold Award (UNICEF UK BFI, n.d. - d). A service is reported to be achieving sustainability when it has implemented and maintained the core Baby Friendly Standards, confirmed by a full reassessment. In addition, a service must have adequate leadership structures in place to support continued maintenance and evaluation of the standards and for progressing and improving the standards over time (UNICEF UK BFI, 2018). Furthermore, the service must also demonstrate that it cultivates a positive and enabling culture for Baby Friendly, which considers the specific cultural and societal challenges in the UK. Once accredited the service is expected to keep a portfolio of successes and challenges relating to all the standards, including evidence of action planning and evaluation and submit this portfolio annually to Baby Friendly. One year after the initial gold accreditation, a meeting will take place with a UNICEF baby friendly assessor to review the portfolio and review the action taken to address any recommendations made. Following this meeting, further formal revalidation meetings will take place with a Baby Friendly assessor every three years.

The four themes of the Achieving Sustainability standards are:

- **Leadership:** To develop a leadership team that promotes the Baby Friendly standards.
- **Culture:** To demonstrate that there are mechanisms in place to support a positive culture for staff and systems to enable parent's and families' feedback to be heard and acted upon (UNICEF UK BFI, 2024a).
- **Monitoring:** To construct robust monitoring processes to support the Baby Friendly standards.
- **Progression:** To continue to develop the service to sustain the Baby Friendly standards.

Following a further review of the Baby Friendly standards for health visiting and Children's Centres in 2023, updated standards for community services have recently been published (UNICEF UK BFI, 2024a)²¹. The changes which can be seen in the table below affect all services (apart from universities) implementing the Baby Friendly standards. For community services (health visiting and Children's Centres), the revised standards now include only one single set of standards.

²¹ Community services will be assessed at stage 3, reassessment and Gold using these new community standards from 1st June 2025.

Table 2: The updated UNICEF UK BFI Standards for maternity, neonatal, community services and hospital-based children’s services (UNICEF UK BFI, 2024a).

Maternity Services	Community Services	Neonatal Units	Hospital-based children’s services
1.Support those who are pregnant to recognise the importance of breastfeeding and early relationships for the health and wellbeing of their baby.	1.Support those who are pregnant to understand the evidence for breastfeeding and early relationships and their influence on the health and wellbeing of them and their baby.	1.Support parents to have a close and loving relationship with their baby.	1.Enable babies to continue to breastfeed and/or receive breastmilk when possible.
2.Support all mothers and babies to initiate a close relationship and feed soon after birth.	2.Protect and support breastfeeding in all aspects of the service and enable mothers to continue breastfeeding for as long as they wish.	2. Enable babies to receive breast milk and to breastfeed when possible.	2.Implement evidence-based practices related to giving foods or fluids other than breastmilk.
3.Enable mothers to get breastfeeding off to a good start.	3.Support parents to make informed decisions regarding the introduction of food or fluids other than breastmilk.	3.Value parents as partners in care.	3.Support close and loving relationships and value parents as partners in care.
4.Support mothers to make informed decisions regarding the introduction of food or fluids other than breastmilk.	4.Support parents to have a close and loving relationship with their baby.		
5.Support parents to have a close and loving relationship with their baby.			

In the next section I will discuss current research which considers the BFHI and UNICEF UK BFI to both introduce and justify the aims and objectives of my research.

2.5 Research into the global BFHI

Much of the evidence relating to the impact of the global implementation of the BFHI identifies how adhering to the 'Ten Steps' and achieving full accreditation is beneficial for maternity services. Benefits include both an increase in breastfeeding initiation and continuation rates and improvements in breastfeeding practices (Lojander et al., 2024; Munn et al., 2016; Patterson et al., 2018; Pérez-Escamilla et al., 2016; Procaccini et al., 2018; Shing et al., 2022; Thomsen et al. 2024). However, it is possible that Finland's breastfeeding friendly public health strategy which entitles women to a longer paid maternity leave may have influenced the positive results of the non-experimental correlational study by Lojander et al. (2024). This study, which examined the factors associated with breastfeeding exclusivity and breastfeeding difficulties in the first days after discharge from a Baby Friendly designated hospital, found that in-hospital postnatal breastfeeding support contributed to higher rates of exclusive breastfeeding and fewer difficulties. Similar results were found by Shing et al. (2022) whose research was undertaken in Hong Kong and by Thomsen et al. (2024) and Patterson et al. (2018) whose research was undertaken in the US.

Research has also explored the cost-effectiveness of BFHI accreditation. Pramono et al. (2021) conducted a case-study in a maternity unit in Australia in a BFHI accredited public hospital to examine the cost and benefits of each of the Ten Steps.

When the Social Return on Investment (SROI) framework was applied, it showed that every dollar invested in maintaining BFHI accreditation generated benefit.

Likewise, de Oliveira Silva et al. (2021) who undertook research to analyse the cost-effectiveness of the BFHI in promoting breastfeeding during the first hour of life and reducing late neonatal mortality in six hospitals in Brazil concluded that the cost-effectiveness of the BFHI in promoting breastfeeding and reducing neonatal mortality rates justified the investments required.

Research into the BFHI has explored how diverse samples of women experience care from both BFHI accredited and non-accredited hospitals and whether BFHI accredited care influences breastfeeding outcomes. Patterson et al. (2019) evaluated the relationship between individual maternity practices and exclusive breastfeeding rates, using a sample of US hospitals, including 69 BFHI hospitals and 654 non-BFHI hospitals. The results of this study showed that hospitals which had Baby Friendly designation had higher exclusive breastfeeding rates across all demographic variables studied, including those for women on a low income.

Likewise, a quasi-randomised controlled trial undertaken by Baerug et al. (2016) to assess the effectiveness of implementing the BFI in community health services in Norway did not identify any significant difference between socio-economic groups. They concluded that most mothers were satisfied with their breastfeeding experience and BFHI in community health services increased rates of exclusive breastfeeding until six months. However, Patterson et al. (2021) evaluated both the geographical distribution of BFHI and non-BFHI across Area Deprivation Index (ADI) categories and examined hospital exclusive breastfeeding rates between BFHI and non-BFHI hospitals in US hospitals across ADI categories. Whilst exclusive breastfeeding rates

were lower in highly deprived areas compared to areas with lower deprivation, BFHI was associated with significantly higher exclusive breastfeeding rates. Moreover, Nobari et al. (2017) used survey data to determine whether the BFHI had a beneficial effect on Baby Friendly hospital practices in the Los Angeles County, California and whether designation status was associated with breastfeeding outcomes among WIC participants. This research concluded that BFHI may help achieve recommended exclusive breastfeeding rates among low-income populations, but additional support strategies are needed for low-income mothers. A broadly similar point has also been made by Robert et al. (2019) who undertook a retrospective cross-sectional study in Belgium. This study compared exclusive breastfeeding prevalence and Baby Friendly practices for mothers giving birth in BFHI and non-BFHI maternity facilities. Whilst BFHI seemed to increase breastfeeding practices among mothers more likely to breastfeed, it did not encourage breastfeeding practices in mothers traditionally less likely to breastfeed, for example mothers with lower education and mothers who gave birth by caesarean section. This study therefore concluded that influencing the breastfeeding practices of mothers less likely to breastfeed requires a particular focus on complementary actions in maternity facilities as well as in community services.

Research by Groleau et al. (2016) compared the maternal experience of breastfeeding promotion and support services of mothers receiving care from institutions with low and high levels of BFI implementation in Canada. The results highlighted the importance of implementing the 'Ten Steps' in a flexible, family centred way. Moreover, this research which used a qualitative case study methodology, concluded that health services implementing the BFHI need to focus

on empowering women, by considering the potential barriers and strategies for overcoming them, rather than simply reaching outcomes.

Available research also identifies the barriers and facilitators for successful implementation of the BFHI. According to Hirani and Ahmadi's (2022) scoping review, strategies for successful implementation of BFHI globally include health care providers' leadership; teamwork/collaboration; adequate staffing and financial resources; education; mentoring; training opportunities for healthcare professionals; continuous monitoring of the BFHI steps; compliance with every step of BFHI; care which utilises a mother-centred approach; and regulation on marketing and sale of breastmilk substitutes. However, results identified the barriers to the successful implementation of the BFHI included the absence of clearly stated policies on breastfeeding; lack of understanding of the BFHI; insufficient support and resources; disagreements/lack of collaboration among health care professionals; maternal circumstances; and hospital routines and practices. Similarly in the scoping review undertaken by Walsh et al. (2023) to review the literature on the BFHI, the results identified the need for national policy and health systems; effective and strong national leadership demonstrated by legislation, funding and policy; government resources; health worker breastfeeding knowledge and training; educational programmes for pregnant and postpartum women and breastfeeding feeding support across the perinatal period. Whilst most studies in this review focused on mothers, babies, or both (n=144) and included ten studies from the UK, 16 studies were published between 1993 and 2000, 62 between 2001 and 2010, 169 between 2011 and 2020, 169 studies between 2011 and 2020, only 31 studies included were published between 2021 and 2022. This is important because studies undertaken

before 2018 would not have been able to explore whether updated BFHI guidance and changes to the 'Ten Steps' had improved breastfeeding practices. Pramono et al. (2019) call our attention to the differences between the 1989 and the 2018 'Ten Steps' to highlight how the changes to the wording of the 'Ten Steps' could influence practice (please refer to section 2.3 for further information about the differences between the 1989 and 2018 versions of the 'Ten Steps').

However, the systematic review by Gavine et al. (2017), which aimed primarily to determine whether education and training programmes for health care staff influence their knowledge and attitudes about supporting breastfeeding women concluded that there is a lack of evidence to determine whether breastfeeding training and education can help improve breastfeeding knowledge and attitudes. Whilst this systematic review included studies by Westphal et al. (1995) and Kronberg et al. (2008) which had primary outcome measures associated with practice of BFHI steps 3-9, (please see appendix 1 for the 'Ten Steps'), these studies were also undertaken before the 'Ten Steps' were updated in 2018.

Research also considers which of the 'Ten Steps' have the most impact on breastfeeding practices. Munn et al. (2016) undertook an integrative literature review using the Socio-Ecological Model to highlight how BFHI implementation influence factors on multi-levels. This review highlighted that prenatal education (step 3), and postnatal breastfeeding support (step 10) are the most difficult steps to implement. Whilst they suggest these steps are the most likely to impact maternal breastfeeding decisions, it is step 10 which they argue has the most potential to influence infant

feeding decision-making. This is because step 10 emphasises the importance of mothers receiving continued breastfeeding support after discharge from hospital which both increases breastfeeding continuation rates and improves breastfeeding outcomes (Aryeetey & Dykes, 2018; Pérez - Escamilla et al., 2016).

A considerable proportion of studies (Esbati et al., 2020; MacDonald et al., 2024; Mäkelä et al., 2024; Pound et al., 2016; Pramono et al., 2022; Salem et al., 2020; Wieczorek et al., 2016) which explore the implementation of BFHI, focus on healthcare professionals' experiences and perceptions. Esbati et al. (2020) used an online survey to explore health professional and stakeholders' perspectives on the uptake and implementation of the BFHI in Australia from an organisational change perspective. A key finding from this study was the perceived impact of formula advertising, social norms, and social media on BFHI implementation. The study by Pramono et al. (2022) which explored midwives' experience of implementing the BFHI in a Baby Friendly hospital in Australia found that motivation underscored by a belief that the BFHI was an excellent initiative helped them to implement the 'Ten Steps'. However senior staff undermining the capacity to support skin-to-skin (step 4) and difficulties implementing step 9 (prohibit pacifier use) were barriers to BFHI implementation. In the qualitative study by Wieczorek et al. (2016) which explored Austrian health professionals' perspectives on the implementation of the BFHI, the different perspectives of midwives, nurses and doctors hindered the integration of the BFHI into practice. The qualitative study by MacDonald et al. (2024) which explored Canadian midwives' perceived barriers and facilitators to BFHI implementation found that breastfeeding and BFI resources were not distributed equitably. According to their study, the COVID-19 pandemic which had led to staff

shortages and healthcare provider burnout had made it difficult to prioritise BFI implementation. A qualitative descriptive study by Mäkelä et al. (2024) highlighted that health professionals felt that the implementation and maintenance of the BFHI in Finland was positively associated with breastfeeding support practices. This work confirmed the findings of an earlier study by the same study team who found that BFHI implementation was positively associated with both healthcare professional's breastfeeding attitudes and breastfeeding support practices in hospital (Mäkelä et al. 2021).

A common theme amongst research into the BFHI is the need for further research and new strategies to establish the transition of care and support for mothers after hospital discharge for breastfeeding continuation (McLelland et al., 2015).

Additionally, the need for further research to explore mothers' experiences and perceptions of Baby Friendly practices has been highlighted (Munn et al., 2016). In the scoping review by Walsh et al. (2023), as only nine of the 210 studies included in their review focused on the Baby Friendly Community Initiative BFCI, a lack of evidence was highlighted.

2.6 Research into the UNICEF UK BFI standards

Although Fallon et al. (2019) argue that there is a lack of UK data which relates to BFI and maternal and infant health outcomes, to date, several studies have explored both the impact of the implementation of the UNICEF UK BFI standards and health professionals' attitudes towards BFI. The mixed methods study by Fair et al. (2024) which explored the barriers and facilitators to Baby Friendly accreditation and the perceived impact of the BFI had mixed opinions about the BFI on breastfeeding outcomes. Despite many stating that the BFI positively impacted upon breastfeeding outcomes, others did not see any associated increases in duration, with some feeling that initial breastfeeding outcomes were not sustained. However, this study identified the importance of staff having the knowledge, competence, and skills to support breastfeeding. Participants identified how staff training empowered them to support women and engage in conversations in a way that they did not prior to the training. A note of caution is due here. Although most of the survey respondents (health care providers, educators, commissioners, and a maternity user representative) were from England²² and worked in services with full accreditation or BFI Gold accreditation, individual interviews were also undertaken with key stakeholders from Australia and Germany. McIntyre and Fraser (2018) undertook a longitudinal case-study to identify the impact of incorporating the UNICEF UK BFI education standards into a midwifery programme. They suggested that BFI university education in accordance with the BFI university education standards facilitated positive changes in midwifery students' reported attitude towards supporting mothers with infant feeding. However, Mulcahy et al. (2022) from a systematic review of 11 papers suggest that there is a fundamental need to improve breastfeeding skills amongst

²² There were 322 respondents to the survey. 60.5% of these were from England.

healthcare professionals. Moreover, Entwistle et al. (2007) in their study to determine whether a BFI course in breastfeeding management would improve midwives' knowledge of and attitudes towards breastfeeding identified only a limited effect of BFI course attendance on the midwives' ability to promote breastfeeding among low-income women.

The cross-sectional study undertaken by Biggs et al. (2018) which was undertaken in two maternity units in the UK with full BFHI accreditation to understand the reasons for the high formula milk supplementation rate found significant associations between the midwives' decisions on non-medical infant-formula supplementation and non-adherence to BFHI standards despite midwifery staff attending the Trust's breastfeeding training. The findings of this study also support those of other studies (e.g. Hunter et al., 2015) which highlight how a lack of time alongside workload issues prevent midwives from supporting breastfeeding.

A grounded theory study by Breckenridge et al. (2019) explored ways to achieve large-scale, sustained improvements and innovations in healthcare organisations, taking learnings from UNICEF UK, NHS Highland, Healthcare Improvement Scotland, and the Baby Friendly Gold accredited East Lancashire Hospital NHS Trust. This study highlights the importance of giving staff the opportunity to understand the impact of BFI in the service²³ to motivate sustained improvement activity.

²³ Staff were motivated to change when they could see the link between service improvements and improvements in the experiences and outcomes of mothers, babies, and families.

A meta-synthesis of five qualitative studies (Hoddinott et al., 2012a; Hinsliff et al., 2014; Lagan et al., 2014; Thomson & Dykes, 2011; Thomson et al., 2015) in the systematic review by Fallon et al. (2019) to determine the impact of the UNICEF UK BFI on maternal and infant health outcomes found that support from health professionals is highly influential to women's experiences of BFI care. However, Fallon et al. (2019) suggested that the current delivery of BFI may both promote unrealistic breastfeeding expectations and hinder care which meets individual women's needs and prevent positive emotional experiences. Moreover, Fallon et al. (2019) propose that the UNICEF UK BFI should consider the specific needs of the UK population and adapt in accordance with the existing cultural context. However, as the UNICEF UK BFI standards were revised in 2012 and this systematic review included papers published between 2002 and 2015, it is very unlikely that these papers reflect care provided by health professionals implementing the revised UK BFI standards. This is important as the revised standards encourage health professionals to adopt a less didactic and more woman-centred approach to infant feeding and take individual circumstances into account.

When discussing the limitations of this review, Fallon et al. (2019) suggest that future infant feeding research conducted in UK hospital or community settings should specify whether this takes place at a BFI accredited organisation and at which stage of accreditation this is. The authors also indicated the need for further research to confirm whether BFI is effective in supporting longer term breastfeeding outcomes.

It has also been observed that the culture of the team or organisation in which BFI is implemented influences the way BFI is implemented in both the hospital and the community. Byrom et al. (2021) used a critical ethnographic approach to explore how the revised BFI standards influenced the culture of a maternity unit in England. This research suggested that the standards, alongside effective leadership, and a team approach, provide staff and service users with informational, practical, and emotional resources to improve infant feeding care. Thomson et al. (2012) undertook a qualitative study to explore approaches to implementing the community BFI standards which highlighted the value of a hearts and minds approach that involved engaging with professionals at all levels.

In the next section I will outline the aims and objectives for my research and provide the rationale for my longitudinal narrative research study.

2.7 Aim of research and study objectives

Whilst Entwistle and Dykes (2018) identify anecdotal evidence which suggests that the revised standards have been well received by infant feeding leads and Baby Friendly Assessors, they also highlight there is no formal evaluation of the new standards. Additionally, evidence from UK based studies highlight gaps in knowledge. These include Fair et al. (2024) who suggest the need for further research to provide evidence of the BFI as an effective intervention and Byrom et al. (2021) who highlight that there are currently no other studies which explore how the revised standards influence women and their families.

Current research on the implementation of the BFI standards in the UK highlights that the process varies greatly and depends on the sociocultural context (Bilson & Dykes, 2009; Byrom et al., 2021) and refers to BFI implementation in maternity units within hospitals (Byrom et al., 2021) and in the community (Thomson et al., 2012). However, there is no longitudinal research relating to how women experience infant feeding care from Gold accredited services across the perinatal period and how this care impacts on their lived experience of infant feeding (Aryeetey & Dykes, 2018). As fully BFI accredited health visiting services are expected to provide routine care, additional services, and specialist services (UNICEF UK BFI, 2017a), it could be suggested that the UNICEF UK BFI is based on a model of progressive universalism. However, there is no evidence which explores whether the socioeconomic context in which infant feeding care is being provided influences the care women receive. This is significant because recently, Hernández-Cordero & Pérez-Escamilla (2022) highlight that there is a need to understand how to tailor interventions to reduce inequalities in breastfeeding practices. Additionally, UNICEF UK BFI in their infant feeding survey in 2022 also identified the need to obtain case-studies or stories to highlight good practice with the intention of reducing the inequity of care provided across the UK. Therefore, this longitudinal narrative research study aims to address this evidence gap by eliciting and exploring stories of how a diverse sample of women experience infant feeding care from UNICEF UK BFI Gold accredited maternity and community services to consider whether their needs have been met.

The study by Renfrew et al. (2012b) which is cited in the evidence for the revised UNICEF UK BFI standards (Entwistle, 2013) suggests that certain types of

communication are more likely to help women feel supported, self-confident and enabled to continue to breastfeed, with 'person-centred' communication, tailored to the setting and the needs of the population being more effective. However, the current UK BFI conversation guidance (UNICEF UK BFI, n.d. - a) do not provide any specific instruction to help staff understand the mother's individual situation or to identify what information/services the mother needs. Additionally, there is no evidence which explores whether a diverse sample of women have specific requirements in relation to the way health professionals communicate infant feeding messages. This provided the rationale for exploring what women/birthing people want from infant feeding communication in my systematic review and exploring how infant feeding care is communicated to a diverse sample of women in my empirical research.

The study objectives are:

To explore how professionals trained in implementing the BFI revised standards have influenced women's experiences and perceptions of infant feeding care during pregnancy up until introducing solid food (around six months postnatal).

To explore whether there are any variations in experiences amongst a diverse sample of women and what influences these.

To explore how infant feeding care is communicated to a diverse sample of women.

2.8 Conclusion to chapter

In this chapter I have used Bronfenbrenner's SEM and intersectionality theory to explore the multi-system level factors which influence a woman's ability to breastfeed in the UK and explore why breastfeeding rates are lower in women of a lower socio-economic status. I have provided a history of both the global BFHI and UNICEF UK BFI. Additionally, I have discussed the previous research which considers the BFHI and BFI to both introduce and justify the aims and objectives of my research and provide the rationale for my systematic review which is the focus of the next chapter.

Chapter 3: Systematic review and meta-ethnography

3.1 Introduction

This chapter presents an overview of the systematic review and meta-ethnography which was undertaken to understand what women and birthing people want from infant feeding communication. To consider different identities and be inclusive of all people in this systematic review I have used the terms 'birthing people' and 'chest feed' in addition to 'women' and 'breast feed.' The eMERGe meta-ethnography reporting guidance (France et al., 2019) has been used to improve the clarity and completeness of the reporting of this meta-ethnography, as suggested by Sattar et al. (2021). This chapter concludes with a discussion about the insights gained from undertaking this review and how this informed the empirical phase of my research.

3.2 Aim of the meta-ethnography

The aim of this meta-ethnography was to address the research question: What do women and birthing people want from communication about infant feeding?

This review aimed to identify:

Women's and birthing people's views, experiences and perspectives of the communication and language used in transmitting infant feeding care.

The barriers and facilitators for women and birthing people in relation to them receiving the communication they want.

As one of the objectives of my empirical research was to explore variations in experience amongst a diverse sample of women, this review also aimed to identify whether a woman's and birthing person's socio-economic background influences their views, experiences, and perspectives of the communication regarding feeding and caring for their baby.

3.3 Rationale for using meta-ethnography.

A meta-ethnography of qualitative studies was undertaken to understand what women and birthing people want from infant feeding communication. Booth et al. (2016) describe how meta-ethnography is an explicitly interpretive, inductive approach which uses the author's interpretations in published primary studies as data. Rather than aggregating findings, this approach develops new explanations and conceptual understandings (Ring et al., 2011). In addition, this approach allows for the synthesis of a range of qualitative studies which are grounded in the experiences of the participants. Booth et al. (2016) proposes meta-ethnography as the ideal method for understanding the context in which health behaviours occur. This approach was therefore considered the most appropriate to both obtain a deep understanding of women's and birthing people's experiences and perspectives and consider the context of emergent findings.

The six phases of meta-ethnographic synthesis by Noblit and Hare (1988), which are listed below, provided the framework for this synthesis:

Phase 1: Getting started (the search).

Phase 2: Deciding what is relevant to the initial interest.

Phase 3: Reading the studies which included assessing the study quality and extracting the data.

Phase 4: Determining how the studies are related – analysing and summarising the study findings.

Phase 5: Translating the studies into one another.

Phase 6: Synthesising translations – meta-analysis.

3.4 Methods

Getting started – the search (Phase 1)

After publishing the review protocol on the PROSPERO register on 23rd July 2021, registration number CRD42021269237 (Atkinson et al., 2021), keywords that would be used in the search were identified using the PEO (Population, Exposure, Outcome) concept framework (Hosseini et al., 2024). To ensure an appropriately constructed search strategy was developed, support was sought from a subject librarian. The public advisors were also consulted to ensure the key words reflected their lived experience. The search strategy was revised several times before final

decisions were made on the content of the searches. The term ‘chest feed’ was included to be inclusive of all the terms currently used to refer to the ways babies are fed human milk. Please see Table 3 for the final search terms based on the PEO framework along with the truncated symbols that were used.

Table 3: Search terms with truncated symbols.

Population	Exposure	Outcome
“Peer Support”	“Bottle feed*”	Counsel*
midwife	“breastmilk”	Communicat*
“Health visitor*”	“Infant feed*”	Language*
“Healthcare practitioner*”	“Bottle fed”	“Infant feeding advice”
“Healthcare professional*”	“Formula milk*”	“Infant feeding information”
Mother*	“Formula feed*”	“Communication train”
nurse	“Chest feed*”	“Motivational interviewing”
“Woman or women”	lactat*	
	“Breast fed”	
	“Breast feed*”	

Deciding what is relevant to the initial interest (Phase 2)

The inclusion and exclusion criteria, which are detailed in Table 4, were determined when designing the review protocol to ensure that only articles that could answer the review questions would be included. The decision to include papers published after 1990 was to limit the inclusion of papers which were published before the BFHI was introduced in the UK (see section 1.5). The decision to include only papers from high-income countries²⁴ was due to differences in infant feeding care provision between low-, middle- and high-income countries.

²⁴ The Development Assistance Committee (DAC) list of Official Development Assistance (ODA) recipients effective for reporting in 2021 (Organisation for Economic Co-operation (OECD, 2022) was used to identify high-income countries.

Table 4: Inclusion and exclusion criteria

	Inclusion	Exclusion
Publications	Published primary studies	<ol style="list-style-type: none"> 1. Secondary sources 2. Grey literature such as opinion pieces.
Focus of paper	<ol style="list-style-type: none"> 1. The views, experiences and perspectives of women and birthing people in relation to the language/communication used in transmitting infant feeding care. 2. Focused on communication used by health professionals. 	<ol style="list-style-type: none"> 1. Studies which focused on women's experiences of infant feeding that were not about the communication used by health professionals. 2. Studies which focused on the views of health professionals and did not focus on women's experiences and perspectives.
Methodology	<ol style="list-style-type: none"> 1. Qualitative designs (e.g. ethnography, phenomenology) 2. Mixed methods with a qualitative component for data collection (e.g. focus group interviews, individual interviews, observation, diaries, or qualitative surveys). 	<ol style="list-style-type: none"> 1. Quantitative designs 2. Quantitative methods
Language	Published in English ²⁵ .	Any studies not written in English ²⁶ .
Timeframe	1990 onwards	Before 1990
Country	High-income countries	Low and middle-income countries

²⁵ Whilst Walpole (2019) suggests that including non-English papers could provide relevant papers which contain insights or a context not provided in English papers, resource constraints meant that it was not possible for me to include non-English papers.

²⁶ These were logged but not translated.

Literature search methods (Phase 2)

The electronic databases CINAHL, MEDLINE, PsycArticles, EMBASE and Maternity and Infant Care databases were searched using the search words in Table 3.

Additional searches included backward and forward chaining and a dedicated search for key authors to identify other papers which were relevant. When undertaking searches, the Boolean operator “OR” was used to combine the keywords within each concept to broaden the search. To narrow and combine the three concepts and their keywords, the Boolean operator “AND” was used. Results were then limited to date and to humans in Embase.

Eligibility assessment methods (Phase 2)

First, I imported records from the databases into Endnote and de-duplicated. I then imported titles and abstracts into Rayyan where they were blinded before being screened independently by two reviewers (my Director of Studies (NC) and I) to determine eligibility for full text review. After screening titles and abstracts, full text articles were retrieved and uploaded to Endnote. NC and I independently reviewed the full text articles against the inclusion/exclusion criteria. Finally, decisions were blinded and recorded independently in Rayyan. Agreements for inclusion were made by consensus. However, there were no disagreements regarding inclusion so the third reviewer, my supervisor (GT), did not get involved at this stage.

Assessing the Study Quality (Phase 3)

Full text articles were quality appraised using the quality assessment tool (Table 5) and grading system (Table 6) developed by Downe et al. (2009) and allocated a score of A-D. Twenty per cent of the full text articles were quality appraised by NC. Booth et al. (2016) explain how quality appraisal is essential within qualitative reviews to identify weaknesses in studies which may impact on the validity of study findings and then collectively the findings reported in the review. Therefore, the decision was made to exclude any paper graded D in view of significant flaws that were evident in the papers. Due to the considerable influence that commercial milk formula companies have on infant feeding choices (see section 2.2.5) and to ensure I enforced the Code in my research (see section 2.2.5), it was important to examine whether any authors declared any conflict of interest which was due to a connection with a commercial milk formula company. Thus, the decision was made to exclude any papers where the authors had declared a conflict of interest which resulted from a connection with a commercial formula milk company.

Please see appendix 4 for the results of the quality assessment.

Table 5: Quality assessment tool (Downe et al., 2009)

Are the aims clear?
Are the participants appropriate for the research question?
Is the design appropriate for the aims and theoretical perspective?
Is the method (s) appropriate for the design?
Is the sample size and sampling justified?
Does the data analysis fit with the methodology?
Is reflexivity present?
Is the study ethical?
Does the data justify the findings?
Is the context described sufficiently?
Is there sufficient evidence of rigour?

Table 6: Grading system (Downe et al., 2009)

A: No, or few flaws. The study credibility, transferability, dependability and confirmability is high.
B: Some flaws, unlikely to affect the credibility, transferability, dependability and/or confirmability of the study.
C: Some flaws that may affect the credibility, transferability, dependability and /or confirmability of the study.
D: Significant flaws that are very likely to affect the credibility, transferability, dependability and/or confirmability of the study.

Reading the studies (Phase 3)

The articles were imported into MAXQDA where they were read repeatedly for familiarity purposes (Sattar et al., 2021). First, I extracted information from each of the studies into a table in excel to collect information on study characteristics and further familiarise myself with the studies. This included information on the author; country; study aims/research question; the study context; methodology; data collection methods; participant characteristics (which included socio-economic background), sampling and the study findings.

I then extracted the 'raw data' from the studies. In a meta-ethnographic synthesis, the 'raw data' are the ideas or concepts which appear in both the results and discussion sections of the included papers (Toye et al., 2014). This raw data therefore included both first and second order constructs. Sattar et al. (2021) explain how the consideration of first order, second order and third order constructs²⁷ are useful for differentiating data when undertaking a meta-ethnography. A benefit of undertaking this process in MAXQDA was that I was able to code data verbatim wherever the data appeared in the paper. As I did not have to summarise the data in a table this also prevented me from losing important detail (Atkins et al., 2008; Sattar et al., 2021).

²⁷ First order constructs represent primary data (the participants' views), and second order constructs represent the authors' views and interpretations of the primary data (participants' views). Merten et al. (2015) explain how first order constructs relate to interpretations of experience and second order constructs to interpretations of interpretations of experience.

Determining how studies are related (Phase 4)

This phase involved creating a list of the key concepts from each paper. Toye et al. (2014) explain how this phase is essential when undertaking a meta-ethnography since concepts are the raw data of the synthesis. Both Cahill et al. (2018) and France et al. (2014) describe a concept as a meaningful idea that develops by comparing particular instances. However, it was important that I developed concepts which explained rather than described the data (Cahill et al., 2018; France et al., 2014). This is because the aim of qualitative analysis is to develop concepts which help to understand an experience (Seale, 1999). The last step during this phase involved reducing the concepts from the different studies into relevant categories. Categories were then labelled using terminology which encompassed all the relevant concepts they contained. However, Sattar et al. (2021) emphasise that it is important to remember that the category labels developed during this phase are descriptive labels rather than third order constructs (see section 3.6).

Process of translating studies (Phase 5)

During this phase, each concept from each paper is compared with all the other papers to check for similarities and differences and organise them into further conceptual categories, which Sattar et al. (2021) argue, results in the development of third order constructs. Malpass et al. (2009) explain how third order constructs refer to the views and interpretations of those undertaking the synthesis or the interpretations of interpretations of interpretations of experience. Since the studies

provided similar findings, this involved reciprocal translation, where concepts in one study incorporated those of another (Noblit & Hare, 1988). As there were no differences in findings between the studies, refutational data were not identified (Noblit & Hare, 1988). During this phase, I used the paper by Burns et al. (2013) which details key concepts relating to health professionals' communications about infant feeding messages to develop a coding framework, as a way of 'orientating the synthesis' (Pope et al., 2007). This coding framework was then used to record the key concepts from the remaining papers and was revised and updated as new concepts emerged. Toye et al. (2014) suggest that this process of categorisation using constant comparison is essential when synthesising qualitative research. This phrase was iterative, and further amendments were made after discussions with the public advisors and my supervisory team, ensuring ongoing reference to the full text articles. This helped to ensure that the sub-themes and themes explained rather than described the data and retained where possible the context and meaning of the primary studies (Atkins et al., 2008).

Synthesising the translations (Phase 6)

Once conceptual categories had been developed, the next stage of this meta-ethnography involved creating a line of argument synthesis or as Noblit and Hare (1988) explain, my interpretation of the relationship between the themes to synthesise all the key concepts. This also helped to emphasise key concepts that may be hidden within individual studies to discover the whole that is greater than the sum of its individual parts (Noblit & Hare, 1988). A conceptual framework was then created to help me visualise my third order constructs and make sense of my

interpretations to understand how women and birthing people experience infant feeding communication.

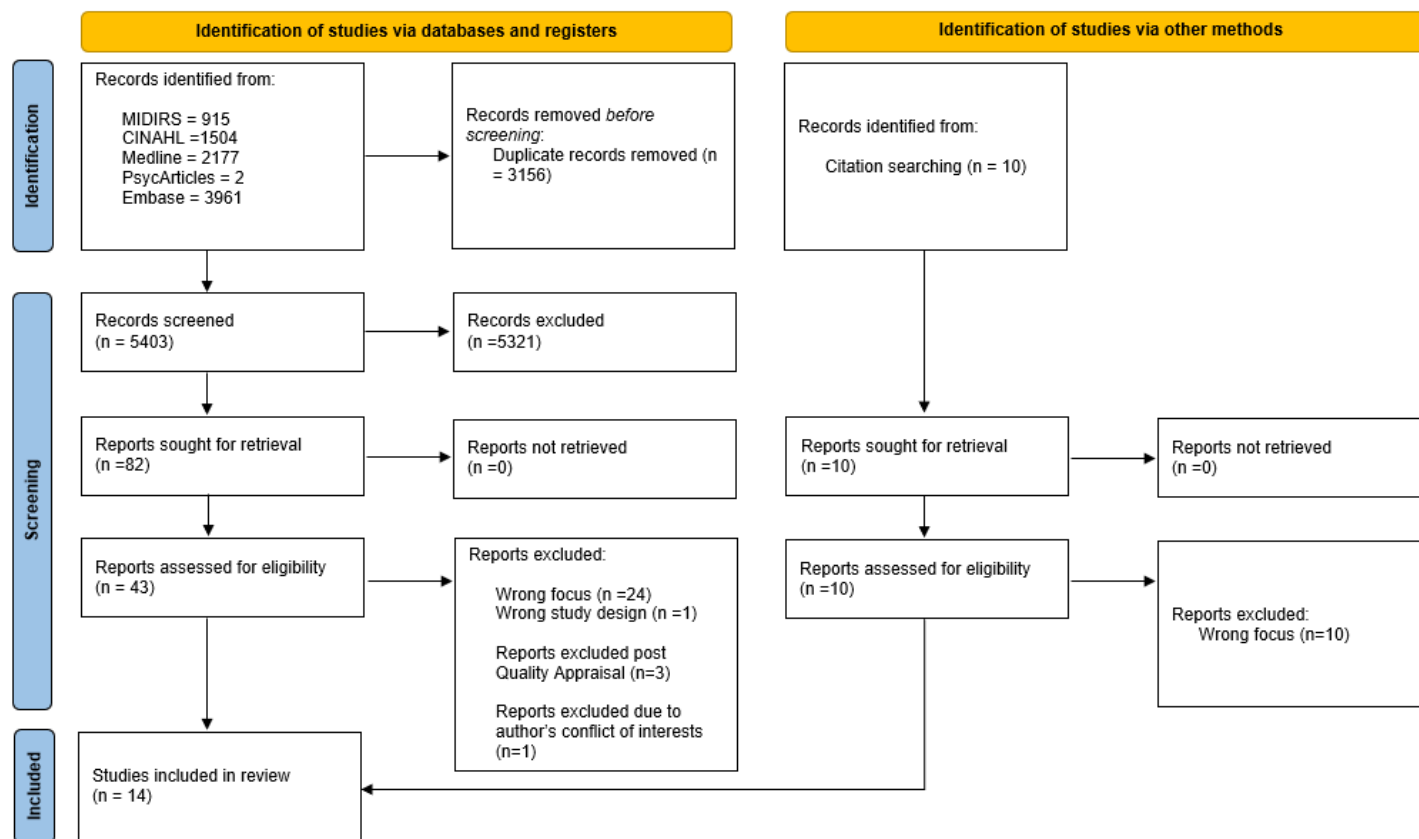
To ensure an equity lens was embedded throughout the review, I asked my public advisors who had lived experience of infant feeding communication for their feedback on the conceptual categories I had developed and my interpretations of the relationship between the themes. This discussion provided me with the opportunity to gain alternative perspectives which helped me to both develop my conceptual framework and reflect on how the findings related to their lived experience of infant feeding communication.

3.5 Results of the search

The final search which was undertaken in October 2021 yielded 8569 studies – 8559 studies from the databases and 10 studies from the additional searches. A flowchart of the identification and selection of studies can be found at Figure 4. However, only 43 full text articles were assessed for eligibility. During the eligibility assessment a further 25 articles were excluded due to the wrong focus or study design employed in the study.

Figure 4: A PRISMA diagram

PRISMA 2020 flow diagram for new systematic reviews which included searches of databases, registers and other sources



Source: Page, M. J., McKenzie, J. E., Bossuyt, P. M., Boutron, I., Hoffmann, T. C., Mulrow, C. D. & Moher, D. (2021). The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. *BMJ*, 372.

Quality assessment

18 papers were assessed for quality (see appendix 4). In view of significant flaws evident in the three papers graded D, these were then removed. Although acknowledging that the papers graded C contained some flaws that may affect credibility, transferability, dependability, and/or confirmability, it was felt that these articles added to the overall data and so were included. There was only one disparity during quality assessment, and this was resolved through discussion with a third reviewer (GT).

Information about funding sources and any conflict of interests was cited on most of the papers. None of the papers included in this systematic review stated conflicts of interest or funding that would have been classed as violations of the International Code of Marketing of Breast-Milk Substitutes (WHO, 1981). Due to the paper by Flaherman et al. (2012) declaring a conflict of interest for one of the authors, Dr Michael Cabana which related to his role as a paid consultant for Abbott Nutrition and Mead-Johnson²⁸ this was excluded.

After removing the three papers graded D and the paper which stated a conflict of interest that would have been classed as a violation of the Code, 14 articles remained. These 14 papers were included in the synthesis.

²⁸ Abbott Nutrition and Mead-Johnson are both commercial formula milk companies. First Steps Nutrition Trust (2025) identify that the commercial formula milk market in the US is dominated by Abbott and Mead Johnson and account for 80% of products sold.

Study characteristics

The fourteen studies included in this review represent the views of 696 women. The studies were undertaken in the UK (n=3), US (n=4), Australia (n=5) and Norway (n=1) and one study which included participants from the UK and US. All studies related to women's experiences of infant feeding communication with health professionals. Six studies reported data relating to women from low socio-economic backgrounds, two studies reported data relating to cultural issues, one study reported data relating to women with disabilities and one study related to the experiences of mothers in same-sex relationships.

The characteristics of the studies included in the review are summarised in Table 7.

Table 7: Characteristics of included studies

Study Number	Author Country	Study Aims/ Research Question	Study Context	Sample Size	Participant Characteristics (Socio-demographics)	Methodology	Data collection methods	Key findings	Quality Assessment (Agreed)
1	Andrews et al. (2021) US	To explore the lived experience of disabled women related to breastfeeding	Mothers with a disability living across the US.	Convenience and snowball sampling. 24 women	Range of disabilities. Some women multiple disabilities. Disability identified through self-identification.	Qualitative Participatory Action	Semi-structured interviews via video, using sign language, interpreters, as necessary.	Four major themes relating to breastfeeding among disabled women: Communication difficulties with lactation consultants. Intense pressure to breastfeed. Milk supply and latch problems. Positive interactions with health care providers.	A
2	Bookhart et al. (2021) US	To identify facilitators and barriers to in hospital exclusive breastfeeding and explore breastfeeding support available from key stakeholders across the socio-ecological model.	Mothers and stakeholders from Grady Memorial Hospital. Interviews took place near the time of hospital discharge.	Purposeful sampling. 20 mothers. 10 EBF. 10 non EBF. 18 stakeholders	Demographic information reported for the 20 mothers who participated	Cross-sectional qualitative	Semi-structured interviews	Several themes identified at the institutional level. These included: Gaps in prenatal education. Consistent information. Adequate practical help. Inadequate staffing.	A
3.	Burns et al. (2013) Australia	To examine the nature and impact of the language and practices of midwives when providing breastfeeding support to women in the early post-partum period.	Midwives and student midwives and breastfeeding women on postnatal wards. Two sites in New South Wales.	77 women observed. 30% of the 77 women randomly selected for interview 4-6 weeks after discharge.	45 first child 32 subsequent children. 74 singles 2 twin births. Birth history recorded.	Qualitative.	Observations of breastfeeding interactions. Interviews. Focus groups with midwives.	Three approaches identified in which midwives communicated and practiced: Mining for liquid gold. 'Breastfeeding – it's not rocket science.' 'Breastfeeding is a relationship.'	A

				Convenience sample of 40 midwives					
4.	Burns et al. (2016) Australia	To examine the following questions: What words and metaphors do health professionals use when referring to the newborn breastfeeding infant? What impact does the language used by health professionals have on a mother's own interpretations of her newborn and its behaviour?	Antenatal educators. Midwives. Lactation consultants. Women in the postnatal unit or receiving midwifery care at home within the first week after birth.	85 mother-midwife interactions (77 women) in the early days after birth. 40 midwives in focus groups. 11 Interviews with senior staff. 23 interviews with individual women 4-6 weeks after birth. Digital recordings of antenatal education sessions for 124 women and their support person.	Information provided re: parity and birth method. Experience of midwife provided.	Social Constructionist Epistemology. Post-structuralist approach informed methodology.	Observations of antenatal education sessions. Recording mother-infant interactions around breastfeeding. Focus groups with midwives. Interviews with senior staff. Interviews with individual women 4-6 weeks after birth. Interactions observed in both hospital and home environment.	Midwives adopted the role of interpreter of infant behaviour. There were only a small number of midwives who constructed breastfeeding as a connected relationship between the mother and infant. By prioritising the relationship and constructing the infant as connected to their mother, midwives introduced different interpretations of breastfeeding infant behaviour.	A
5.	Burns & Schmied (2017) Australia	To explore the similarities and differences in breastfeeding communication styles, language and practices used.	Postnatal women. Private practicing midwives (PPM) Trained peer support counsellors (PSC). Two settings – a 'drop-in' lounge and women's homes.	22 breastfeeding women. 5 PPM. 4 PSC	PPM experience ranged from two years to 25 years, and one had a qualification as a lactation consultant. Four PSCs, two of which had qualifications as a lactation consultant.	Discourse Analysis.	Observations of non-verbal communication. In-depth interviews at 6 weeks post birth. 16 individual interactions recorded. 6 women participated as part of a group session.	Three discourses identified that shaped language and practice: Breastfeeding is normal. Your body your choices. The right help at the right time.	B

							Interviews with 14 women after discharge.		
6.	Dykes (2005) UK	To explore the nature of encounters between midwives and breastfeeding women within postnatal wards.	Two maternity units in the North of England. Neither hospital had Baby Friendly accreditation.	39 midwives. 61 postnatal women.	Women who were admitted to the postnatal wards who had commenced breastfeeding and were able to communicate in written and verbal English. Midwives.	A critical ethnographic approach	Observation of interactions between midwives and breastfeeding women. 106 focused interviews with postnatal women. 37 focused interviews with midwives.	Connected and disconnected communication in relation to the woman's context and personal agenda. Disconnected encounters: Managing breastfeeding. Providing insufficient information. Connected communication: Taking the time. Understanding individual needs. Relational communication.	A
7.	Hauck et al. (2011) Australia	To explore women's perceptions of conflicting advice around breastfeeding from formal support networks, specifically health professionals involved in postnatal support	Breastfeeding women, discharged from a metropolitan public maternity hospital in Western Australia. Women recruited three weeks after discharge. Women studied for a three-month period.	62 women.	Demographic information obtained from each participant. Majority of women from socially disadvantaged groups.	Qualitative exploratory design using the critical incident technique.	Written accounts and telephone interviews. 12 women provided written accounts. 50 women interviewed over the phone.	Factors identified which influenced whether mothers perceived advice as conflicting.	B
8.	Hoddinott et al. (2012a) UK	feasibility, acceptability, and fidelity of a feeding team intervention with an embedded randomised controlled trial of team-initiated (proactive) and woman-initiated (reactive) telephone support	Postnatal Ward Scotland. Mixed urban and rural population The feeding team and staff working on the postnatal ward or in disadvantaged community areas.	9 steering group meetings. 40 women. 17 members of staff.	Focused on women from disadvantaged areas. Mixed urban and rural population	Participatory approach informed by principles of action research. Quantitative and Qualitative data.	Postnatal ward observations. Interviews with women x 40. Follow up telephone interviews with women x 11.	Ways to establish a trusting relationship identified which included: observed. Responsive communication. Woman-centred approach. Continuity of care. Barriers identified:	B

		after hospital discharge.						Availability of support. Time.	
9.		To explore infant feeding practices among Somali-born mothers in Norway and the ways in which they navigate among different information sources	Somali mothers. Living in Oslo or nearby counties. 4–8-month infant born in Norway	22 Somali mothers. Snowball sampling. Multi-recruitment strategy	All mothers Muslim. Most of them came to Norway as a child. Ages ranged from 21–40 years, and most were married. Most mothers were multiparous. Mothers with different education levels in both interviews and focus groups.	Qualitative.	Semi-structured interviews and focus groups. First interview when infant 4–8 months old. Focus groups when children approximately 24 months of age.	Attitudes towards breastfeeding. Reasons for early cessation of breastfeeding. Experiences related to receiving advice from health care providers. Advice from different sources. Navigating among different information sources.	B
10.	Hoddinott & Pill (2000) UK	To look at how communication by health professionals about infant feeding is perceived by first time mothers.	Deprived inner London Health Authority.	21 women recruited. 19 interviewed Purposeful sampling.	White, low-income women. Expecting first baby. Women intending to breast and formula feed.	Qualitative.	Semi-structured interviews.	Barriers to discussing infant feeding antenatally and postnatally identified. Barriers included: Differing goals. How health professionals communicated information.	C
11.	Juntereal & Spatz (2020) UK and US	To explore the lactation experiences and level of lactation support of birth mothers in a same sex relationship.	Participants had prenatally decided to breastfeed. Aged 21 years or older. English as a main language. Identified as in a same sex relationship.	68 participants completed the online survey. 18 birth mothers interviewed.	Characteristics of gestational mother identified included age, race/ethnicity, breastfeeding duration.	Mixed methods.	Online surveys. 1.1 interviews.	Five themes identified. Three themes related to communication: Sources of information. Involvement of partner. Need for inclusive and educated health care practitioners.	B

12.	Raisler (2000) US	To examine the experiences of low-income nursing mothers in the health system about integrating breastfeeding into their daily lives.	Breastfeeding mothers participating in the WIC programme.	Convenience sample 42 women.	Ages ranged from 16-39 Black women, white women, and multiracial women. 23 first-time mothers. All but 2 currently breastfeeding.	Qualitative.	Focus groups.	Factors which helped or hindered mothers breastfeeding experiences identified. Influence of the WIC programme discussed. Importance of understanding the mothers' lived experience of breastfeeding beyond the health care system identified.	B
13.	Rossiter (1998) Australia	To examine, from the Vietnamese women's perspective their experiences of infant feeding and their perceptions of the attributes of nurses, midwives and other health professionals and the health care system that they considered to be important in encouraging them to breastfeed.	Ethnic Vietnamese women or Chinese Vietnamese women recruited from community agencies in western and south-western suburbs of Sydney.	Convenience sample. Last infant born in Sydney. 124 women.	Women born and reared in Vietnam and had their last infant born in Sydney about 6 months previously.	Ethnographic approach.	Semi-structured interviews.	Nine concepts identified to describe the process of decision making, experiences and perceptions of breastfeeding:	B
14.	Wandel et al. (2016) Norway	To explore infant feeding practices among Somali-born mothers in Norway and the ways in which they navigate among different information sources.	Somali mothers. Living in Oslo or nearby counties. 4–8-month infant born in Norway.	22 Somali mothers. Snowball sampling. Multi-recruitment strategy.	All mothers Muslim. Most of them came to Norway as a child. Ages ranged from 21-40 years, and most were married. Most mothers were multiparous. Mothers with different education levels in both interviews and focus groups.	Qualitative.	Semi-structured interviews and focus groups. First interview when infant 4-8 months old. Focus groups when children approximately 24 months of age.	Attitudes towards breastfeeding. Reasons for early cessation of breastfeeding. Experiences related to receiving advice from health care providers and other sources.	B

3.6 Synthesis findings

In this section I present the findings and line of argument synthesis and conceptual framework which were developed from the findings. Three overarching themes and eight sub-themes were developed from the initial sixteen codes. Please see Table 8 for the first order interpretations (codes), second order interpretations (sub-themes), and third order interpretations (themes) and table 9 for the third-order interpretations (themes) and second order interpretations (sub-themes) linked to the individual papers.

Table 8: Themes, sub-themes, and codes.

Themes	Sub-themes	Codes
Equitable Connections	Understanding the context and the mother's circumstances.	Mother's individual circumstances. Understanding a mother's needs.
	Empowering the mother.	Supporting the mother and infant. Focusing on the mother-baby relationship.
	Trusting interactions.	Relationship focused approach. Building Trust.
Connected Interactions	Responsive communication.	The right help at the right time.
	Facilitative language.	Supporting choices and decision making. Being realistic and normalising experience.
	Supportive encounters.	Caring. Using relational, interpersonal communication skills.
Disconnected Interactions	Differing priorities.	Task based approach. Breast is best.
	Communication Difficulties.	Conflicting advice. Insufficient information.

Table 9: Themes and sub-themes linked to the individual papers

Paper	Equitable Connections			Connected Interactions			Disconnected Interactions	
	Empowering the mother	Trusting interactions	Understanding the context and mother's circumstances	Responsive communication	Facilitative language	Supportive encounters	Differing priorities	Communication difficulties
Andrews et al. (2021)	X	X	X	X	X	X	X	X
Bookhart et al. (2021)		X	X	X	X	X	X	X
Burns et al. (2013)	X	X	X	X	X	X	X	X
Burns et al. (2016)	X	X	X	X	X	X		
Burns & Schmied (2017)	X	X	X	X	X	X	X	
Dykes (2005)	X	X	X	X	X	X	X	X
Hoddinott et al. (2012a)	X	X	X	X	X	X	X	
Hoddinott & Pill (2000)	X	X	X	X	X	X	X	X
Juntereal & Spatz (2020)	X		X	X	X	X	X	X
Hauck et al. (2011)	X	X	X	X	X	X	X	X
Heinig et al. (2008)	X	X	X	X	X	X	X	X
Raisler (2000)	X	X	X	X	X	X	X	X
Rossiter (2000)	X	X	X	X	X	X	X	
Wandel et al. (2016)	X	X	X	X	X	X	X	X

Theme 1: Equitable Connections

The first overarching theme 'Equitable Connections' recognises the importance of relational aspects of infant feeding communication. As such this theme highlights how health professionals should 'understand the context and the mother's circumstances,' 'empower the mother' and develop a 'connection with the mother' when communicating infant feeding messages and infant feeding care to facilitate equitable infant feeding communication.

Understanding the context and the mother's circumstances

All fourteen papers contributed to this sub-theme which highlights the influence of wider contextual factors on a mother's and birthing person's experience of receiving infant feeding communication. All the studies identified the importance of a health professional understanding the mother's or birthing person's individual circumstances and context to tailor infant feeding communication according to individual requirements (Andrews et al., 2021; Bookhart et al., 2021; Burns et al., 2013; Burns et al., 2016; Burns & Schmied, 2017; Dykes, 2005; Hauck et al., 2011; Heinig et al., 2009; Hoddinott et al., 2012a; Hoddinott & Pill, 2000; Juntereal & Spatz, 2020; Raisler, 2000; Rossiter, 1998; Wandel et al., 2016).

Specific contexts in which health professionals needed to adapt their communication skills to meet a mother's and birthing person's needs were described: women who had disabilities (Andrews et al., 2021) mothers in same-sex relationships (Juntereal & Spatz, 2020), women from culturally diverse backgrounds (Bookhart et al., 2021) and women from minority groups (Wandel et al., 2016).

In the study by Andrews et al. (2021) which considered mothers with disabilities and Juntereal and Spatz's (2020) study which explored the experiences of mothers who were in same sex relationships, mothers wanted health professionals to be more inclusive and understand what they needed in relation to information. For some of the mothers in the study by Juntereal and Spatz (2020) being more inclusive meant acknowledging the non-gestational parent as an equivalent to the gestational parent and communicating infant feeding messages to the non-birth mother antenatally. For example, one mother in this study explained the way in which she wanted her health professional to talk to her partner:

'Talk to her as a mom and how she can support her baby' (p.26)

Some of the mothers with disabilities in the study by Andrews et al. (2021) appreciated health professionals who demonstrated inclusivity by using creative solutions when communicating infant feeding messages for example providing sign language interpreters or using eye contact when communicating. For example, one mother in the study by Andrews et al. (2021) explained:

'They want to help the parent...They knew that they had to look at me to get my attention, all of that' (p.86).

Women and birthing people wanted health professionals to both see them as individuals and use a personalised approach when communicating infant feeding messages (Andrews et al., 2021; Bookhart et al., 2021; Burns et al., 2013; Dykes, 2005; Hauck et al., 2011; Juntereal & Spatz, 2020; Wandel et al., 2016). For some of the women in the study by Juntereal and Spatz (2020) this involved health professionals seeing their family in the same way they would see any other family. For example, one mother in this study stated:

‘I would like them to come and see us as an individual family, the way they might see any other family’ (p.27).

Providing needs-based information was particularly important antenatally for women from culturally diverse backgrounds to enable informed decision-making (Bookhart et al., 2021; Hoddinott & Pill, 2000; Hauck et al., 2011; Juntereal & Spatz, 2020; Raisler, 2000; Rossiter, 1998; Wandel et al., 2016). Women from culturally diverse backgrounds appreciated health professionals who used culturally sensitive communication and considered their cultural needs when tailoring infant feeding communication (Bookhart et al., 2021; Rossiter, 1998; Wandel et al., 2016). Significantly, one mother in the study by Rossiter (1998) explained how culturally sensitive communication and tailoring information according to her culturally specific needs had helped her to breastfeed:

‘Breastfeeding education programme conducted in Vietnamese by the hospital was very good. It considered our cultural differences and needs and helped me to understand the importance of breastfeeding. If not, I would have just breastfed for a short time’ (p.602)

Five studies (Bookhart et al., 2021; Hauck et al., 2011; Hoddinott & Pill, 2000; Raisler, 2000; Wandel et al., 2016) identified the importance of understanding whether women had any previous breastfeeding experience to ensure women received information which met their needs. This was necessary even when women had breastfed before. A woman in the study by Hauck et al. (2011) said:

‘With my second child, I had confidence to persist because I just sort of realised by then that my body took a while to sort of up the supply’ (p. e160).

For mothers in the study by Bookhart et al. (2021) breast feeding counselling which provided the opportunity to discuss previous breastfeeding experiences encouraged them to breastfeed. One mother explained:

‘I had to go to work with my daughter and I didn’t have an electric breast pump then, and now I know better. Like I got an electric breast pump, so I am going to go longer this time’ (p.1713).

Six studies (Bookhart et al., 2021; Dykes, 2005; Hauck et al., 2011; Heinig et al., 2009; Hoddinott & Pill, 2000; Wandel et al., 2016) highlighted how a mother’s individual situation influenced whether infant feeding information was perceived as conflicting or helpful and could be trusted. Women in the study by Wandel et al. (2016) were more likely to consider information helpful if it reflected the Norwegian setting. One woman in this study explained:

'When it comes to the health clinic, I usually take the parts of advice that suit me the most. That (advice) is something that is suitable for them, but I have my background and culture' (p.491)

In the study by Hauck et al. (2011) the importance of the health professional understanding how a woman's individual circumstances would influence her ability to interpret infant feeding communication was highlighted. For example, anxious first-time mothers and mothers who had an unsettled infant or an infant who was not responding to suggested strategies were less likely to have the confidence and ability to interpret infant feeding information.

Three papers (Dykes, 2005; Hoddinott & Pill, 2000; Raisler, 2000) highlighted the importance of health professionals tailoring infant feeding information for women of a lower socio-economic status according to the woman's individual requirements. Moreover, women of lower socio-economic status in the studies by Hoddinott and Pill (2000) and Raisler (2000) identified barriers to breastfeeding such as breastfeeding in front of others or when returning to work, highlighting the importance of health professionals discussing how to integrate breastfeeding into women's daily lives when communicating infant feeding messages.

One mother in the study by Raisler (2000) explained:

'There's constantly people comin' over, everybody want to see the new baby. So, I'll give him a bottle, or we gotta go upstairs to breastfeed' (p.259)

Empowering the mother

Thirteen papers (Andrews et al., 2021; Burns et al., 2013; Burns et al., 2016; Burns & Schmied, 2017; Dykes, 2005; Heinig et al., 2009; Hoddinott et al., 2012a; Hoddinott & Pill, 2000; Hauck et al., 2011; Juntereal & Spatz, 2020; Raisler, 2000; Rossiter, 1998; Wandel et al., 2016) contributed to this subtheme which describes the importance of health professionals using infant feeding communication to empower the mother and support the developing mother-baby relationship.

In two studies (Raisler, 2000; Rossiter, 1998) breastfeeding women described how breastfeeding facilitated maternal-infant bonding, highlighting the importance of health professionals using communication to empower the mother to breastfeed.

One woman in the study by Rossiter (1998) explained:

‘We don’t have time to hold my baby and love him properly. Breastfeeding gives me the chance to relax with him’ (p.601)

One woman in the study by Raisler (2000) stated:

‘There’s such a closeness with the baby...it makes you feel motherly’ (p.258)

When health professionals viewed the mother as the ‘expert’ on her infant and focused on the mother’s priorities and needs, this both built the mother’s confidence and capacity to breastfeed and encouraged her to use her intuition when feeding her infant (Burns & Schmied, 2017; Hauck et al., 2011). Moreover, this enabled mothers

and birthing people to interpret their experience more positively (Wandel et al., 2016). However, mothers also wanted health professionals to use infant feeding communication to normalize their infant's behaviour, emphasise that their infant was learning to breastfeed (Burns et al., 2016; Burns & Schmied, 2017) and learn how to do things for themselves (Burns et al., 2013; Burns & Schmied, 2017). One woman in the study by Burns and Schmied (2017) reported:

'The way they normalise everything... they are continuing to look at what's going right, instead of focusing on the things that could go wrong. They give you confidence' (p.391).

Furthermore, mothers wanted health professionals to use positive language and communication to emphasise progress and achievement with breastfeeding as well as confirm their baby's enjoyment and well-being (Burns & Schmied, 2017; Dykes, 2005; Hoddinott et al., 2012a; Hoddinott & Pill, 2000). One woman in the study by Hoddinott and Pill (2000) commented:

'The midwife came to see me at home, she watched her feed, and she said she could see the milk at the side of her mouth, so I knew I was feeding her quite well' (p.231).

Trusting interactions

Thirteen papers (Andrews et al., 2021; Bookhart et al., 2021; Burns et al., 2013; Burns et al., 2016; Burns & Schmied, 2017; Dykes, 2005; Hauck et al., 2011; Heinig et al., 2009; Hoddinott et al., 2012a; Hoddinott & Pill, 2000; Raisler, 2000; Rossiter, 1998; Wandel et al., 2016) contributed to this sub-theme which describes how the interactions women have with health professionals influence their experience of infant feeding communication.

In four studies (Burns et al., 2013; Dykes, 2005; Hauck et al., 2011; Raisler, 2000) women discussed how they wanted health professionals to focus on building rapport and establishing a relationship with them. When women developed a personal relationship with a health professional this increased trust in the advice they gave and facilitated breastfeeding by enabling follow-up regarding breastfeeding issues (Heinig et al., 2008; Hauck et al., 2011; Wandel et al., 2016). For example, one mother in the study by Hauck et al. (2011) stated:

‘There were a few other midwives that we had consistently on shift with us while we were in hospital and that’s just so reassuring because they know what happened the day before and if you had a problem they can come and follow up with you’ (p. 159).

Furthermore, in five papers women highlighted the importance of an ongoing relationship with the same health professional (Burns et al., 2013; Burns & Schmied, 2017; Hauck et al., 2011; Hoddinott et al., 2012a; Raisler, 2000). One mother in the study by Burns and Schmied (2017) stated:

'I think having known them during your whole pregnancy....and building that relationship really enabled you to feel comfortable to ask them anything about breastfeeding without feeling...a little bit stupid' (p.393)

Continuity of carer was highly valued, particularly when health professionals were making follow up calls or supporting women with breastfeeding issues (Burns & Schmied, 2017; Hauck et al., 2011; Hoddinott et al., 2012a). Some of the women in the studies by Hoddinott et al. (2012a) and Burns and Schmied (2017) felt that continuity of carer enabled the health professional to know their 'whole story'. One woman in the study by Burns and Schmied (2017) stated:

'I didn't have to tell the same story over and over and over again... I could just pick up the phone and just say what do you think about this' (p.394)

For some women in the study by Hauck et al. (2011) the personalised approach used by certain midwives compensated for a lack of continuity of carer:

'Some of them were so fantastic that I would almost cry when they walked in the door because you did just think 'oh thank God she's here' (p. 159).

Connected interactions

The second overarching theme 'connected interactions' describes the following practical strategies used by health professionals 'responsive communication,' 'facilitative language' and 'supportive encounters' to facilitate both equitable and personalised infant feeding communication and the positive infant feeding experiences and connections that women and birthing people want.

Responsive communication

All fourteen papers (Andrews et al., 2021; Bookhart et al., 2021; Burns et al., 2013; Burns et al., 2016; Burns & Schmied, 2017; Dykes, 2005; Hauck et al., 2011; Heinig et al., 2009; Hoddinott et al., 2012a; Hoddinott & Pill, 2000; Juntereal & Spatz, 2020; Raisler, 2000; Rossiter, 1998; Wandel et al., 2016) contributed to this sub-theme which highlights how women value timely infant feeding communication which meets their needs. One mother in the study by Burns and Schmied (2017) reported:

'Knowing that she's just on the other end of the phone 24/7 really, especially in the early couple of days' (p.394)

It was important to mothers and birthing people in eight studies that their health professional was appropriately trained and could communicate accurate, consistent, evidence-based infant feeding messaging (Andrews et al., 2021; Bookhart et al., 2021; Hauck et al., 2011; Heinig et al., 2009; Juntereal & Spatz, 2020; Raisler, 2000; Rossiter, 1998; Wandel et al., 2016). Information from an 'expert' was particularly valued when women needed technically skilled help (Hauck et al., 2011; Heinig et al., 2009; Raisler, 2000). One woman in the study by Heinig et al. (2009) reported:

'I had a lot of different people telling me different things...but the best advice I got was from the nurse practitioner...It was the only thing that worked' (p. 167).

Facilitative language

All fourteen studies contributed to this sub-theme which considers how tailoring infant feeding communication can help women to make infant feeding choices that meet their individual needs. In the study by Hauck et al. (2011) when women were offered a rationale for the advice offered, they were more able to accept the information and make judgments about the relevance of this for their own situation. One woman stated:

'It definitely helps if you know they say we advise you to sit like this and this is the reason why it makes a lot more sense' (e.159)

It was evident in four studies that the language used by health professionals when communicating infant feeding messages influenced decision making (Andrews et al., 2021; Burns et al., 2013; Burns & Schmied, 2017; Hauck et al., 2011). One mother in the study by Hauck et al. (2011) stated:

'To have someone say to you, you know there isn't one right way to do it, it is very good, it's very helpful' (e.159)

Mothers appreciated health professionals who used an encouraging approach (Hauck et al., 2011; Raisler, 2000; Wandel et al., 2016) and offered reassurance

(Andrews et al., 2021, Hoddinott & Pill, 2000). One mother in the study by Andrews et al. (2021) described how her health professional had eased her anxiety about giving commercial formula milk:

‘You do whatever you need to do for you. Don’t feel guilty. You need to do what works for you’ (p.87)

Mothers wanted to be informed of their choices and supported to make their own decisions (Andrews et al., 2021; Hauck et al., 2011). Some of the mothers in the study by Hoddinott and Pill (2000) described how being supported to make their own decisions had been empowering and built confidence. In addition, having common misconceptions dispelled (Burns et al., 2013), being prepared for what could happen next and any feeding difficulties which might occur (Heinig et al., 2009; Hauck et al., 2011; Hoddinott & Pill, 2000), or normalising infant behaviour (Burns et al., 2016) were vital to reassure women of the normalcy of their experience and increase their confidence in their mothering abilities (Burns & Schmied, 2017; Dykes, 2005; Hoddinott et al., 2012a; Hoddinott & Pill, 2000).

Hoddinott et al. (2012a) when discussing the women’s perspectives on receiving daily calls commented on the importance of staff providing normalising explanations:

‘How experiences could change even within 24hours was a source of anxiety particularly for first-time mothers and the team provided normalising explanations with pointers as to what might happen next’ (p.9).

Supportive encounters

There was a consensus amongst all fourteen papers about the skills health professionals should use when communicating infant feeding messages to meet mother's and birthing people's needs.

Across nine of the studies (Burns & Schmied, 2017; Dykes, 2005; Hauck et al., 2011; Heinig et al., 2009; Hoddinott & Pill, 2000; Hoddinott et al., 2012a; Raisler, 2000; Rossiter, 1998; Wandel et al., 2016) women reported how they valued health professionals who used a reassuring, kind, caring, personable, woman-centred communication style when communicating about infant feeding care. One mother in the study by Heinig et al. (2009) stated:

'They say: Experience, just give it time. They are very, very comforting to women' (p.167)

A caring attitude was vital when women were struggling with feeding to increase confidence (Dykes, 2005; Hauck et al., 2011; Hoddinott et al., 2012a; Raisler, 2000).

Women wanted their health professionals to 'listen' to their story. This was essential to acknowledge individual needs and helped women feel validated (Burns et al., 2013; Burns & Schmied, 2017; Heinig et al., 2008; Juntereal & Spatz, 2020; Hauck et al., 2011; Raisler, 2000). One mother in Burns et al.'s (2013) study reported:

'She wanted to know the story. She asked the story. So how did the birth go?
She was the first person who asked who really listened to that story' (p.67)

Disconnected interactions

The third overarching theme 'disconnected interactions' identifies the barriers 'differing priorities' and 'managing the interaction' which prevent women and birthing people from accessing equitable infant feeding communication.

Differing priorities

Thirteen papers contributed to this sub-theme which describes how a mismatch between women's needs and health professional priorities prevents infant feeding communication from being prioritised. Moreover, this sub-theme suggests that a lack of understanding of women's and birthing people's individual needs can prevent health professionals from communicating infant feeding messages effectively (Andrews et al., 2021; Bookhart et al., 2021; Burns et al., 2013; Burns & Schmied, 2017; Dykes, 2005; Hauck et al., 2011; Heinig et al., 2009; Hoddinott et al., 2012a; Hoddinott & Pill, 2000; Juntereal & Spatz, 2019; Raisler, 2000; Rossiter, 1998; Wandel et al., 2016).

Women in three papers described dissatisfaction with the way health professionals promoted breastfeeding (Andrews et al., 2021; Hoddinott & Pill, 2000; Wandel et al., 2016). Women felt that health professionals were 'overzealous' in promoting breastfeeding or focused on the health benefits of breastfeeding, rather than telling

them what they wanted to know which resulted in pressure to breastfeed (Andrews et al., 2021; Wandel et al., 2016). Some women in the study by Wandel et al. (2016) described how pressure to breastfeed had negatively influenced their breastfeeding experience:

'I felt an enormous pressure to breastfeed at the health clinic, and it was a bit like breastfeed, breastfeed, breastfeed. In a way you felt like a failure if you couldn't do it' (p.490).

Women also described how health professionals who used a 'taking over' or 'hands-on' approach (Burns et al., 2013; Hauck et al., 2009) undermined their confidence which negatively influenced their breastfeeding experience. One mother in the study by Burns et al. (2013) stated:

'Yeah, just physically put him on me. Didn't talk to me about the process of anything. Just put him on me and then she was gone, and I was just feeding the baby, and my husband was there, and we were just like, well what do we do now' (p.66)

Women were also dissatisfied when specific tasks and institutional pressures resulted in disconnected and rushed communications. Nine papers (Dykes, 2005; Bookhart et al., 2021; Burns et al., 2013; Hauck et al., 2011; Heinig et al., 2009; Hoddinott et al., 2012a; Hoddinott & Pill, 2000; Raisler, 2000; Wandel et al., 2016) discussed how a lack of time prevented women from being provided with opportunities to explore what they knew about breastfeeding, to observe a

breastfeed, update knowledge or receive the information they needed. One woman in the study by Hoddinott et al. (2012a) stated:

'I specifically asked a couple of midwives 'please sit with me till she feeds, until she's finished' and they either didn't come back, or they just took one look at me and went 'oh yeah, you're doing fine' and walked away again...they were so rushed off their feet doing other things' (p.8).

One woman in the study by Wandel et al. (2016) explained:

'They never had time to give advice at health clinic X and I felt that I was a burden to them' (p. 490).

Communication difficulties

This sub-theme, which relates to ten papers (Andrews et al., 2021; Bookhart et al., 2021; Burns et al., 2013; Dykes, 2005; Hauck et al., 2011; Heinig et al., 2009; Hoddinott & Pill, 2000; Juntereal & Spatz, 2020; Raisler, 2000; Wandel et al., 2016) highlights how communication difficulties such as receiving insufficient information or conflicting advice negatively influences women's infant feeding experiences.

When health professionals provided women with insufficient information about breastfeeding both antenatally (Bookhart et al., 2021; Hoddinott & Pill, 2000; Juntereal & Spatz, 2020) and postnatally (Bookhart et al., 2021; Dykes, 2005) this prevented them from being able to feed effectively and undermined confidence.

Rather than providing pre-defined packages of information (Dykes, 2005), women wanted their health professionals to increase their learning opportunities by tailoring information according to their knowledge and interest level (Raisler, 2000). One woman in the study by Raisler (2000) stated:

'It was like...If you're not interested, I'm going to take the time to make you interested, like trying to encourage you to breastfeed. But since I don't have to do that, OK, here you go' (p.255)

Women in the studies by Hoddinott and Pill (2000) and Hauck et al. (2009) described strategies they used when they felt health professionals were providing conflicting advice or advice which was not perceived relevant to their individual

situation. A few women in the study by Hoddinott and Pill (2000) described how they had lied to health professionals. Most women in the study by Hauck et al. (2009) felt that they had withheld information when they had been provided with inconsistent or contradictory advice. One mother in the study by Hauck et al. (2000) explained:

‘You need to get off them [nipple shields], you need to get off them, and I went ‘ok fine.’ I just did not tell her [child health nurse] I was still using them’ (p. 160)

Deaf women in the study by Andrews et al. (2021) described challenges relating to communicating with lactation consultants. Some deaf women felt this was due to the lactation consultant being unfamiliar with the deaf population and the inability to request an ASL interpreter during a drop-in clinic. One woman in the study by Andrews et al. (2021) stated:

‘The lactation consultant had never worked with a deaf person before. She had a hard time trying to figure out how to show me what to do with the baby’ (p.85).

Health professionals were unable to communicate infant feeding information effectively, when they did not possess the appropriate knowledge (Hauck et al., 2011). In the study by Juntereal and Spatz (2020) women felt that health professionals were unable to provide appropriate information on induced lactation and co-nursing to women in same-sex relationships. One mother in the study by Juntereal and Spatz (2020) stated:

'I wish we could've known (about induced lactation). Because then we really would've sat down and said, 'Is this something we really want to do.' She (non-gestational partner) really would've considered it' (p. 25)

Additionally, the environment in which health professionals communicated infant feeding care also influenced women and birthing people's ability to ask questions and remember what was said. Some women in the study by Wandel et al. (2016) described health clinics as stressful and in the study by Heinig et al. (2008) as unwelcoming. One woman in the study by Heinig et al. (2008) stated:

'They're not friendly if you call them and ask them for their (the clinic) address. They say they can't tell you' (p.168).

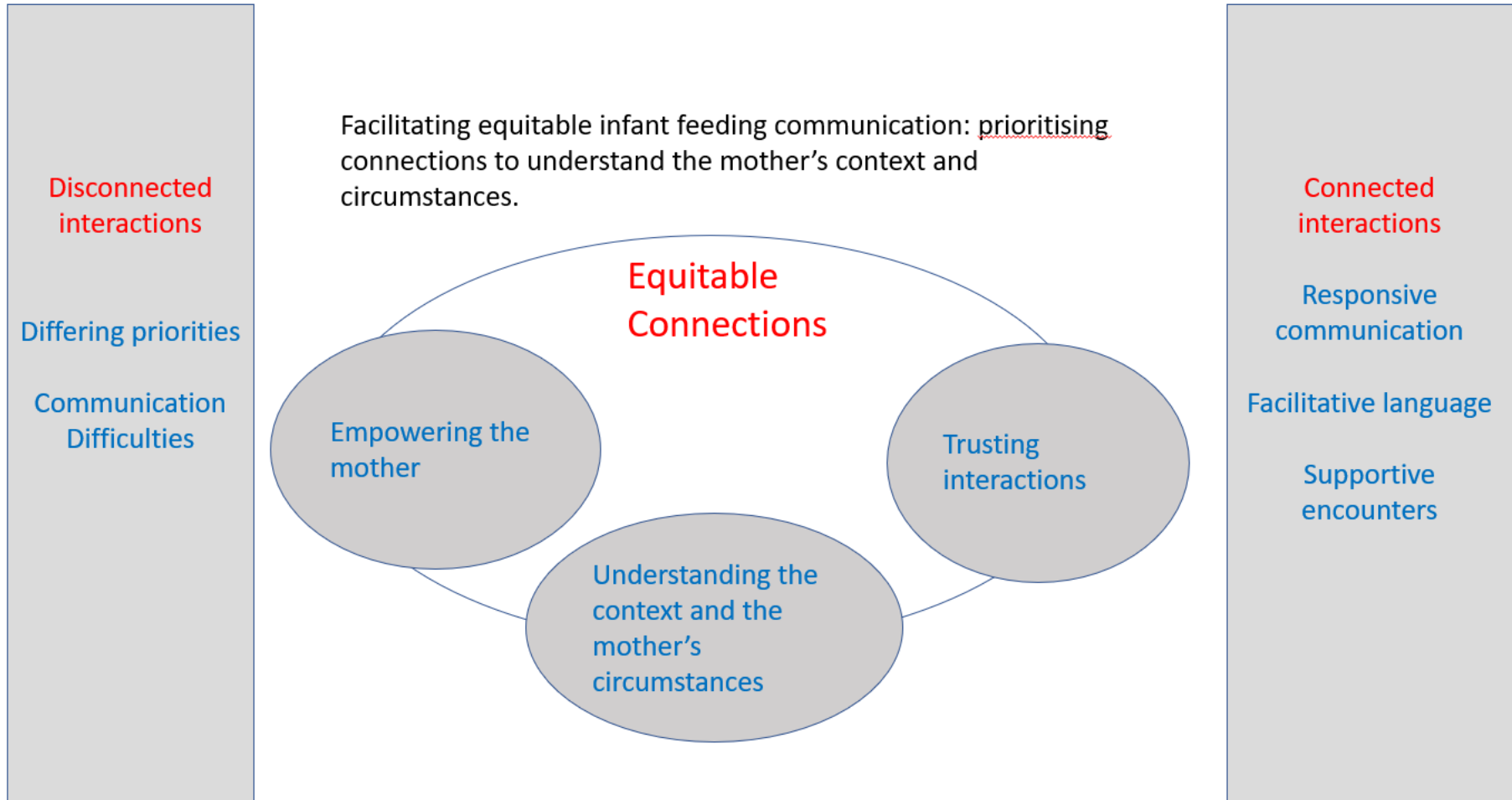
Line of Argument Synthesis

The evidence highlights a polarised perspective regarding infant feeding communication. Women who have negative experiences that comprise of communication difficulties with health professionals who possess differing priorities can lead to disconnected encounters. Positive experiences are underscored by responsive communication with health professionals' who develop connections and use facilitative language within supportive encounters to empower mothers within their individual context. Therefore, to facilitate the infant feeding communication that women and birthing people want, health professionals need to prioritise relationships and connected interactions to ensure they communicate infant feeding messages in accordance with the mothers' needs, context, and circumstances. This is particularly important for women with specific communication needs, for example, women from lower socio-economic backgrounds, women with disabilities and women from different cultures.

Conceptual framework

The conceptual framework (Figure 5) illustrates the relationships between the third order interpretations (themes) and second order interpretations (sub-themes).

Figure 5: Conceptual Framework



3.7 Summary of findings

Over a decade later, my findings support and extend the findings of the earlier seminal review by Schmied et al. (2011) which highlighted the importance of woman-centered communication and relationships with professionals when supporting women to breastfeed. Whilst my review has also emphasised the significance of connections when communicating infant feeding messages (both between the mother and baby as well as the connection between mother and health professional), this review suggests that infant feeding communication which considers both the mother's context and individual circumstances is key to facilitate the equitable infant feeding communication women and birthing people want. This finding differs from earlier reviews and highlights the need for my empirical research. Moreover, this review highlights the importance of health professionals considering both equity issues and the specific communication needs of women from lower socio-economic backgrounds, women with disabilities and women from different cultures which get lost in a one-size-fits all approach.

Whilst this review has highlighted that being on a low income can exacerbate the communication barriers women face, this review has not identified how communication should be tailored to the setting and the mother's needs and circumstances. However, my empirical work in chapters 7,8 and 9 begins to address this.

3.8 Strengths and limitations of this review

This review used a systematic approach to enhance the validity and reliability of the synthesis findings. Using a published protocol (Atkinson et al., 2021) to guide this review ensured that the review was planned rigorously. Furthermore, there were no deviations from the published protocol. A comprehensive search strategy helped to identify published sources which were relevant and would help me answer the review question, as supported by Denscombe (2021). To ensure included studies reported on communication in a health care context, only studies that reported women's and birthing people's views, experiences and perspectives of the communication used by health professionals in transmitting infant feeding care were included. Since Stoll et al. (2019) discuss how using a second reviewer increases the number of relevant studies identified, twenty per cent of the full text articles were quality appraised by NC. Using the eMERGe meta-ethnography published reporting guidance (France et al., 2019) which related to how each stage of the review should be conducted ensured transparency, as highlighted by Sattar et al. (2021). Furthermore, the studies identified similar issues, and it was relatively straightforward to organise the findings for analysis purposes.

Extracting information on study characteristics for each study into a table in excel was useful to provide context for interpretations and explanation for each study (Feast et al., 2018). However, the studies used different measures to determine the participant's socio-economic background. Burns et al. (2013); Rossiter (1998) and Wandel et al. (2016) used data about the participant's education levels. The studies

by Raisler (2000), Heinig et al. (2008) and Bookhart et al. (2021) included participants who were participating in the WIC programme (please see section 2.2 where further information is provided about WIC). Andrews et al. (2021) included data relating to the participant's income but only 20% were on a low income. Hauck et al. (2011) used the participant's postcode to determine social disadvantage but only 16.6% of participants had a postcode which represented disadvantage. Hoddinott and Pill (2000) included women on a low income, but the classification and the socio-economic characteristics of the participants were not included in the paper. Hoddinott et al. (2012a) included women living in disadvantaged areas but did not include demographic data about the study participants. Moreover, in some of the studies (Burns et al., 2016; Burns & Schmied, 2017; Dykes, 2005; Juntereal & Spatz, 2020) authors did not provide any demographic information to determine the participant's socio-economic status. Therefore, it was not possible to systematically explore how a woman's socio-economic background influenced what she would want from infant feeding communication. This is an important methodological constraint for this qualitative synthesis (Atkins et al., 2008) and was an important consideration when undertaking my empirical research. Please see section 5.4 where I discuss how I determined SES in my research.

In comparison with the systematic review by Schmied et al. (2011) which focused on breastfeeding, this review aimed to capture all infant feeding experiences to reflect all experiences of infant feeding communication, irrespective of feeding method. Although a broad definition of infant feeding was used during the literature search, most of the included studies (11 out of the 14) focused on women's experiences of breastfeeding support. When commercial formula feeding was mentioned, this was

in relation to negative experiences and pressure women had faced when they had decided not to breastfeed or had stopped breastfeeding when they had faced specific challenges. This limits the possible application of the synthesis findings for women who choose to commercially formula feed their babies.

The quality appraisal process highlighted that most papers failed to sufficiently describe the methodological approaches used and did not adequately consider reflexivity. Another possible limitation of this synthesis was the type of health professional included in the studies. Although a range of health professionals that provide infant feeding care were included in the search, most of the papers focused on midwifery and there was a lack of clarity about the meaning of health professional in most of the papers. Therefore, I felt it important to clarify how I used the term 'health professional' in my research. Please see my glossary of terms and abbreviations where I have explained how I have used this term in my research.

It is also important to consider my effect on the systematic review process. My professional background and experience as a health visitor and lactation consultant could have influenced the interpretation of data and the synthesis findings. To counteract this, initial codes and the final sub-themes, themes and conceptual framework were shared with my public advisors and feedback was requested. However, feedback was positive and confirmatory, and no further changes were required. Additionally, discussions with my supervisors (NC and GT) were vital to discuss my interpretations and the synthesis findings.

3.9 Conclusion

This chapter has discussed a systematic review which aimed to understand what women and birthing people want from infant feeding communication. In the next chapter, I discuss how the findings from this review in relation to the equity issues women from a lower socio-economic status experience influenced my decision to employ social constructionism as my epistemological and ontological standpoint and the theoretical framework symbolic interactionism.

Chapter 4: Theoretical positioning and methodology

4.1 Introduction

The previous chapter presented the findings of a meta-ethnography which was undertaken to understand what women and birthing people want from infant feeding communication. As outlined in chapter 2, my empirical research aims to explore how a diverse sample of women experience infant feeding care from UNICEF UK BFI Gold accredited maternity and community services. This chapter discusses how my philosophical position influenced both my decisions to, firstly, employ social constructionism as my epistemological and ontological standpoint for this research and, secondly, to use the theoretical framework symbolic interactionism to underpin my research. Furthermore, in this chapter I discuss how my philosophical position informed my use of a narrative inquiry methodology to collect the stories of the women's infant feeding care experiences and understand the meaning they gave to them to answer the study objectives:

To explore how professionals trained in implementing the BFI revised standards have influenced women's experiences and perceptions of infant feeding care from pregnancy until they are introducing their baby to solid food (around six months postnatal).

To explore whether there are any variations in experiences amongst a diverse sample of women and what influences these.

4.2 Reflecting on my philosophical position.

Before commencing my research, I considered the way that I believed my research should be conducted (Denscombe, 2021). This involved reflecting on my philosophical position, my assumptions about the nature of reality (ontology) and knowledge (epistemology) in relation to the purpose of my research. Ontology, Snape and Spencer (2003) explain is concerned with the nature of the world and what we can know about it whereas Crotty (2015) refers to how epistemology relates to the way we look at the world and make sense of it. As I agree with Spencer (2000) that researchers must have a theory of ontology before a theory of epistemology, since my beliefs about the nature of reality informs what I claim to know as a researcher (Killam, 2013), I reflect on my ontology in the following section before I discuss my epistemology.

My ontology and epistemology

As a researcher I assume a relativist ontology since I believe that there is no single reality, but multiple realities which vary from person to person (Lee, 2012). My own diverse nursing and health visiting background underscores my ontological stance. As I agree with Levers (2013) that reality is human experience, the purpose of research is to understand people's subjective experience and uncover multiple realities. Assuming this ontology was important in relation to my research to ensure I gained an in-depth understanding of the women's perspectives and experiences of their infant feeding care. Moreover, I challenge the scientific realist assumption that reality is out there to be discovered and reject the idea, as explained by Crotty (2015), that objective-based inquiry is possible.

As a researcher, I align with a subjectivist epistemology. As argued by Benoliel (1996), I perceive knowledge to be reflective of specific circumstances and exist in multiple forms as representations of reality. This contrasts with an objectivist epistemology, where the discovered and known reality is measurable or quantifiable (Garrett & Cutting, 2015). Moreover, I believe that multiple realities can be explored and meaning made of them through the interaction between the researcher and the research participants (Kant, 2014). Whilst it was important that I understood the women's experiences and perceptions of their infant feeding care experiences, it was also important I recognised that my involvement would shape my understanding (Burr, 2015) and I would be unable to detach myself from my research. This meant it was essential that I paid attention to reflexivity to examine my influence on the research process and the generation and construction of knowledge (Holloway & Galvin, 2023). Please see section 5.9.1 where I discuss reflexivity further.

In the section below I bring together my ontological and epistemological views on my assumptions of reality and knowledge to discuss the interpretivist and constructionist paradigm which underpins my research.

Interpretivist and constructionist paradigm

My ontological and epistemological views align most closely with the interpretivist and constructionist paradigm. Reality from the interpretivist perspective is intersubjective (Denscombe, 2021). This means that there is an emphasis on shared beliefs and shared actions. As human beings can engage with the same reality and make sense of it in different ways, Merriam and Tisdell (2016) argue that multiple realities or interpretations of a single event exist. Additionally, within the interpretive paradigm, meaning or knowledge is not there to be discovered but individually or socially constructed (Crotty, 2015). According to the interpretive paradigm the purpose of research is to both uncover multiple realities, where individuals are understood to form their own reality of the world in different contexts, through interactions with others (Denscombe, 2021).

Whereas public health research has often been aligned with a positivist paradigm to objectively quantify a specific problem (Maycock, 2015), as a nurse I agree with Bowleg (2017) that a subjective epistemology is essential for health equity research. As individuals perceive the world differently because of their own experiences research needs to explore and understand people's subjective meanings to understand the way individuals make sense of the world (Denzin & Lincoln, 2011; Goldkuhl, 2012). According to Golden and Wendel (2020) using a social ecological paradigm is essential to advance health equity. Underscoring this perspective is the importance of understanding the factors which influence a person's health. This helps the researcher to understand the social context in which the individual exists and the role factors at the different levels of the SEM have on an individual's behaviour. Therefore, aligning my research with an interpretive paradigm helped me

to both focus on health equity within my research and answer my research question. Since I have argued in chapter 2 that factors at each level of the SEM interact to influence a woman's infant feeding behaviours, my research needed to be underpinned by a paradigm that would allow me to consider how infant feeding inequities and the women's interactions in different contexts would influence the women's infant feeding outcomes and experiences.

Social constructionism

As my intention through my research was to understand the process by which women constructed and reconstructed meaning when sharing their infant feeding stories with health professionals, this research used a social constructionist approach. The way people construct the social world (Denscombe, 2021) where meaning is not discovered but created by individuals through social interaction (Crotty, 2015), underscores social constructionism. Thus, this approach relies on peoples' subjective experiences of everyday life and how they understand the world (Andrews, 2012).

As such, it is vital to understand the ways in which knowledge emerges and gains significance through social processes (Galbin, 2014). According to Green and Clarke (2016) it is by understanding social interactions that we can uncover how issues and events shape a person's actions and beliefs. Thus, the focus is not on the individual person but rather on the social interaction (Gergen & Gergen, 2010). Therefore, adopting social constructionism as my epistemological and ontological position for this research provided me with the opportunity to emphasise the socially interactive

basis through which the participants would construct meaning during their interactions with health professionals.

Social constructionism assumes a relativist position which means that there are multiple, meaningful realities (Andrews, 2012). This consideration was important for my research as I believed that my participants' varied viewpoints would yield different types of understandings about their experience of receiving BFI accredited care.

One distinguishing feature of social constructionism is that it places emphasis on the complexity and interrelatedness of factors which influence the experiences of individuals (Burr, 2015). In addition, Dickerson and Zimmerman (1996) discuss how meaning is located through an understanding of how ideas and attitudes are developed within a particular social context. A key aspect of my research was understanding how socio-economic status influenced the women's experiences and perceptions of BFI accredited care. Therefore, adopting this position helped me to understand the relationship between context and experience and identify how the specific cultural context in which the participants lived influenced the way they both viewed and interpreted their reality and constructed meaning. This also aligns with my decision to use the SEM within data analysis.

4.3 Theoretical perspective

Aligned with social constructionism is symbolic interactionism in which Dewey (1925) asserts that to understand a participant's social world it is necessary to understand human behaviour and the way people create meaning through

interaction. Using symbolic interactionism helped inform my decision to undertake a longitudinal study to understand whether the meanings the women attributed to their infant feeding care experiences changed over time. Within the symbolic interactionist perspective, as life is seen as a moving process and perspectives change over time as individuals make sense of their situations, Charon (2009) explains it is important to consider thinking within the individual. It is through reflection, that Blumer (1998) suggests meaning of what has been experienced can be communicated. Reynolds and Herman-Kinney (2003) argue that it is through thinking and reflecting on previously gained experiences that individuals understand and create meaning. Moreover, it is by sharing experiences that individuals create, interpret, and alter meanings and actions in relation to what has been experienced (Oliver, 2012).

Symbolic interactionism was a useful theoretical underpinning for this research because first I wanted a theoretical framework which would help me uncover the rich meanings the women attached to their infant feeding care experiences. Although infant feeding decision making is influenced by a variety of interconnected factors (as discussed in chapter 2), using symbolic interactionism enabled me to focus on the way the women had interpreted their infant feeding interactions with health professionals. This was important to understand how their infant feeding care experiences had influenced their infant feeding behaviours based on what their infant feeding care experiences had meant to them.

Second, Blumer (1998) suggests that using symbolic interactionism can reveal the dynamic nature of social interactions and how individuals construct and reconstruct

their world and realities. This means that the focus of research within symbolic interactionism is both individual and collective social interaction (Carlson, 2013). Within social interactionism, other people become social objects, and their presence and actions then become events that are used to guide action (Blumer, 1998). Social interaction is therefore an important cause of what an individual does in situations (Charon, 2009). Reynolds and Herman-Kinney (2003) explain how the individual and their environment are inextricably linked, and meaning is created in relation to what has been experienced. Therefore, human beings can only be understood within the context of their interactions (Benzies & Allen, 2001). Moreover, Golden and Wendel (2020) suggest the SEM is underscored by social interaction. Supporting this, Ali et al. (2021) used a combination of ecological systems theory and symbolic interactionism to explore how diverse factors at different levels of the system and interactions between and among them over time influenced Indigenous peoples' experiences of disaster risk reduction over time. From this perspective, I also felt that applying a symbolic interactionism framework to my research would help me understand how multi-level factors (discussed in chapter 2) influenced the women's infant feeding care behaviours.

Finally, as the symbolic interactionism approach provides researchers with a way of knowing about public health issues and understanding them from the person having those experiences, Maycock (2015) describes how this framework is particularly useful for public health research to understand health issues in different settings. Using this theoretical framework was therefore ideally suited to this research to ensure I maintained a focus on health equity to understand how the women's socio-

economic status influenced their experiences and perceptions of the infant feeding care they received from UNICEF UK BFI Gold accredited health services.

In the next section I justify my use of qualitative research and a narrative research methodology to provide women with opportunities to reflect on the meaning of their infant feeding care experiences over time through the stories they told.

4.4 Qualitative research

Qualitative research stems from interpretivism and constructionism. According to Lim (2024a) this is because qualitative research captures the richness of social phenomena involving human experiences and perspectives. This contrasts with quantitative research where positivism tends to provide the philosophical basis (Denscombe, 2021). As Lim (2024b) explains quantitative research concentrates on measurable variables to objectively identify social phenomena.

Many authors agree that qualitative research provides opportunities for researchers to inform health equity (Griffith et al., 2017; Sandelowski, 2004; Shelton et al., 2017). As argued by Griffith et al. (2017) qualitative research enables the researcher to understand the settings and social context in which disparities arise. Similarly, Shelton et al. (2017) explain how qualitative research helps researchers to acknowledge the complex interplay of factors across the levels of the SEM to move towards health equity.

As my research aimed to capture the stories of the women taking part in the research to understand how a diverse sample of women experience infant feeding care from UNICEF UK BFI Gold accredited maternity and community services, I would rely on qualitative data. To put it simply, I was interested in understanding the in-depth meanings the women gave to their infant feeding stories which could not be defined by numbers.

4.5 Narrative inquiry

Narrative inquiry is a qualitative research methodology which focuses on stories of individual experience and the way that people construct or give meanings to their experiences through storytelling (Bruce et al., 2016). This methodology therefore provides a means of capturing life experiences as narrated by those who live them (Thorsen et al., 2020). According to Charon (2007), human beings absorb, interpret, and respond to stories which results in narrative knowledge. As an integral component of narrative inquiry is narrative analysis to organise and make sense of stories in a meaningful way (see section 5.7), interpretivism underscores this process. Since this methodology provides opportunities for individual reflection, using this methodology is useful for obtaining in-depth understanding of the meanings people ascribe to their experiences (Colla & Kurtz, 2024; Corbally & O'Neill, 2014; Huber et al., 2013; Polkinghorne, 1988; Reissman, 2008; Seidman, 2013). As a result, many nurse-researchers have used narrative inquiry to focus on the individual person's experience and 'what matters' to them (Haydon et al., 2018) to influence health care practice. As a nurse researcher myself, I also felt that enhancing narrative knowledge from creating stories would lead to a deeper understanding about the women's infant feeding care experiences.

Justifying my decision to collect stories through narrative inquiry

Whilst Bruner (1990) suggests that humans have an inborn tendency to tell and understand stories, my clinical experience as a specialist health visitor for infant nutrition suggests this is even more pronounced for mothers. Supporting this view,

Carter (1995) argues that since mothers tell stories to recall events which are important to them, most mothers have an infant feeding story to tell. Although Lewis and Hildebrandt (2019) explain that story and narrative provide the foundation to many qualitative methodologies, this research adopts a narrative inquiry approach. I decided that this would be an appropriate methodology to provide women with opportunities to first explore and reflect on the meaning they gave to their infant feeding stories and understand how these meanings would change over time.

Narrative inquiry was one of the more practical ways of understanding the women's infant feeding experiences from the stories that they told and to appreciate the temporal nature of experience. Since narrative methodologists argue that there is no single or static reality but several realities, a person's perspective of their experience constantly changes (Moen, 2006). This aligns with the interpretative paradigm which recognises that research cannot operate through a value-free objective standpoint (Reissman, 1993). Therefore, this requires researchers to spend time with participants to explore the layers of meaning within and across stories (Reissman, 2008), supporting the longitudinal study design employed in this research. Gergen and Gergen (2010) concur that using a narrative approach is more suitable when it is necessary to offer participants the opportunity to reflect on how their understandings and experiences of reality are sustained and change over time.

From this perspective, Squire (2013) explains how a person narrating their story, will include all sequential and meaningful stories of personal experience. When a person tells a story they connect events into a sequence that is consequential for later action

and for the meanings that they want listeners to take away from the story (Reissman, 1993). This is significant because through the process of storytelling past events are reconstructed and people make sense of their experiences and perceptions (Mangone, 2023). Moreover, Clandinin (2016) suggests that past experiences influence how future experiences are perceived. It is the sequential temporal ordering of human experience into narrative that is not just characteristic of being human, but as Ricoeur (1984) argues, makes us human.

Several authors have also used longitudinal studies to identify how stories change over time. Coxon et al. (2015) undertook a longitudinal narrative study to enable women to reflect on their recent birth and consider whether their experiences influenced where they would plan to give birth in the future. They found using a narrative approach allowed them to both gain insight into the women's experiences but also any changes which occurred over the course of their pregnancy. Thorsen et al. (2020) used a narrative approach during their longitudinal study to obtain insights into dementia experiences. They found the longitudinal design enabled them to identify how the coping mechanisms of those with dementia developed and changed over time. My own view is that using a longitudinal, narrative approach would help me understand the women's experiences in relation to the specific stage of their infant feeding journey (i.e. antenatally, perinatally, and postnatally). This would help me align my research with the BFI standards which are intended to be delivered by midwifery and health visiting services (see section 2.4). Additionally, it was essential to consider how the women's infant feeding care experiences changed over time, since a woman's antenatal experiences before pregnancy (for example, knowledge about infant feeding, seeing others breastfeed, family and cultural influences – see

section 2.2 where this is discussed further) and during the antenatal period, influence their feeding experiences postnatally.

Using narrative to consider health equity

A narrative inquiry approach also aligns with the health equity focus which underscores my research. Banks (2012) explains how stories provide the opportunity to explore how individuals respond to experiences including social inequality. Agreeing with this perspective, Reissman (2008) identifies how narrative inquiry can be used to capture the unique experiences of disadvantaged and oppressed people. Additionally, East et al. (2010) suggest that through narrative the differences and similarities in the way values and emotions are expressed in personal stories can be explained. Moreover, using narrative inquiry would help me consider how the context would influence a diverse sample of women's infant feeding care experiences. This is because the narrative inquiry approach assumes that stories are shaped by and within the participant's social, economic and cultural context (Moen, 2006; Ntinda, 2019; Randall, 2016).

Narrative inquiry uses a person-centred approach to collect stories.

Since the narrative is the starting point by which experience is then interpreted and meanings and knowledge constructed (Petty et al., 2018), the women's individual experiences and narratives would form the basis of data analysis. Using a narrative inquiry approach would therefore allow me to adopt a person-centred approach and keep the women who participated in the research at the centre. Using a woman-centred approach in my research was important to be congruent with that of the

UNICEF UK BFI where the mother and baby are put at the heart of care (UNICEF UK BFI, n.d. - e).

Whilst Denscombe (2021) explains how phenomenology holds similar philosophical assumptions to narrative research, the aim of phenomenology differs. With phenomenology the aim is to describe the meaning several individuals give to their lived experiences of a concept or a phenomenon rather than to understand individual perspectives over time (Cresswell, 2007). Therefore, this approach would not have been appropriate for this study as my intention in my research was not only to direct attention towards the social contexts of the women's infant feeding stories but how they changed over time.

In the following sections I discuss how the narrative inquiry approach I took both aligned with my epistemological and ontological position of social constructionism and theoretical framework of symbolic interactionism and helped me to answer my research questions.

Narrative inquiry aligns with social constructionism and symbolic interactionism.

This methodology aligns with my social constructionist epistemology, where Petty et al. (2018) identify meaning making is central and emphasis is placed on the creation and sharing of knowledge. Since stories are accounts of experience that are constructed within (Carter, 1995), Squire (2013) proposes how experience can become part of consciousness through stories. Therefore, this methodology encourages participants to tell their whole story to help them make sense of their experiences and enables the researcher to study and understand experience (Clandinin & Connelly, 2016). Additionally, and aligned with my theoretical framework, symbolic interactionism, using narrative inquiry would enable me to obtain rich, detailed data since individuals negotiate their identities and roles through social interactions.

In the following section I discuss the different narrative approaches and justify my decision to consider narratives as stories of experience.

Narratives as stories of experience

While narrative methodologies encompass a wide umbrella of approaches (event-centred²⁹, experience-centred, and socio-culturally orientated approaches to narrative), data collection and analysis were guided by the experience-centred narrative approach (Squire, 2013). Narratives were considered as stories of experience since this approach was the most suited to my theoretical positioning and methodological approach. An experience-centred narrative approach recognises that personal narratives are not just about events but also about the meaning and significance attributed to those events (Squire, 2013). Furthermore, the experience-centred narrative approach centres the individual's context as playing a crucial role.

Experience, according to Dewey (1997), is influenced by both the environment and the individual's situation. Furthermore, Williams (2004) explains how narrative research provides the opportunity to explore the links between social context and experience and between explanation and action. For example, research undertaken by Squire (2008) in South Africa used an experience-centred narrative approach to consider commonalities and differences between participants in different neighbourhoods. To answer my research question, being able to understand how the environment influenced the way the diverse sample of women both constructed their stories and interpreted their experiences was essential.

²⁹ The event-centred or Labovian approach defines narrative as being primarily about events (Patterson, 2013).

Moreover, the experience-centred narrative approach recognises the temporal nature of experience and how experiences change over time (Reissman, 1993). This was important for my research to allow the women to build their stories sequentially which would allow me to understand how their experiences and perceptions changed over time. Furthermore, experience-centred narratives can include past and future as well as present stories (Squire, 2008). This is due to narratives of experience considering narratives to be sequential and meaningful, re-present experience, and display transformation or change (Squire, 2013). Patterson (2002) illustrates the importance of being able to compare past, future, and hypothetical narratives to understand the context in which subjective experiences of trauma are narrated. Although the socio-culturally-orientated approach to narrative emphasises the influence of social and cultural contexts on the construction and interpretation of narratives and is less prescriptive than the experience-centred approach (Squire, 2013), it is less concerned with temporal progression (Squire, 2013). Therefore, this approach did not suit this research which used a longitudinal design.

When criticising the experience-centred narrative approach, Squire (2013) suggests that there is a risk of over-interpretation. She also explains how focusing on experience can reduce the significance of language. However, I felt these limitations could be overcome by reflexivity (see section 5.9.1) and focusing on the content of the women's infant feeding stories (see section 5.7).

4.6 Conclusion

This chapter has discussed how my philosophical assumptions led me to use social constructionism as my epistemological and ontological standpoint and symbolic interactionism for my theoretical framework. In addition, this chapter has justified how my philosophical assumptions informed my use of narrative inquiry methodology to collect the women's infant feeding stories, understand what they meant to them and how they changed over time. The next chapter will provide information about my study design; the methods I used to collect and analyse the women's narratives and a discussion about ethics and trustworthiness.

Chapter 5: Methods

5.1 Introduction

In the previous chapter I explored how my philosophical assumptions informed my decision to use a narrative inquiry methodology. In this chapter I first describe how I designed and undertook my study. Second, I discuss how I used diaries and interviews to collect the women's stories. Then I describe the narrative analysis methods I used to analyse the women's stories. I conclude this chapter with a discussion about the ethical issues I considered and how I ensured trustworthiness in my research.

5.2 Study design

A longitudinal, qualitative study of women's experiences using a narrative inquiry approach was undertaken between September 2021 and April 2023. The Health Inequalities Assessment Toolkit (HIAT) (Lancaster University, 2022) was used to design the study (please see appendix 3 for the HIAT) and ensure that my public advisors and advisory group contributed throughout. Integrating an equity focus into this research helped to ensure that the data collection methods and supporting documents for my ethics application would be accessible to a diverse sample of women. Using the HIAT also ensured that those with relevant lived experience and practice expertise contributed to each stage of the research process (see section 1.13 where I discuss how my public advisors were involved and section 5.9.1 where I discuss how my advisory group were involved in this research).

5.3 Study context

I decided to undertake this research in the areas covered by East Lancashire Hospitals NHS Trust. This was because all the health services in this area (hospital and community) which provided infant feeding care were Gold accredited.³⁰ This meant that these services were both embedding and further developing care related to the Baby Friendly standards. Whilst I initially explored the possibility of using more than one site (Baby Friendly accredited versus not Baby Friendly accredited) and focusing my research on the experiences and perceptions of socio-economically deprived women only, I decided to obtain the experiences of a diverse sample of women instead. This was essential to understand how the revised BFI standards influenced the care provided to the women and identify whether there were any variations in experience.

East Lancashire Hospitals NHS Trust is a major acute trust located in Lancashire. According to figures from the Census (2021) East Lancashire Hospital Trust covers a total population of 559,808³¹. Additionally, over 6000 women choose East Lancashire Hospitals NHS Trust to have their baby each year (East Lancashire Hospitals NHS

³⁰ In 2017, East Lancashire Hospital Trust initially accredited as Gold (Baby Friendly with Sustainability). The Trust revalidated their gold status in 2021 and more recently in June 2024 (personal communication, Sue Henry 2024). Lancashire Health Young People and Families Service and Lancashire County Council Children's Centres accredited as Gold in 2020 and re-accredited in April 2024 (personal communication, Katie Wharton, 2024).

³¹ Ribble Valley (61,561), Pendle (95,757), Burnley (94,646), Rossendale (70,871), Hyndburn (82,234) and Blackburn with Darwen (154,739).

Trust, n.d.). Whilst one area covered by the trust, Ribble Valley, is ranked in the least deprived 20% in England, two areas, Burnley, and Blackburn with Darwen rank in the 10% most deprived nationally. Statistics for 2022/23 indicate that 19.7% of children under 16 lived in absolute low-income families, compared with the national average of 15.6%. When comparing children living in relative low-income families this was higher with 25.5% compared with the national figure of 19.8% (Lancashire County Council, 2025).

Whilst the number of babies receiving breastmilk in East Lancashire has increased (UNICEF UK BFI, 2024b), the percentage of babies being either totally or partially breastfed at 6-8 weeks of age in East Lancashire is lower than the 6-8 breastfeeding rate for England³². However, rates vary across the area with significantly lower breastfeeding at 6-8 weeks in the more deprived areas compared with the more affluent areas. For example, 6-8 breastfeeding rates in Burnley were 36.8% compared with 53.2% for Ribble Valley.

This research commenced towards the end of the global COVID-19 pandemic (from September 2021) when the economy had reopened, and rules and regulations had mostly been replaced with advice and guidance on the practical steps to take to reduce the transmission of the virus (Cabinet Office, 2021). Women continued to be

³² In East Lancashire, 38.9% of babies at 6-8 weeks were either totally or partially breastfed during quarter 4, 2022- 2023 (Data for East Lancashire from personal communication, Katie Wharton, 2024) compared with 49.5% of babies being totally or partially breastfed in England.

seen by their midwife antenatally as per NICE guidelines (NICE, 2021a) which are detailed in Table 10 below:

Table 10: NICE guidelines for midwifery care for women having their first baby (NICE, 2021a).

Midwifery care for women having their first baby
Booking appt (<10/40 weeks)
Dating scan (12 weeks)
16 weeks
Anomaly scan (20 weeks)
25 weeks, 28 weeks, 31 weeks, 34 weeks, 36 weeks, 38 weeks, 40 weeks, 41 weeks

Women used the BadgerNet Maternity app, an electronic maternity healthcare record system, to both access their maternity records and information recommended by the midwife. In addition, this electronic record contained the full library of the hospital's pregnancy patient information leaflets. Whilst NHS in-person antenatal classes had been discontinued and replaced with on-line information accessible through the BadgerNet app, women could access private in-person antenatal classes in the local area.

Postnatally midwives provided care at day 3, day 5, day 7 and day 10-14 after birth as per NICE guidance (NICE, 2021b). Health Visitors undertook an antenatal contact

around 28 weeks of pregnancy and completed the new birth visit when a baby was between 10 and 14 days old. A further contact was made when a baby was between 6 and 8 weeks of age. As well as these contacts families living in the study area had access to additional home visits from the health visiting service if required and could access a range of virtual information sessions – some which were live, and others pre-recorded (Lancashire Healthy Young People & Families Service, n.d.).

Whilst this research was being undertaken, the FAB Team provided breastfeeding peer support. This team provided peer support on the maternity ward, weekly support groups within Sure Start Centres as well as 1.1 home visits and a 24-hour helpline as part of Lancashire Health Young People and Families service offer. Therefore, all peer supporters had access to UNICEF UK BFI training.

5.4 Participant sampling and recruitment

Purposeful sampling was used to recruit women for this study. With purposeful sampling participants are selected due to certain characteristics (Campbell et al., 2020). Additionally, Coyne (1997) suggests purposeful sampling is used to select information-rich cases, which are selected to fit the study. In my research purposefulness was ensured by recruiting women pregnant with their first baby who lived in the chosen study area, were aged 18 or over, were fluent in English and were from both high and low socio-economic status (SES). Thus, this purposeful sample would ensure that participants would share stories which were relevant to the research and would enable me to answer my research questions. Recruiting first-time mothers was important for this study. Sweet et al. (2022) discuss how first-time

mothers have significantly different breastfeeding experiences than those who have breastfed a child previously. Furthermore, according to Gianni et al. (2020) first-time mothers are at higher risk of early breastfeeding discontinuation and negative mental health outcomes when transitioning to motherhood. Moreover, I needed to recruit women who lived in the chosen study area to ensure that they were receiving infant feeding care from professionals employed by BFI Gold accredited organisations. Women needed to be fluent in English as I did not have the funds to pay for interpreters. I excluded women who had been recruited into research studies which were being undertaken in the same area to avoid participant burden. To identify how the women's backgrounds influenced the women's experiences, it was necessary to include a diverse sample of women.

I decided to use a combination of the woman's occupation and income to identify the women's socio-economic status. This enabled me to use information that health professionals routinely collect from women antenatally, which includes household income, number of adults in the household, occupation, and receipt of benefits, to determine socio-economic status. Although it is important to clearly measure social inequality to understand possible inequalities between groups, Binelli et al. (2015) suggest a lack of available frameworks to do so. However, Connelly et al. (2016) suggest that individuals within each social class share similar levels of income and work situations. Furthermore, these factors have been shown to be reliable when measuring socio-economic disadvantage (Taylor, 2017).

When deciding on my sample size, I made a pragmatic decision to recruit eight women from both a low and high socio-economic background. I was also aware that samples in qualitative studies tend to be much smaller than those used in quantitative studies (Denscombe, 2021). However, I wanted to recruit sufficient women to obtain the 'information-rich cases,' which Patton (2002) suggests is essential when using purposive sampling, rather than achieve data saturation. In addition, as I was undertaking narrative research and to align with my study aims, I needed an appropriate sample size to obtain rich detailed stories from the women about their infant feeding experiences and how these changed over time. Furthermore, it was also essential my sample size would be practical and manageable in the time available, as suggested by Wells (2011). Therefore, I also considered the number of times the participants would be interviewed. Sandelowski (1995) supports the use of judgment when determining an adequate sample size. She argues that the sample size should be large enough to obtain rich detailed accounts, but small enough to allow for in-depth analysis.

The National Statistics Socio-economic Classification (NS-SEC) Operational Categories (Office for National Statistics, 2021) were used to classify the women's occupation and employment status. Please see Table 11 for the NS-SEC Operational Categories and appendix 5 for the category descriptions. The operational categories for employment with the NS-SEC were used as Erikson and Goldthorpe (1992) argue that they are key to allocating individuals into social class categories.

Table 11: The operational categories within the National Statistics Socio-Economic Classification (NS-SEC) (Office for National Statistics, 2021):

Operational Categories
L1 Employers in large establishments
L2 Higher managerial and administrative occupations
L3 Higher professional occupations
L4 Lower professional and higher technical occupations
L5 Lower managerial and administrative occupations
L6 Higher supervisory occupations
L7 Intermediate occupations
L8 Employers in small establishments
L9 Own account workers
L10 Lower supervisory occupations
L11 Lower technical occupations
L12 Semi-routine occupations
L13 Routine occupations
L14 Never worked and long term unemployed

When identifying the participant's socio-economic status, I used the Department of Work and Pension's (2023) classification of a low-income household. This defines a low-income household (a couple but no children) as having an annual income of up

to £17,100 before housing costs (Department of Work & Pensions, 2023).

Occupational Categories were determined by matching textual occupational descriptions (from the participant's answers to the demographic questions – see appendix 6 for the demographic questions) with a standardised list of occupations.

Recruitment for this study opened in September 2021 and closed in September 2022. Initially midwives were asked to identify women for this study on my behalf. Unfortunately, due to significant pressures on midwives between September and November 2021 midwives were not able to identify any women for the research. Therefore, I submitted a substantial amendment to my original ethics application in December 2021 to allow for additional ways to identify potential participants for this research. This substantial amendment involved significant changes to the study documents and revisions to the recruitment strategy so that I could use various methods to recruit women for this research. This was important to ensure as many women as possible who were pregnant with their first baby would be able to access information about the research. Additionally using multiple methods of recruitment would increase the likelihood of recruiting women from both high and low socio-economic backgrounds which was necessary to answer my research questions. Moreover, my public advisors felt it was necessary to use various methods to recruit women to ensure I was sensitive to inequalities, in particular material disadvantage.

Initially I designed a survey on Qualtrics to both provide women with further information about the research and obtain their demographic information which would be used to check whether a potential participant was eligible to take part in the study, determine their socio-economic status and understand their personal

circumstances. The demographic data I collected on this survey included age, ethnicity, current employment status and occupation if in employment, total household income and benefit status. Please see appendix 6 for the demographic questions which were used on the survey. I amended the information flyer (see appendix 7 for flyer used) to include my contact details and a QR code which potential participants could scan to obtain further information and the demographic questionnaire on Qualtrics. Additionally, a poster and social media advert were created with either a QR code or link to enable women to access the Qualtrics questionnaire and express their interest in participating in the study. This made it easier for potential participants to find out more about the study and for their contact details to be shared. Please see appendix 8 for the poster and appendix 9 for the social media advert used to share information about the study.

With support from the midwifery manager, staff working in midwifery and members of the research team at one of the hospitals the posters were used to share information about the study in all spaces where pregnant women would either wait or be seen by a midwife i.e., waiting rooms and clinic rooms at GP surgeries, Children's Centres and in local hospital antenatal clinics. The social media advert was shared on a Trust specific Facebook page³³, Instagram, Twitter, and Mums Net. Additionally, the information flyer was added to BadgerNet, and midwives were asked to make this flyer recommended reading for all first-time mothers. After obtaining a research passport, I also recruited in-person over several days in various antenatal clinic settings and locations within my study area, giving the information flyer to women who expressed interest in participating. For those who were recruited in person, I

³³ Please see appendix 10 for a screenshot of the Facebook page.

collected demographic information and checked eligibility for the study when the women consented to take part in the study.

5.5 Data collection

This research used qualitative data collection methods to obtain the women's infant feeding stories. Whilst not all qualitative methods are aligned with an interpretivist approach (Willis, 2007), Holloway and Gavin (2023) suggest that qualitative methods offer an effective way of facilitating person-centred and holistic enquiry which is important for health professionals, such as nurses to focus on interaction.

To participate in the study women were asked to complete entries in a diary following an appointment with a health professional who had provided them with information about feeding and caring for their baby (see section 5.5.2) and participate in interviews (see section 5.5.3) to build on information from the diary at each stage.

Specific points during the mother's journey in pregnancy until around six months postnatal were used to collect data. Table 12 below shows the data collection points that were used. The NICE (2021) guidance recommends women should have discussions about feeding after 28 weeks gestation. This provided the rationale for prompting pregnant women to complete diary entries at 28 weeks and 36 weeks and to undertake interviews at 30 weeks and 38 weeks. Postnatal data collection points were based on NICE guidance for postnatal contacts (NICE, 2021b) and guidance for universal health visiting face to face contacts when infant feeding would be discussed (new baby review and 6-to-8-week review) (Office for Health Improvement & Disparities, 2023). This also ensured there would be a sufficient time lag between

each data collection point to ensure there would be health professional contacts to discuss.

Table 12: Data collection points

Antenatal data collection points	
Diary prompts:	Interviews:
28 weeks	30 weeks
36 weeks	38 weeks
Postnatal data collection points	
Diary prompts:	Interviews:
2 weeks	4 weeks
3 months	4 months
	6 months

5.5.1 Using solicited diaries and semi-structured interviews to collect data

This research used solicited diaries and in-depth, semi-structured interviews for data collection to align to this study’s epistemological, theoretical, and methodological underpinnings. As Crotty (2015) highlights how the methodology shapes the research methods used, it was essential that I chose data collection methods which would allow the participants to tell their story and then explore their stories in detail. This was important to both identify in the women’s stories how their experiences and perspectives reflected their social contexts and understand how they interpreted and gave meanings to their experiences and interactions over time. Maxwell (2021)

supports the use of interviews to enable the researcher to understand how the social and cultural context has influenced the meanings, beliefs, and values of participants. As participants were encouraged to record their thoughts, feelings, and experiences in their diary in real time, this mitigated the recall issues that are discussed by Thomas (2015). In addition, as interviews were undertaken after diary entries had been completed, this gave the participants the space necessary to reflect on their experiences which allowed for a deeper understanding of their experiences. Supporting this, Eidse and Turner (2014) explain how providing the time and space for participants to reflect on a specific topic allows for more nuanced understandings.

5.5.2 Solicited diaries

The decision to use solicited diaries³⁴ was based on my decision to use a longitudinal study design (as described in section 5.2) since this method is particularly useful for collecting participant experience over time (Boz & Okamus, 2017), when experiences are expected to change (Travers, 2011). This method has also been used by researchers to capture women's infant feeding experiences which influenced my decision to use this method in my research. For example, Hinsliff-Smith and Spencer (2016) used solicited diaries to obtain insight into the lived experience of the early stages of breastfeeding. They found that the solicited diaries offered a useful way of bringing the participants' experiences to life by providing a richness of data that enabled a deep understanding of how the mothers felt about breastfeeding. Similarly, Taylor et al. (2019) used video diaries to capture the breastfeeding experiences of first-time mothers. They also found that the video

³⁴ When research participants keep diaries, diaries are referred to as solicited diaries (Morrison, 2012).

diaries helped them to understand the meanings the women gave to their breastfeeding experience. Moreover, they found that the mothers included in their study welcomed the opportunity to share their breastfeeding experiences and found the process therapeutic.

Whilst the COVID-19 pandemic and logistical difficulties with providing participants with a paper diary influenced the decision to use online diaries, the use of digital research diaries is increasing (Seguin et al., 2022). For example, Rudrum et al. (2022) used online diaries to obtain rich, qualitative data of the experiences of pregnant women, supporting the use of online diaries in my research. Despite dedicated diary apps being available to capture women's thoughts and feelings, my research study utilised OneNote, a digital notebook and note-taking app. First, this app was available to me without a subscription. Second, as OneNote is part of Microsoft Office, the notebook could be stored on the University's OneDrive for Business, eliminating the need to share data with a third-party organisation and thus providing greater data security. Most importantly, participants did not need Microsoft 365 to use the notebook although they did need a free Microsoft account. This would also enable them to download Microsoft's free OneNote app and access the diary on their mobile phone. However, Khan and Garrett (2020) highlight the importance of considering literacy levels, access to equipment and the internet when using diary methods. Therefore, the public advisors tried the OneNote notebook and provided feedback in relation to its accessibility. This was essential to ensure that all participants, irrespective of their background would be able to access it. Finally, as OneNote notebook automatically saves and syncs information this allowed me to access data immediately.

Each participant was provided with their own individual notebook with a password protected section for their diary entries. Prior to data collection, women were orientated to their OneNote notebook during a Teams call. This Teams call was undertaken around 24 weeks gestation or later if women were consented at a later gestational age. During this initial meeting, I shared my screen and showed the participants how to access their diary and the information which I had added to a section within the notebook. This information included the diary guide (see appendix 11), tips sheet (see appendix 12) and step-by-step instructions (see appendix 13) for recording diary entries that had also been added to their notebook. Women were also asked during this call how they would like to receive their prompt reminders for completing diary entries - by text message, email, or both. Women were aware that they could complete as many entries in their diaries as they wished, but that they would be prompted to complete entries at the key data collection points.

As a known disadvantage of the diary method is the tendency for participants to deviate from the focus of the intended study (Alaszewski, 2006), I provided a diary guide for the participants which I hoped would keep them focused on the research topic. The diary guide encouraged the participants to reflect on the care they received, how they felt about their care and whether the support they received influenced the way they fed and cared for their baby. Morrison (2012) supports the importance of using a diary guide to ensure participants are familiar with the research objectives. The tips sheet provided further information about completing diary entries and signposted those participants interested in using creative methods

to further resources available on the Maternal Journal website³⁵ (Maternal Journal, 2022). The step-by-step instructions provided information on the tools available in the notebook for completing diary entries. OneNote provided the participants with various options to record their experiences and enable them to record as little or as much as they wanted.

5.5.3 Interviews

Interviews provided the participants with both the opportunity to explore and expand on the issues that they had discussed in their diary entries and reflect and make sense of their experiences, as suggested by Mishler (1986). As interviews were undertaken during the pandemic when in-person interviews were not possible, women were given the choice of undertaking their interviews over the phone or via Teams. However, all but one participant decided to undertake interviews over the phone.

Whilst Kvale and Brinkmann (2008) argue that undertaking interviews via Teams can be more personal as the interviewer can see the participant, there are significant advantages to undertaking interviews over the telephone. Saarijärvi and Bratt (2021) suggest telephone interviews enable participants to be interviewed who have unstable internet connections and Krouwel et al. (2019) discuss how telephone interviews enable participants to be interviewed who do not have access to the technology required to undertake interviews virtually. Furthermore, telephone

³⁵ Maternal Journal kindly gave their permission to adapt the wording of the tip sheet on their website for this research.

interviews enable those who may not feel comfortable with a camera to participate in research (Krouwel et al., 2019).

As the purpose of the interviews was to elicit the women's stories, open-ended questions were used to enable the women to focus on what they felt was important. For example, 'could you tell me what happened when?' Or 'could you tell me what happened next.' Using open-ended questions was essential to obtain rich descriptions of the participant's infant feeding experiences and how these developed over time (Reissman, 2008; Silverman, 2013). As Kvale (2007) suggests, active listening was particularly important for telephone interviews as I needed to signal that I was listening and interested in what the participants were saying. Therefore, I used words such as "hmm," "yes," "I see" and "okay" to let the participants know I was listening carefully to what they were saying. As Wells (2011) identifies that researchers should consider how they emotionally respond to participants to ensure they are person-centred, it was important that I allowed the women to tell their stories at their own pace, did not interrupt the women while they were telling their stories and waited for gaps in the conversation to either reflect on what had been said, seek clarification or encourage greater elaboration. In addition, Emery et al. (2023) explains how creating personal connections particularly with people of lower socio-economic status is essential to provide a deeper understanding of their lived experiences. Therefore, whilst the women were talking, I took notes so that I could use their words to enable them to further reflect on their experiences.

Where a participant had not completed a diary entry before the interview, the question on the diary guide 'what did you discuss about feeding and caring for your baby' was used to focus reflections on relevant experiences.

Five interviews were offered per participant. All but two participants participated in all five interviews. When interviews were missed, experiences that would have been discussed were captured during later interviews. The fifth and final interview was undertaken around six months postnatal. First, this interview provided the women with the opportunity to reflect on their participation in the study. Both Meth (2003) and Morrison (2012) highlight how reflecting on the experience during the final interview is common within narrative research. Second, the women were able to reflect on their infant feeding experiences over the course of the research and whether their perspectives had changed. All participants were given a £10 shopping voucher after participating in each interview and a further voucher at the end of the study to thank them for the time they had spent participating in the study.

5.6 Transcription

All interviews were audio-recorded. Telephone interviews were recorded with a digital recorder and then uploaded to the University's secure network where they were transcribed. Interviews that were undertaken on Teams were audio-recorded on Teams. I transcribed the interviews myself as I wanted to obtain a greater familiarity with the data, as described by Merriam and Tisdell (2016). This also enabled me to

learn more about myself as a researcher and allowed for active reflection on the interviews.

Reissman (1993) discusses how decisions regarding what to transcribe and how to transcribe shape how the interview is presented and therefore, the subsequent analysis. To obtain an accurate account of the interview I transcribed the interviews verbatim. This meant that I did not 'tidy up' ungrammatical or colloquial speech (Poland, 2002) and included pauses. According to Wells (2011) the production of a verbatim transcription is crucial when undertaking narrative research because the way the story is expressed is part of the data. Additionally, Nasheeda et al. (2019) highlight how keeping the entire verbatim of the participant, is both in keeping with a narrative inquiry methodology and increases the trustworthiness of the study. Once each interview had been transcribed, the transcripts were carefully checked against the audio recordings to ensure that accurate accounts were obtained.

5.7 Data analysis

Whilst there are a variety of ways that narrative analysis can be undertaken (Bruce et al., 2016), this study required a combination of analytic approaches to both examine the women's stories as individual stories and then across socio-economic groups to identify any similarities and differences. I therefore undertook data analysis in the following four ways:

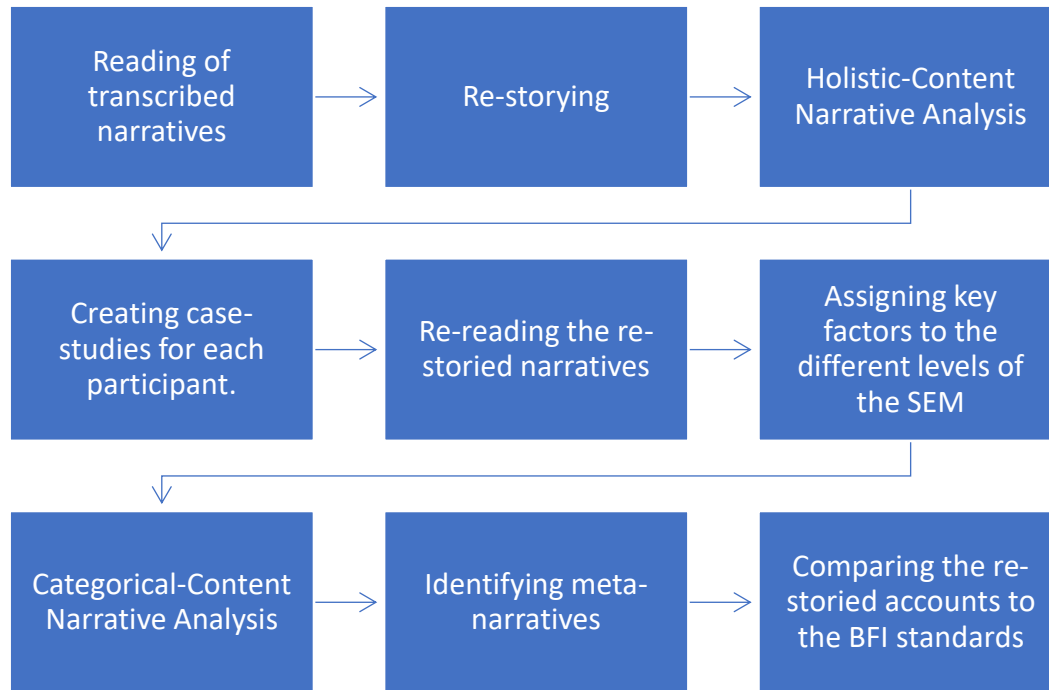
1. Re-storying informed by the experience-centred narrative approach.

2. Holistic-Content narrative analysis informed by social constructionism to create stories.
3. Categorical content analysis using the SEM informed by social constructionism to compare the stories.
4. Consideration of the women's stories in relation to the UNICEF UK BFI revised standards to answer my research questions.

Conducting the data analysis with these different approaches offered the opportunity to first consider the content of the women's infant feeding stories and how the context in which they told their stories influenced the way they constructed their stories. Second, examine the women's stories as individual stories and then identify similarities and differences in the way a diverse sample of women constructed their stories. Finally, locate the women's infant feeding care experiences in time and place to consider the meaning and consequences of their infant feeding care.

The stages of data analysis are illustrated in Figure 6.

Figure 6: The different stages of data analysis



I will now discuss the stages of narrative data analysis in more detail.

Initially I read the transcribed narratives to get a feel for them as they were told, as discussed by Edwards (2016).

Re-storying

As Bruner (1987) suggests that narratives are not told in a linear manner, the women's narratives were re-storied to identify sequence (chronology, temporality, time and place), contextual issues (social and personal aspects) and consequence (description of what happened next or what the participant predicted would happen next) for each of the women's narratives (Riessman, 2008). I followed the process outlined by Whiffin et al. (2014) to re-story the narratives and create stories from the women's diary entries and interview transcripts. It was important to identify sequence and consequence to align with my experience-centred narrative approach where narratives are both sequential and meaningful (Squire, 2013).

Supporting this Riessman and Quinney (2005) argue that it is sequence and consequence which is the most significant difference between narrative and other text-based data. By identifying context, I was able to reflect the social constructionist approach taken in this research and my belief that narratives are inseparable from the social context of which they are a part. Re-storying the narrative data also helped me to re-construct the told from the telling (Mishler, 1995) which is necessary when using a constructionist framework.

Holistic content narrative analysis

Once participant's narratives had been re-storied, the next step in the within-case analysis involved a holistic content narrative analysis to make meaning out of the women's infant feeding experiences. The rationale for undertaking a holistic content analysis after re-storying is because the created story becomes the unit for further

analysis (Mishler, 1995). However, Lieblich et al. (1998) discuss how it is important when using holistic approaches to view the individual's story as a whole and interpret the parts within it in relation to the other parts of the story. This involved identifying key factors from each of the women's stories to focus on what happened in each story (Beal, 2013). This was particularly important from my epistemological standpoint to both obtain a holistic understanding of the women's infant feeding experiences and reveal the meanings of their stories (Zelčāne & Pipere, 2023). Furthermore, as suggested by Casey et al. (2015) this approach enabled an in-depth exploration of each participant's narrative over time to be undertaken.

Table 13 illustrates both the re-storying of narrative data associated with Michelle's 32-week antenatal appointment and the key factors identified through holistic-content narrative analysis:

Table 13: Re-storying and identifying key factors

Sequence	Context	Consequence	Key Factors
32-week antenatal appointment with midwife	<p>'Partner's not around'</p> <p>'It's a bit all over the place with my house and job and things.'</p> <p>'It's not been an easy pregnancy with regards to the situation'</p>	<p>'Going through a tough time.'</p> <p>'It is what it is'</p>	<p>Challenging personal situation (includes house and job). Partner not around.</p>
	<p>'Only concern is that each appointment is with a different person. Only met allocated midwife once.'</p> <p>'If I am struggling with something and I've confided in a midwife, I would have to go over that again.'</p>	<p>'I don't see what benefit there is telling a different person the same story over and over again, so I don't now. I just say I'm fine.'</p>	<p>Sees different midwives and not able to share information about personal situation.</p>

This stage culminated with the writing of a narrative account in the form of a case-study to illustrate the women's stories (see chapter 7). Whilst Byrne (2017) criticises this approach by highlighting how it is inevitable that the researcher's voice will be present in the text produced, I remained close to the voices of the participants by using the participant's own words within the case-studies. I entitled each case-study with a pseudonym and a quote from the interview text that I felt illustrated each woman's experience. For example, the quote I chose for Michelle 'My situation has

not made it easy' reflects her challenging circumstances she experienced due to her individual situation and how this influenced her infant feeding journey.

Before the next step of data analysis which involved comparing the key themes between the re-storied accounts, I re-read the re-storied accounts again to become fully immersed in the narrative process and ensure I obtained an overall understanding of each narrative.

Categorical-content analysis using the SEM to compare key factors.

The next step in the analysis involved a categorical-content analysis to compare the key factors across cases. Supporting this Beal (2013) argues that whilst a group of stories is rich in its portrayal of individual experience, it is limited in its ability to illuminate a more general understanding of the topic under study and answer the research questions.

However, before I could complete this stage, I realised I needed a structure to sort the key factors and identify the inter-relationships between them which I could then use to compare the key factors across cases. I decided to use the SEM (as outlined in chapter 2) to structure my categorical-content analysis. Using the SEM aligned with my social constructionist standpoint and the importance of exploring the multiple elements of narratives on various levels (Esin et al., 2013). Furthermore, using the SEM reflected the symbolic interactionist approach that I adopted in my research (see section 4.4). Moreover, this was an important part of the process because experiences identified in one system-level often were related to experiences in

another system-level. For example, for Michelle her challenging circumstances were influenced by both her self-employed status (individual level), lack of support (significant others level) and lack of continuity of midwife (organisation level) which influenced her ability to share information about her challenging circumstances antenatally.

Table 14 illustrates how the key factors identified through holistic-content analysis for Michelle’s 32-week antenatal appointment were organised into the levels of the SEM for categorical content analysis:

Table 14: Organising key factors into the levels of the SEM.

System Level	Key Factor
Individual Level	Challenging personal situation (includes house and job).
Significant Others Level	Partner not around.
Organisational Level	Sees different midwives and not able to share information about personal situation.

Factors were then considered between women of the same socio-economic background and then between women to identify similar and dissimilar

characteristics of participants' experiences and answer my research question. This approach was necessary, as suggested by Lieblich et al. (1998) to compare themes across the data from the multiple research participants. Furthermore, by comparing the women's experiences this enabled variations in their experiences to be identified.

Identifying meta-narratives

Once the women's experiences had been compared and similarities and differences had been identified, I then looked for meta-narratives. Bruce et al. (2016) proposes that meta-narratives both provide a framework for understanding experiences and help with sense-making. Adopting a similar position, Bruner (1987) suggests meta-narratives can be collective stories as they are produced and shared by those in a particular culture. Once provisional meta-narrative titles had been determined these were used to group women with similar experiences together which also helped to synthesise key factors at each level of the SEM (see chapter 7). This stage concluded with a synthesis being written in the form of a critical summary for each meta-narrative. The critical summaries (which can be found in chapter 7) demonstrate the interplay between the factors at each level of the SEM which influenced the women's experiences.

Considering the findings in relation to the standards

To answer the research question, the meta-narratives were considered in relation to the BFI standards to suggest where, in the women's infant feeding stories, the care they received provides evidence of the BFI standards and identify any variations in experience due to the women's socio-economic status. See Tables 21 and 22 in chapter 8. As discussed previously, this table was discussed with members of my advisory group (BFI leads and Professional Officer for Policy and Advocacy at UNICEF UK BFI (although now retired) to gain alternative perspectives.

5.8 Ethical considerations

The key ethical issues considered in my study are discussed as follows:

Ethical Approval

This study was approved by the HRA and Health and Care Research Wales on 13th of August 2021 and the Health Ethics Review Panel at the University of Central Lancashire on 8th of September 2021. Capacity and Capability for my study was obtained from East Lancashire Hospitals NHS Trust on the 14th of September 2021. Please see appendix 13 for the approval letter from the HRA and Health and Care Research Wales.

The substantial amendment was approved by the HRA on the 26th of January 2022 and by the Health Ethics Review Panel at the University of Central Lancashire on the 7th of February 2022 (see appendix 14). A non-substantial amendment was completed in November 2022 when Dr Claire Feeley joined the supervisory team. A research passport and Letter of Access were obtained on the 22nd of April 2022 which enabled in-person recruitment for the research.

Informed consent

Any woman expressing interest in participating in the study and who met the eligibility criteria was provided with a participant information sheet (see appendix 15). This information sheet included clear, detailed information about the study and what engagement in the study would entail so that participants could make an informed

decision about participating in the study. Participants were informed through the participant information sheet and the consent form that they had the right to decide not to participate in the study and to withdraw from the research at any time during data collection without giving a reason. Participants were also advised that if they decided to withdraw from the study, any data collected up to that point would still be used. Women were then consented via a Teams or telephone call during which the contents of the information sheet were discussed, and women were asked if they had any questions about the study. This call was undertaken around 24 weeks gestation or later if women were consented at a later gestational age. During this call I checked that the women understood what the study involved, and the time commitment required before asking them whether they would like to participate. To obtain consent I read out the consent statements on the consent form (appendix 16) and asked participants to state that they agreed to the statements. I also asked the participants to state at the end that they agreed to participate in the research, giving their name and date. This consent process was audio recorded and stored on Microsoft Teams in a secure channel.

In line with the approach of others e.g., Klykken (2022), I viewed consent as a continuous approach. Therefore, at the start of each interview participants were asked if they were happy to go ahead with the interview and re-clarified their permission to audio record our conversation.

Maintaining confidentiality and anonymity

Personal details of the participants, consent recordings, diary entries, recordings of interviews and transcriptions were all treated as confidential information. On recruitment to the study participants were assigned a sequential code number. This was used to link the participants with data collected during the study as a way of protecting their anonymity. The personal details of the participants and the codes which linked their names to the data were stored in a separate location to the coded data. Each participant was provided with their own OneNote notebook with a password protected section for their diary entries, which could only be accessed by myself and the participant. Each participant was given their own notebook to minimise the potential loss of any data by another participant accidentally deleting a notebook. Individual notebooks were stored on the University's OneDrive for Business which is password protected and encrypted. Prior to the initial meeting with the participant, a link to their individual notebook was emailed to them. The password for their diary section was then emailed to them in a separate email.

Participants were not asked to share personal information or names during their diary entries or interviews but if they did, these were removed during transcription. All recordings of the interviews were deleted once the interviews had been transcribed. Personal data which included the recordings of verbal consent will be kept for five years.

The date of birth of women participating in the study were shared securely with the research team at the local NHS trust to ensure that I could be notified in the event of pregnancy loss or stillbirth. The research team used this information to add women to Edge, which is a research management programme to track them through the study.

Data protection

Subject to the requirements of the Data Protection Act (2018) secure folders on Teams were created to store participant information (which included the demographic information collected on the Qualtrics survey) and consent recordings. Access to these files has been limited to myself and my supervisors.

5.9 Trustworthiness

The trustworthiness of the study will be considered in this section using Lincoln and Guba's (1985) criteria: credibility, transferability, dependability, and confirmability.

5.9.1 Credibility

Using multiple methods (diary entries and interviews) increased the credibility of my findings by enabling me to demonstrate that my findings were accurate and true to my data. This is because I was able to check and explore the meanings women gave to the experiences they had documented in their diaries during interviews. Please see section 5.5.3 where I have provided an example.

Audio-recording interviews was important to obtain the exact words used by the women in the interviews. Furthermore, the inclusion of verbatim transcription in the case studies ensured that the participant's perspectives and experiences were represented accurately. However, I did discuss with my supervisory team about how much of the participant's story to include.

Reflexivity played a crucial role in enhancing the credibility of my research findings. As my research was underpinned by a social constructionist approach, it was essential that I constantly reflected on how my assumptions and knowledge of infant feeding and experience of implementing the revised BFI standards would influence the research process. Galbin (2014) argues that reflexivity is crucial when taking a social constructionist standpoint as the traditional positivist approach to knowledge has been rejected. As my acts and values are not objective and value free, Olmos-Vega et al. (2023) discusses how researchers should undertake reflexivity on a continual basis to critique, appraise and evaluate how their subjectivity and context influence their research. Completing a reflexive interview with my Director of Studies before I commenced my research, enabled me to critically reflect on my biases and assumptions and consider my own situated knowledge (please see section 1.10 where I position myself within this research). I engaged in reflexive writing continuously throughout data collection, when transcribing the interviews and during data analysis to consider how my knowledge and understanding as a health visitor and Lactation Consultant influenced how the women were telling their stories and how I had interpreted them. I also discussed my interpretations during data analysis with my supervisors on a regular basis.

The participants were aware that I was a PhD student with an interest in infant feeding. However, they were not aware of my professional background as a health visitor and IBCLC. This was important to ensure that the participants would discuss openly their thoughts and feelings about the infant feeding care they had received. If the participants had been aware of my professional background this may have affected the stories they reflected on. Denscombe (2021) supports the importance of making a conscious effort to minimise the effect that a researcher's identity might have on the information participants provide.

Interpersonal reflexivity (Olmos-Vega et al., 2023) was important at all stages of the research to also consider the relationships I had with my public advisors, advisory group, (see section 1.13 where I have introduced my public advisors and advisory group) and my supervisors and how these relationships impacted on the decisions I made during my research and on the results of the study. Please see section 1.13 where I discuss the involvement of my public advisors in the research

The study advisory group met four times during the research. Initially the advisory group were consulted to seek their perspectives on the exact approach that would be taken. The advisory group supported recruitment of study participants by sharing information about the study. They were invited to listen to the reading of two of the full stories and make suggestions about the wording of the meta-narratives. Finally, the table which considers the women's re-storied accounts to the revised BFI standards was shared with the Baby Friendly Leads and the Professional Officer for

Policy and Advocacy at UNICEF UK BFI (now retired) to reflect on the decisions made. The academic researcher was asked to comment on both the meta-narrative titles and the visual metaphor to understand whether this accurately represented the research findings.

Credibility was also ensured through prolonged engagement with the participants due to the longitudinal study design. First, I was able to identify how the women's experiences and perceptions had changed over time. Second, by using multiple data collection points I was able to obtain in-depth, detailed data which allowed for a deeper analysis of the stories. Finally, undertaking a longitudinal study enabled me to obtain a contextual understanding of how external factors and the wider socio-cultural context had influenced the women's experiences.

5.9.2 Transferability

Contextualising the research (Andrews, 2021), by providing information about the study area and participants was essential not only to increase the transferability of the research but to answer the research questions. This included providing the eligibility criteria I used to select participants for my research (see section 5.4), purposefully selecting participants and detailing the participant's demographic and socio-economic data (see section 6.2).

The processes by which data was collected and analysed were reported accurately. Justification for the epistemological and theoretical basis of my work including the

methodology and the methods I used to collect the women's stories was given. Filep et al. (2017) discuss how they ensured trustworthiness in their study which used diaries by giving a detailed account of diary practices and provided rationale for the methodology.

5.9.3 Dependability and Confirmability

The involvement of public advisors and members of the advisory group in this research enhanced the confirmability and dependability of my results. When interpreting the women's stories, I referred to the notes I had written during and after meetings with my public advisors and advisory group. In these meetings we reflected on the meaning of the women's stories, reviewed the titles of the meta-narratives, and discussed how I had considered my findings in relation to the revised BFI standards. Additionally, I discussed my findings on a regular basis with my supervisory team. The final interview provided an additional opportunity for the women to clarify or elaborate on their stories. This reduced the risk of misinterpretation and increased the confirmability of findings. I also used these final interviews to reflect on my own influence on the research process and outcomes. For dependability, I have also provided examples of how I got to the themes from my raw data.

5.10 Conclusion

In this chapter I have described and justified the methods I used to collect the women's stories and the narrative analysis approach taken to identify the findings which I will discuss in the next chapter.

Chapter 6: Introduction to findings chapters

6.1 Introduction

In the previous chapter I described and justified the methods I used to both collect and analyse the women's infant feeding stories. I start this chapter by introducing the women who participated in the research. Then, I introduce and justify the adapted SEM I used to identify the interplay of factors which influenced the women's infant feeding experiences and outcomes. I conclude this chapter with an overview of the research findings and introduce the meta-narratives that will be discussed in the next chapter.

6.2 Introducing the participants.

Eight women, who were having their first baby, participated in the study. While nine women were recruited, one participant decided to withdraw from the study before any data was collected. All women who participated in the study met the eligibility criteria and an equal number of women (n=4) with a high and low socio-economic status were recruited. All participants were female and described their ethnicity as White. The women were within the age brackets 18-24 (n=1), 25-34 (n=5) and 35-44 (n=2). The women's demographic details are outlined in Table 15.

Pseudonyms have been used to preserve the anonymity of the participants.

Participants were offered the opportunity to choose their own pseudonym or to have

one chosen for them. All but two of the participants asked for a pseudonym to be chosen for them.

As previously discussed in section 5.4, operational classes (Office for National Statistics, 2021) were used with information relating to income to classify women as either of high or low socio-economic status. The following example shows how socio-economic status was determined:

For Michelle (classified as low socio-economic status):

Total household income between £8,000 and £14,000 and on universal credits.

Self-employed curtain maker classified as being in L9 (own account worker).

For Anna (classified as high socio-economic status):

Total household income over £50,000. Not on benefits.

Employed full time, as a divisional personal assistant, classified as being in L5 (lower managerial and administrative occupation).

Table 15: The participants' demographic details

Participant Pseudonym	Household	Employment status	National Statistics Socio-economic Classification (NS-SEC)	Total household income	Benefit status
Isabella	Lives with husband	Employed, full time	L6	Over £50,000	Not on benefits
Louise	Lives with husband	Employed, full time	L6	Over £50,000	Not on benefits
Anna	Lives with partner	Employed, full time	L5	Over £50,000	Not on benefits
Charlotte	Lives with wife	Employed, full time	L6	Over £50,000	Not on benefits
Michelle	Lives on her own	Self-employed, full time	L9	Between £8,000 and £14,000	On Universal Credit
Catherine	Lives with partner	Self-employed full-time	L8	Between £26,000 and £32,000	Not on benefits
Ashleigh	Lives with partner	Not currently in work	L12	Between £15,000 and £25,000	Not on benefits
Irene	Lives with husband	Employed, part time	L12	Between £15,000 and £25,000	Not on benefits

The following table explains what data was collected from each participant to provide an indication of the density of data.

Table 16: Description of data collected from each participant

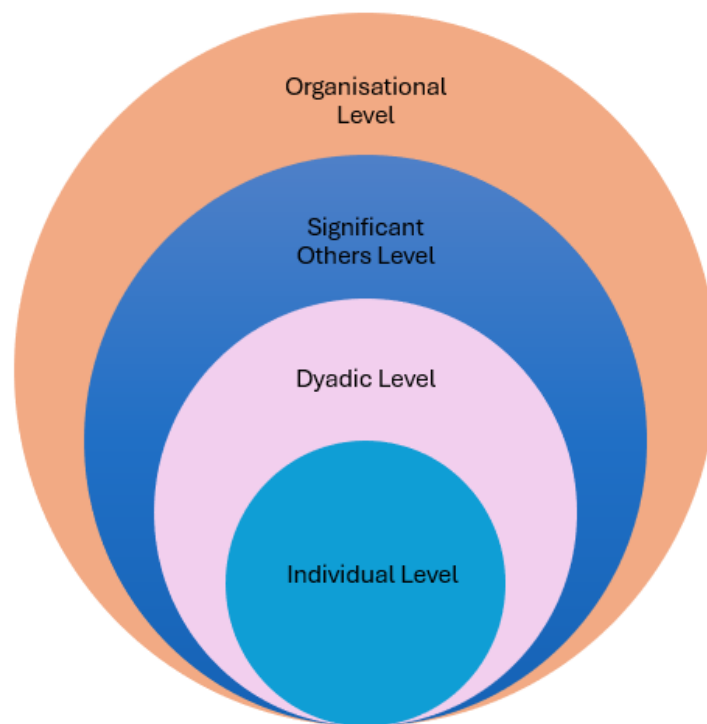
Data collected	Isabella	Louise	Michelle	Catherine	Ashleigh	Irene	Anna	Charlotte
Antenatal interview 1 (Duration, minutes and seconds)	21:33	20:34	7:28	22:23	9:43	31:47	23:26	8:03
Antenatal diary entry 1 (Lines)	25	53	12	6	No data	34	22	No data
Antenatal interview 2 (Duration, minutes and seconds)	21:54	21:11	12:45	No data	38:43	44:48	16:03	34:08
Antenatal diary entry 2 (Lines)	10	35	54 (36 and 38 weeks) and 34 (34 weeks)	11	55	108	46	18
Postnatal interview 1 (Duration, minutes and seconds)	57:13	31:57	39:38	25:59	31:28	45:55	25:40	44:51
Postnatal diary entry 1 (Lines)	No data	137	58	No data	No data	158	47	No data
Postnatal interview (Duration, minutes and seconds)	28:54	23:49	23:44	21:57 (included final interview)	22:21	No data	15:11	15:52
Postnatal diary entry (Lines)	18	27	14	No data	48	64	5	No data
Final interview (Duration, minutes and seconds)	23:06	34:42	15:27	See above	12:26	42:17	24:20	21:48

6.3 Introduction to the socio-ecological model used.

For my research, I adapted the system-levels used by Snyder et al. (2021) and Thomson et al. (2022) to explain how interconnected, multi-level factors influence mother's infant feeding experiences and infant feeding outcomes on multiple levels. Whilst Munn et al. (2016), in their integrative literature review used the SEM (discussed in chapter 2) to consider factors at the mother/infant level, organisational level and policy level, I wanted to consider the mother's individual factors and mother-infant factors separately. At the individual level I considered women's personal attributes such as confidence and motivation to breastfeed as well as individual factors influencing the woman's capability to achieve breastfeeding goals, such as employment status and health issues. To recognise that the mother-infant feeding interaction is an interactive dyadic exchange between a mother and infant, in which each respond and reacts to the other (Sumner & Spietz, 1994), I considered mother-infant factors at the second level of the SEM. At the dyadic level, I considered mother-infant factors around birth and in the postnatal period which affected the women's experiences and infant feeding outcomes, as suggested by Thomson et al. (2022). At the third level, I have considered how support from significant others such as family, friends, and work colleagues influenced the women's infant feeding behaviours. At the fourth level, the organisational/institutional level I considered how BFI accredited infant feeding care provided by midwives, health visitors and the FAB team influenced the women's infant feeding outcomes and experiences positively and negatively. The policy level which is typically considered when using the SEM (Munn et al., 2016; Roll & Cheater, 2016; Snyder et al., 2021) and was discussed in section 2.2.5 was not considered to be relevant

during data analysis. This was because my research focused on the interactions which influenced the women's infant feeding experiences and outcomes, rather than wider system factors such as policy.

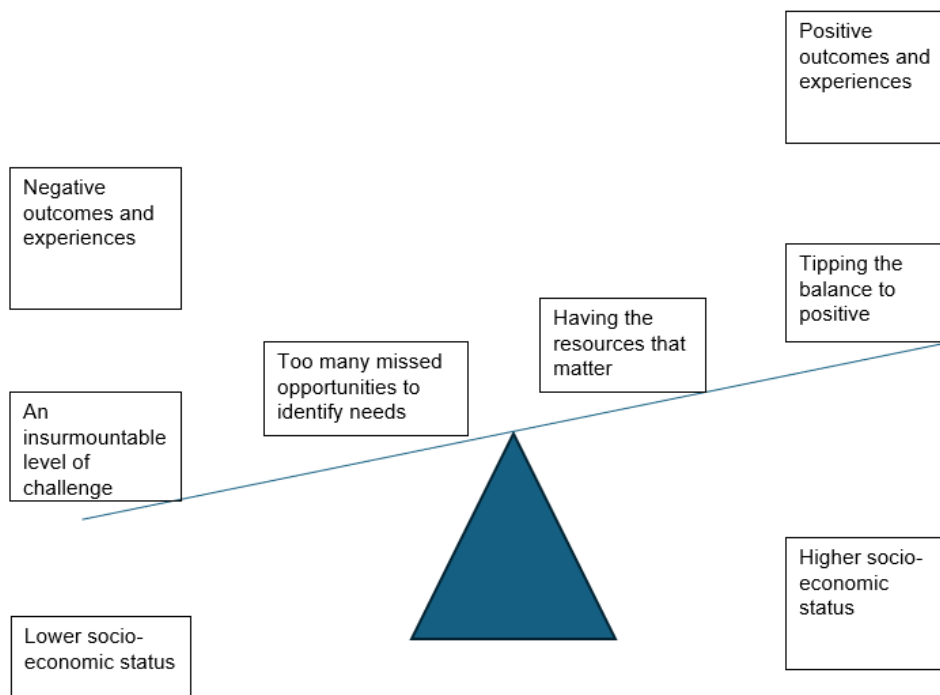
Figure 7: The SEM used in this research.



6.4 Introduction to the findings

To illustrate the range of experiences in the women's stories, four meta-narratives (which are discussed in more detail in chapter 7) were developed. Figure 7 illustrates the variations in experience and outcomes from negative to positive as identified in the meta-narratives and highlights the inequities that women of a lower socio-economic status experienced.

Figure 8: Variations in the women's experiences and outcomes.



The meta-narrative 'an insurmountable level of challenge' encompasses the stories of Michelle and Ashleigh (both of whom were of lower socio-economic status). It illustrates how challenging personal situations (individual level) and limited practical and social support (significant others level) prevented the women from achieving their infant feeding goals.

The meta-narrative 'Too many missed opportunities to identify needs' presents the stories of four women – Irene, Catherine, Isabella, and Charlotte (women of both lower and higher socio-economic status). These women experienced poor infant feeding care experiences and outcomes due to a lack of responsive and appropriate infant feeding care. Unidentified needs included a lack of understanding about these women's ability to access information and infant feeding care (individual level), missed opportunities to identify infant feeding challenges (dyadic level) and inability to identify the impact of negative vicarious experiences of family and friends (significant others level).

The third meta-narrative 'having the resources that matter' highlights how having the necessary resources enabled Louise (of higher socio-economic status) to achieve her infant feeding goals. Factors which helped her to breastfeed and introduce solid foods as per current guidance included having the necessary resources to access information (individual level), having a normal birth and being able to breastfeed without any challenges (dyadic level) and receiving support to breastfeed (organisational level).

The final meta-narrative 'Tipping the balance to positive' identifies the multi-level factors which enabled Anna of higher socio-economic status to have a positive infant feeding outcome and experience. This meta-narrative highlights the importance of having a supportive health professional throughout the infant feeding journey and receiving timely and appropriate infant feeding information and help to achieve effective breastfeeding and introduce solids confidently. Factors which facilitated Anna's positive outcomes and experience included having a normal birth and feeding difficulties resolved quickly (dyadic level), sufficient practical, emotional, and informational help (significant others level) and the provision of practical information that enabled effective breastfeeding (organisational level).

6.5 Conclusion

This chapter has introduced the women that participated in the research and the SEM which was used to identify how factors interacted and influenced the women's infant feeding experiences. This chapter has also introduced the meta-narratives, which will be discussed in more detail in the next chapter.

Chapter 7: Second findings chapter

7.1 Introduction

In this chapter I present four meta-narratives (an 'insurmountable level of challenge;' 'too many missed opportunities to identify needs;' 'having the resources that matter'; 'tipping the balance from negative to positive') which encompass the infant feeding experiences of the women who participated in this research. For each meta-narrative, I first provide case-studies to illustrate the women's experiences. Second, a table of key findings identifies the multi-level factors which interacted and influenced the women's experiences. Each meta-narrative concludes with a critical summary to highlight how the women's socio-economic status appeared to have influenced their experiences. The chapter concludes with a summary of the main constructs that were derived from the meta-narratives. Table 17 provides an overview of the meta-narratives, which participant the meta-narrative relates to and the title of each participant's individual story.

Table 17: Meta-narratives, participants and story titles.

Meta-narrative	Participant	Story title
An insurmountable level of challenge	Michelle	My situation has not made it easy.
	Ashleigh	There was more support when I was pregnant.
Too many missed opportunities to identify needs	Catherine	I sorted it myself.
	Charlotte	It has been intense.
	Isabella	I feel sad that breastfeeding didn't work out.
	Irene	It's been hard for me to understand breastfeeding can be difficult.
Finding the resources that matter	Louise	I found breastfeeding quite easy.
Tipping the balance to positive	Anna	I've had a lot of support.

7.2 Meta-narrative: 'An insurmountable level of challenge.'

This meta-narrative includes Michelle's narrative 'My situation has not made it easy' and Ashleigh's narrative 'There was more support when I was pregnant.' Whilst these women both possessed the antenatal intention to breastfeed; their narratives illustrate disparities related to these women's lower socio-economic status which put them at greater risk of poor infant feeding outcomes and experiences and could explain why they were unable to achieve their breastfeeding goals.

Michelle's case-study (low income): 'My situation has not made it easy'

Michelle is 32 years old and of White ethnicity. Michelle felt lucky that her '*actual pregnancy*' had been '*quite good.*' She lived alone as her partner '*wasn't around.*' In addition, she was self-employed, and her job was '*a bit all over the place.*' Whilst she acknowledged the '*tough time*' she was having due to her '*situation*' [home and work], she had a pragmatic approach, evidenced in statements such as '*it is what it is.*' Antenatally, her '*only concern*' was that she had only met her allocated midwife once. She was concerned that if she '*struggled with something and confided in a midwife*' she would have to go over her story again. To prevent this from happening, she stopped telling her story and just said she was '*fine.*' Michelle spoke of wanting to '*try*' to breastfeed and express with a pump so her baby could '*be fed by others.*' She believed she would persevere if she found breastfeeding difficult but would not '*beat herself up,*' as her friends had done. Neither her midwife nor health visitor provided her with opportunities to discuss breastfeeding, and she was not '*interested*' in attending antenatal classes, wanting to take birth and parenting '*as it comes.*' She

found retaining information difficult unless she wrote it down and in reality, this was difficult as she had *'just not had time.'*

Michelle was relieved when her daughter latched on straight away. Initially she felt that she'd had the *'best help'* from the hospital midwives as they'd gone *'above and beyond'* to discharge her so she could be with her dad who was on *'end of life care'*. However, the midwives had dismissed her concerns about the clicking noise her daughter made while feeding. With hindsight and after looking at information on Instagram, she felt the hands-on approach and advice she had received to *'push the baby on as quick as you can'* was not *'the right way'*.

On her second night at home, Michelle felt overwhelmed due to a lack of sleep and intensity of nipple pain *'it felt like someone was nipping them every suck.'* She began to have doubts of breastmilk insufficiency and her capacity to breastfeed, leading to feelings of failure, a situation magnified by living on her own. She tried to express her milk, but when nothing came out, she worried that her *'boobs had stopped working.'* It was during the middle of the night when Michelle decided to introduce formula, but with a lack of guidance her only option was to *'hope for the best.'* Michelle contacted the FAB team, but they could not visit until a week later and the midwives who visited her at home continued to negate that anything was wrong. By the time the FAB team came to help her with breastfeeding, she was already mixed feeding. She felt that she may have been able to *'scrap the formula'* if she had received help sooner.

Michelle contacted her health visitor when her daughter was four weeks old as she had not had a birth visit at 10-14 days. She wondered whether an earlier visit would

have meant she received more help. The health visitor spoke of safe sleep and while she only '*briefly touched*' on breastfeeding there was no discussion about formula feeding.

After four weeks of '*loving the feeling of breastfeeding*' Michelle was back at work. This meant she couldn't spend the time she needed to express. She felt '*bad*' when her milk supply subsequently reduced, and she was expressing '*next to nothing*,' a situation she described as '*annoying*'. Due to family members providing contradictory advice about when to introduce solid foods, she questioned whether the guidance provided by her health visitor was '*trustworthy*' and began complementary feeding for reasons not supported by available evidence.

During her last interview, Michelle wished she had known about the realities of breastfeeding, such as how to attach and '*have enough of your nipple in the mouth*'. If she breastfed again, she felt her experience would be different because she would know what to expect.

Ashleigh's case-study (low-income): 'There was more support when I was pregnant' Ashleigh aged 23 years, of White ethnicity lived with her partner. Antenatally, she had a lot of support from the specialist midwife and the '*extra people*' involved due to her mental health issues³⁶. She described having a '*good relationship*' with her midwife which enabled her to '*be open and honest*.' Ashleigh felt '*happier*' about

³⁶ Ashleigh experienced difficulties with her mental health throughout her pregnancy including 'bad mental health days' when she would cancel appointments due to not wanting to see any health professionals that day.

breastfeeding when she learnt '*how many benefits there were to mum*' from the online '*Bumps and Baby*' course she attended. Even though the course '*did say a bit about complications,*' she felt she learnt more about breastfeeding from her mum who had breastfed her. Ashleigh felt that the information she had been given antenatally had not influenced the way she would feed her baby but rather the way she would care for her baby – '*knowing the benefit of skin to skin, I think we'll both be doing it a lot more than what we previously thought*'. As a '*visual learner,*' Ashleigh found it hard to read a lot of information. She found the videos suggested by her health visitor and verbal explanations of '*how the nipple works*' enabled information to '*go in better.*' She had looked forward to attending a breastfeeding group which she felt would be '*honest and more like the real thing.*' However, in reality she did not attend any groups as she '*struggled with mornings*' and did not do '*well*' on public transport.

After her son was born, Ashleigh was able to have skin to skin but '*struggled*' to attach him for feeds. Her son was diagnosed with a '*really bad*' tongue tie which made feeding '*difficult,*' until it was cut two weeks later. Although Ashleigh believed she'd had '*some good information*' about breastfeeding, she felt the midwives in hospital had '*different opinions and beliefs*' and recalled two '*bad experiences*' when a midwife in hospital and on day 3 at home, had '*upset*' her. However, she appreciated the '*kind and patient breastfeeding specialist*'³⁷ who had '*non-judgmentally watched*' her feeding in hospital and '*encouraged*' her '*to carry on*' and enabled her to believe she could '*do it.*'

³⁷ It is possible that the breastfeeding specialist Ashleigh refers to here is the hospital infant feeding lead. However, I did not clarify this with Ashleigh.

Initially, she saw her health visitor *'more often'* due to her mental health. After six weeks of exclusive breastfeeding, Ashleigh was not sleeping at night and was struggling with the *'demand'* of breastfeeding. She decided to introduce formula for her *'mental health'*. She felt exclusive breastfeeding was *'starting to affect her bond'* and she wanted to have the occasional *'night off feeding.'* The FAB team offered to visit her, but as they had previously referred to formula as *'nasty'* she didn't want *'that pressure'*. Unfortunately, her baby had an allergic reaction to the formula and was diagnosed with a milk allergy. She found her health visitor to be *'supportive'* when she explored her reasons for introducing formula. Although her health visitor did not discuss sterilising or making up bottles, Ashleigh felt *'relieved'* that she had discussed how much milk to give as she had *'panicked'* she was giving too much.

After her 6–8-week check, a *'lot of services'* (Perinatal Mental Health and Family, Children and Wellbeing) discharged her. Ashleigh found it *'concerning'* that *'no-one'* had checked up on her. At 4.5 months Ashleigh's son was mainly formula fed but she still offered the breast. His tongue tie had required cutting again as it had healed and was restricting his feeding. Due to her son's milk allergy, she wanted to wait until she saw a nutritionist to introduce him to solid foods. However, she was unable to attend the appointment because of her anxiety. She struggled *'online'* and felt *'anxious'* about attending a group *'with ten other families.'* She did not have a discussion with any health professional about introducing her baby to solid foods which she described as *'frustrating.'* As a result, she looked online for information and advice but found it *'very generic.'* During her last interview, Ashleigh reflected on how she

had '*really struggled*' with her mental health postnatally. Whilst she admitted to '*feeling better,*' she wished that she had received more information about introducing her baby to solid foods and for services to consider what she wanted.

Table 18: Key findings for ‘An insurmountable level of challenge’

System Level	Key Factor	Example (s) Illustrating Key Factor
Individual Level	Challenging personal situations.	Michelle – self-employed with restricted maternity leave meant she had no time to express. Ashleigh – poor mental health (anxiety)
Individual Level	Inability to access information	Both women experienced difficulties reading written information. Ashleigh’s poor mental health prevented her from accessing on-line health services postnatally.
Dyadic Level	Infant feeding challenges	Michelle’s feeding challenges were not resolved in the immediate postnatal period. Ashleigh’s baby had both a tongue tie which affected feeding and a milk allergy.
Significant Other Level	Limited practical and social support	Michelle – lack of practical and social support (single parent and father terminally ill) Ashleigh – due to her poor mental health she found it difficult to leave the house to attend breastfeeding groups.
Significant Other Level	Others negative experiences	Michelle’s friends had not breastfed successfully. Ashleigh had been breastfed.
Organisational Level	Lack of continuity of care	Michelle had different midwives which prevented her from sharing information about her personal situation. Whilst Ashleigh had the same midwife antenatally, when information was not shared about her mental health between midwifery and health visiting her individual needs were not recognised postnatally.
Organisational Level	Ineffective care	For Michelle and Ashleigh hands on care reduced satisfaction with care and confidence in ability to breastfeed.
Organisational Level	Supportive health professional	Both Michelle and Ashleigh appreciated positive encouragement. Ashleigh appreciated being shown how to breastfeed in a non-judgmental way.
Organisational Level	Practical information that enabled effective breastfeeding	Practical information important to enable both women to achieve effective breastfeeding.
Organisational Level	Lack of responsive care	A lack of responsive care resulted in the introduction of formula (Michelle). A lack of responsive care reduced Ashleigh’s confidence about introducing solid foods.
Organisational Level	Lack of breastfeeding assessments	Unidentified breastfeeding challenges reduced Michelle’s ability to breastfeed long term.
Organisational Level	Insufficient information about formula feeding and introducing solid food.	Neither Michelle or Ashleigh received sufficient information about formula feeding and introducing solid foods.

Critical summary for 'An insurmountable level of challenge'

The findings suggest that inequities experienced by women of a lower socio-economic status influenced both capabilities to achieve infant feeding goals and contributed to negative infant feeding care experiences. Both Michelle and Ashleigh experienced difficulties accessing digital information antenatally. In addition, Michelle felt, her self-employed status, lack of practical and social resource as a single parent and having a father who was terminally ill made her pregnancy challenging. Furthermore, without continuity of midwife she felt unable to share this information, which appeared to prevent her midwife from understanding her individual situation. For Ashleigh, a trusting relationship with her midwife and positive vicarious experiences from her mother meant that she felt able to manage her mental health issues antenatally and obtain information about breastfeeding. However, her premature discharge from health services postnatally appeared to prevent health professionals from recognising a deterioration in her mental health and inability to access local breastfeeding groups and online health care services.

For both Michelle and Ashleigh, a combination of insufficient information and a lack of infant feeding help appeared to compound postnatal infant feeding challenges and undermine both their access to and use of future care provision. Due to a restricted maternity leave, Michelle appeared to internalise the blame and failure she felt when her milk supply reduced. However, practical information antenatally about how to breastfeed and responsive help postnatally to achieve effective attachment could have mitigated the challenges she faced. In the absence of information from health professionals about bottle feeding and introducing solid foods Michelle mistrusted

information and relied on contradictory advice from her friends and family. This resulted in her introducing solids for reasons not supported by available evidence. Ashleigh felt that positive encouragement and being shown how to breastfeed in a non-judgmental way postnatally increased her confidence in her ability to breastfeed. Whereas insensitive communication from midwives and the FAB team and a perceived lack of information and help to introduce her baby to solid food appeared to compound the effects of her early discharge from health services.

7.3 Meta-narrative: 'Too many missed opportunities to identify needs.'

This meta-narrative includes Irene's narrative 'It's been hard for me to understand that breastfeeding can be difficult,' Catherine's narrative 'I sorted it myself', Isabella's narrative 'I feel sad that breastfeeding didn't work out' and Charlotte's narrative 'It has been intense'. Whilst these women all planned to breastfeed antenatally, the data suggests 'too many missed opportunities to identify needs' prevented them from receiving the infant feeding care they needed to mitigate the infant feeding challenges they faced and to breastfeed for as long as they had wanted. Although these women were from a diverse sample (Irene and Catherine– low SES and Isabella and Charlotte high SES), findings suggest that health professionals missed opportunities to identify needs at the different levels of the SEM which influenced their infant feeding outcomes and experiences.

Irene's case-study (low-income):

'It's been hard for me to understand breastfeeding can be difficult'

Irene, aged 26 years and of White ethnicity, was married but had no '*family here*' as she was not originally from the UK. Although her mother '*couldn't*' breastfeed and everyone she knew had '*used formula*' she was adamant antenatally she was going to breastfeed for at least a year. Antenatally, Irene felt that there was a lot of support and information about breastfeeding. She saw the same midwife whom she felt knew her '*and her story.*' She did her own research online to enable her to ask questions during her appointments. Irene was surprised that she received '*so much information*' about breastfeeding from her health visitor which included '*amazing*' information about breastfeeding groups.

When Irene had her son, all the requests on her birth plan were '*fulfilled.*' She had immediate skin to skin and her midwife helped her son '*latch on the breast properly.*' Despite believing '*she had got it [breastfeeding],*' on day 3 she started to have sore nipples. After her midwife helped her to understand her nipple was '*not going deep enough*' into her son's mouth, and to put her hand '*around his shoulders*' breastfeeding was '*just fine.*' Irene gave her baby '*some formula*' when she was '*fed up*' with breastfeeding. Although she knew that her mum '*didn't really know*' [about breastfeeding], she was '*desperate for sleep*' and decided to listen to her mum's advice that '*a little bit of formula*' would '*help baby and I to sleep better.*' However, when her baby started '*sleeping really bad again,*' she realised what she had been told '*was not true.*' Therefore, she decided to '*go back to breastfeeding*' and attended her local breastfeeding group to see a lactation consultant. However, as the group was '*just a group of mums breastfeeding*' she felt unable to access the

lactation advice she felt she needed. She felt *'disappointed,'* as she had *'expected more from the NHS'* particularly as attending the group was *'very hard'* as she did not drive. Irene stopped breastfeeding when her son was 17 weeks old. She felt sad and blamed her lack of *'a strong support system, people around her who understood breastfeeding'* and the NHS for not telling her everything she needed to know about *'breastfeeding and sleeping.'*

During her final interview, Irene reflected on how her satisfaction with the care she had received had changed. With hindsight, she felt that midwives *'weren't informative about breastfeeding'* and only gave information *'on the benefits.'* She wished that she had been told antenatally that breastfeeding *'could be difficult at times'* and that introducing formula would *'kill her milk supply'*. She had not seen her health visitor since her 6-8 week visit and missed someone *'checking up'*. She knew she could call a helpline but felt *'they don't know you or your routine'*. She did not feel she could ask for help from her health visitor as she could not *'express'* herself *'that well.'* With a lack of information about starting on solid foods, she felt she needed a professional to *'tell'* her whether her son was ready. Although she felt sad and disappointed that she had stopped breastfeeding, she felt she would know what to do next time and would be aware of the *'obstacles you go through.'*

Catherine's case-study (low income): 'I sorted it myself'

Catherine, aged 35 years of White ethnicity, lived with her partner. Initially, she was *'happy'* that she had not discussed anything about *'baby care or feeding'* with her midwife. She felt *'relaxed about things'* and *'didn't really have any questions.'*

However, with hindsight as she had '*different midwives*' and did not discuss anything '*further than the birth,*' she acknowledged that she did not get '*the depth of information*' she expected and had '*relied*' on her '*knowledge*' of '*rearing animals*' and her sister who had '*two children.*' Catherine '*didn't like*' reading information on her Badger app due to her '*small mobile screen*' and '*struggled*' to watch the videos that were linked in the app due to her '*Wi-Fi connection*': she wished she had been provided with '*paper leaflets*' instead. Whilst she did manage to do the online antenatal course on the Badger app, this only provided her with '*information*' about '*antenatal colostrum collection.*'

Catherine described her postnatal journey as '*rocky.*' Her daughter was born via an emergency c-section, under general anaesthetic with an '*unusual tongue tie*' and struggled to latch on the breast. Although, she felt that the midwives were '*really good*' at '*guiding her through what was best*' for her situation³⁸ she felt she relied on her prior experience of rearing and feeding animals. Catherine was determined to breastfeed and expressed '*multiple times a day*' to maintain her milk supply. However, when the FAB team were unable to visit after her daughter's tongue tie was fixed, a lack of help when she '*really needed*' it, led her to feel '*let down.*' She was adamant that she would '*express as much*' as she could but with her daughter struggling with '*reflux and wind,*' breastfeeding was becoming a '*hassle.*' Although she '*figured out*' about '*winding and acid reflux,*' after a viral illness her '*milk production dropped*' and she decided not to '*get it back up.*' She '*hadn't had any time off*' since having her daughter and knew she would only be able to express for a

³⁸ Catherine's baby struggled to attach to the breast after birth due to a tongue-tie. Due to this, she expressed, and bottle fed her baby from birth (breastmilk and commercial formula milk).

few months due to work commitments. However, she was happy to go with what her *'body was telling'* her.

Despite not receiving *'sufficient'* support initially, Catherine found her health visitor *'really supportive.'* Catherine believed she *'understood'* her situation and did not *'question or judge.'* However, Catherine did not see a health visitor antenatally and wished she had known they *'could help with breastfeeding.'* Catherine particularly liked that when discussing *'how to go about'* introducing solid food, her health visitor had provided her with *'some leaflets'* and had documented their discussion *'in the red book.'* She felt reassured that she had *'her direct line'* and felt able to *'give her a call'* if she had *'any worries.'* During her final interview, Catherine reflected on how she had *'relied'* on her sister for information in the absence of information and support from health professionals, particularly in the beginning. However, she felt *'lucky'* that she had *'prior experience'* of [lactation from rearing animals] as she would have *'struggled a lot more'* without this.

Isabella's case-study (high income): 'I feel sad that breastfeeding didn't work out'

Isabella aged 30 years of White ethnicity was married. Although she looked forward to her midwifery appointments, they were not *'what she expected.'* She believed *'every contact'* with her midwife was important to discuss how she *'planned to feed her baby.'* However, as her antenatal appointments were *'clinical and short,'* she did not have the conversations about breastfeeding that she had hoped for. Despite having an antenatal visit from her health visitor, Isabella felt she just *'talked about safe sleep a lot.'* She felt lucky that her mother-in-law was a midwife and reflected

on how she would have been '*more lost and overwhelmed*' without her. She also felt '*glad*' that she had paid to attend an in-person antenatal course as this '*trumped*' the online course on her app.

Isabella had her daughter by planned C-section. Although she spent 24 hours on the postnatal ward, the ward was '*busy*', and she did not get the '*additional support*' she needed to '*teach*' her '*about attachment*'. Isabella described her initial postnatal experience as '*really stressful*,' believing this was due to her '*situation*' (feeding challenges) rather than '*the care and support*' she received. However, she had a '*really bad experience*' when she had an '*issue*' latching her daughter on and a midwifery support worker dismissed her requests for help. An experience she described as '*disappointing*.' When her daughter failed to gain weight, she felt she '*had*' to introduce formula. It was only when her mother-in-law made a referral to the tongue tie clinic that her daughter was diagnosed with a '*posterior tongue tie*.' Initially breastfeeding improved when her daughter's tongue tie was '*done*' at four weeks of age, but her daughter continued to be unsettled after feeds due to reflux.

Despite introducing formula, Isabella's baby continued to lose weight. As Isabella wanted '*consistency*,' she asked her mother-in-law to take over her care. She felt she could not talk to her health visitor due to feeling she was '*being assessed*.' She also did not see the FAB team until her daughter was nearly five weeks old, due to having three appointments cancelled. However, with hindsight, Isabella believed the FAB team were not '*qualified enough*' to address her daughter's '*more complex*' needs.

During an admission to hospital at five weeks postnatal Isabella's daughter was diagnosed with a cow's milk allergy, prescribed a '*special formula*' and referred to the infant feeding team. Isabella believed that the infant feeding team's '*knowledge*' and '*wealth of experience*' enabled her to continue to give breastmilk to her daughter until she was around three months old, despite feeling '*pressure*' as her daughter was vomiting so much after feeds and believing she '*couldn't do it anymore.*' With a lack of information '*from anyone*' about introducing solid foods, she introduced solid foods when her daughter was four months old. Although she had read that introducing solids early when a baby has reflux could '*sometimes help,*' her daughter was '*not ready.*' As there were no '*classes for weaning,*' she did '*her own research*' and spoke to friends who were doing it. Despite there being '*a lot of conflicting advice*' she did not want to contact her health visitor as she believed that she '*didn't have a clue*' about what she had been '*going through*' and would say, '*she's not six months yet.*'

When reflecting on her experience, Isabella admitted that '*part*' of her had not '*enjoyed feeding*' as it had '*been so stressful*' and felt '*sad*' that breastfeeding had not worked out how she had '*wanted it to.*' Although Isabella felt she received '*a lot of support*' to breastfeed, without her mother-in-law she '*probably wouldn't have got anywhere.*' She referred to friends who had started breastfeeding but had stopped after a week or two because '*the support is not always there.*' She believed that she had not been '*prepared*' antenatally for breastfeeding and felt that if she had been in '*contact*' with the infant feeding team sooner she would '*probably still be breastfeeding.*'

Charlotte's case-study (high income): 'It has been intense'

Charlotte, aged 30 years and of White ethnicity, was married in a same-sex relationship. She had '*made up her mind*' antenatally that she '*wanted to breastfeed.*' She felt prepared to harvest her colostrum as a student midwife had explained this [colostrum harvesting]³⁹ '*quite well*'. Although she found the information that had been added to her BadgerNet Maternity app (see section 5.3) '*helpful*', working full-time made it [reading information on the app] difficult to '*keep up*'. She had seen her health visitor antenatally, but discussions had focused on '*what to do if you can't stop your baby from crying*'. Charlotte spoke of feeling '*anxious*' about breastfeeding and worried she had put too much pressure on herself. She also worried about her wife '*not being involved*'. Despite other '*people's stories*' which made her worry about being '*able*' to breastfeed, she was able to do her own research to '*settle her mind*' and planned to '*take things step by step*'.

Although Charlotte had a difficult birth due to a forceps delivery and found it difficult to attach her son for his first feed, she felt '*supported*' by a midwife watching her feed and helping her identify '*what to look for going forward.*' However once on the postnatal ward, Charlotte spoke of feeling '*overwhelmed.*' She felt unable to '*ask for help*' [to breastfeed] as she did not find her midwife '*approachable.*' In addition, she wished her concerns about giving a syringe of colostrum had been considered and she had not been left to '*wing it.*'

³⁹ Colostrum harvesting refers to the antenatal expressing and storing of colostrum

Charlotte found breastfeeding '*intense*' on discharge from hospital and struggled to breastfeed due to sore nipples and the frequency of feeding. Although the FAB team reassured her that frequent feeding was '*normal*,' Charlotte felt she '*couldn't do it*' and started to express and give her son breastmilk in a bottle. In addition, Charlotte worried about breast milk insufficiency and wanted to help her son sleep '*a bit longer*' at night. However, she felt happy with her decision to combi-feed explaining that as '*both of us*' can feed '*it's not as intense*.' She believed she had been supported to do what was '*right*' for her and her wife. With hindsight, Charlotte felt that she may have tried to '*persevere*' with breastfeeding rather than expressing if she had known '*it would be intense at the beginning*.' Although the health visitor gave her information about '*positioning for formula feeding*,' with a lack of information about sterilizing or making up formula she again felt she had to '*wing it*.' While the health visitor had '*pushed*' current guidance about introducing solid foods at six months, Charlotte introduced baby rice and baby porridge at three months to help her son sleep '*a bit longer*,' although the food was '*everywhere*'⁴⁰. She wished she had been given information about introducing solid foods which was relevant '*what else can I do if he's hungry*.'

⁴⁰ Indicating that he was not developmentally ready for solid food.

Table 19: Key findings for ‘Too many missed opportunities to identify needs’.

System Levels	Key Factor	Example (s) illustrating key factor
Individual Level	Ability to access information and infant feeding care.	Isabella could pay to attend in-person antenatal classes. Irene was unable to drive, which made it difficult to access breastfeeding groups. Catherine had limited material resources which made it difficult to access digital information.
Individual Level	Having the time	For Charlotte working full time meant that she had limited time to access information antenatally. For Catherine online antenatal classes fit around her work. Catherine’s self-employed status meant she had limited maternity leave and would only be able to express her breastmilk for a few months.
Individual Level	Understanding /experience/knowledge	Catherine’s experience of rearing animals increased her understanding of lactation.
Dyadic Level	Impact of birth and baby issues on breastfeeding	Both Catherine and Charlotte had difficult births and struggled to attach their babies for their first feed (Catherine - emergency c-section under anaesthetic and her baby had a tongue tie. Charlotte had a forceps delivery).
Dyadic Level	Missed opportunities to identify infant feeding challenges	Isabella’s baby had a tongue tie which resulted in a low milk supply. Irene introduced commercial formula milk due to concerns about her baby’s sleep. Charlotte’s baby had an undiagnosed feeding challenge.
Significant Other Level	Negative vicarious experiences	Isabella’s friends had negative breastfeeding experiences. Irene’s mother had been unable to breastfeed, and she did not know anyone who had breastfed.

Significant Other Level	Significant others provided support	Charlotte's wife was supportive of breastfeeding. Catherine received support from her sister. Isabella received help and information from her midwife mother-in-law.
Organisational Level	Missed opportunities to provide responsive care	Isabella did not receive the help she needed in the immediate postnatal period to breastfeed. There was a delay in identifying Isabella's baby's tongue tie. Isabella was referred to the specialist service too late to continue breastfeeding. Charlotte did not receive the support she needed to give a syringe of colostrum to her baby. For Charlotte, a lack of information about newborn feeding meant she felt her breastmilk was not sufficient for her baby's needs.
Organisational Level	Supportive health professional	Catherine felt her HV understood her situation. Catherine felt confident about introducing solid foods due to the conversations she had with her health visitor.
Organisational Level.	Support to mix feed	Health professionals supported Charlotte to mix feed. Catherine received support in hospital to express and give formula top ups.
Organisational Level	Missed opportunities to develop relationships with health professional.	Isabella felt unsupported antenatally due to seeing different midwives. Whilst Irene had continuity of midwife antenatally and trusted the information she had been given, postnatally she realised her midwife had not provided her with relevant information.

Organisational Level	Missed opportunities to provide adequate, timely information about introducing solid foods.	Neither Isabella nor Irene was provided with the information they wanted about introducing solid foods. A lack of information about introducing solid food resulted in Charlotte introducing solids at three months.
Organisational Level	Inadequate information about mixed feeding.	Irene did not receive the information she needed about mixed feeding.

Critical summary for 'Too many missed opportunities to identify needs'.

Irrespective of these women's socio-economic status, the findings suggest that when health professionals did not identify individual needs the potential for negative infant feeding experiences and not achieving infant feeding goals increased.

The findings indicate that when health professionals did not use opportunities antenatally to discuss infant feeding realities and personalise information, women appeared unable to develop realistic expectations of newborn behaviour and explore negative vicarious experiences. Whereas Irene believed that continuity of carer antenatally had enabled her midwife to provide information which met her needs, her midwife did not identify her self-professed lack of exposure to breastfeeding. Since health professionals did not appear to provide Charlotte with information about the realities of breastfeeding this left her with unrealistic expectations of the reality of life with a baby. For Isabella, a lack of discussion about breastfeeding meant that she did not obtain realistic information or reconsider misconceptions that she had heard within her friends' experiences. Whilst Catherine received informational support from

her sister and had relevant experience from rearing animals, this only partially compensated for a lack of information from health professionals about breastfeeding.

Although these women possessed the motivation to proactively obtain information, they appeared to differ in their ability to access the information they needed. Despite Isabella and Charlotte (higher socioeconomic status) possessing the financial resource to pay to attend private antenatal classes, a lack of relevant information from their health professionals appeared to have wider negative repercussions which included an inability to develop trusting relationships. For both Irene and Catherine (of lower socioeconomic status) difficulties such as an inability to drive to breastfeeding groups and limited material resource to access digital information appeared to compound a lack of helpful information from health professionals.

Health professionals appeared to miss opportunities to provide responsive and appropriate infant feeding care at specific junctures during these women's infant feeding journeys which prevented them from being able to breastfeed for as long as they had wanted to. For Charlotte both the midwives in hospital and the FAB team failed to identify the reasons for her baby's feeding challenges. Whilst Irene felt confident in her midwife's ability to prepare her for breastfeeding antenatally, this confidence was eroded postnatally when she felt her midwife had not provided her with information about the impact introducing formula milk could have on her milk supply. Despite Isabella's midwife mother-in-law filling a gap left by health services, health professionals appeared to fail to identify her infant feeding challenges in the early days which resulted in a delay to her receiving the timely and skilled help she

needed. Although midwives identified Catherine's baby's tongue tie and supported her to maximise her breastmilk in the immediate postnatal period, she felt that a lack of infant feeding help after her baby's tongue tie division prevented her from returning to full breastfeeding as she had planned.

Whilst health visitors supported Catherine and Charlotte's decision making about combination feeding, they both felt they had received insufficient information to commercially formula feed responsively and as safely as possible. Only Catherine appeared satisfied with the information and care she received in the later postnatal period about introducing solid foods. For Charlotte it was the lack of personalised information which resulted in the introduction of solid foods earlier than recommended. Despite Isabella receiving appropriate support from the infant feeding team, her health visitor did not provide her with information she felt she needed about introducing solid foods which appeared to further reduce her confidence. For Irene, a lack of information about her baby's readiness for solid food prevented her from being able to identify whether her baby was developmentally ready.

7.4 Meta-narrative: 'Having the resources that matter.'

This meta-narrative identifies Louise's (of higher socio-economic status) narrative 'I have been lucky', which identifies the personal resources which appeared to help her achieve her infant feeding goals, despite a perceived lack of infant feeding information both antenatally and after six weeks postnatal relevant to her needs.

Louise's case-study (high income): 'I have been lucky'

Louise, aged 35 years, of White ethnicity, was married. Antenatally, she believed she would '*attempt*' breastfeeding but did not want to put '*pressure*' on herself. She felt '*lonely*' during her pregnancy, due to a perceived lack of professional support and '*overwhelming*' information on her BadgerNet app. As her midwife was '*too busy and distracted*', she did not get an answer to her question about the routine suggested in the book she was reading. A situation she described as '*frustrating*'. She wanted to confirm information she had obtained through her '*own research*' with the professional '*who knows what they are talking about*'. However, with a lack of practical information '*from the midwives*' she attended private antenatal classes.

Louise felt the care she received in hospital after giving birth to her son was '*amazing*' and her extended hospital stay '*cemented*' her ability to breastfeed. She was '*keen*' to breastfeed her son straight away, after her assisted delivery and was supported to feed him '*the first colostrum*.' The reassurance, suggestions '*of things to try*' and confirmation that breastfeeding '*looked correct*' increased her confidence. Although she felt lucky that breastfeeding had come '*easy and naturally*,' she worried, as other mothers in her bay were either bottle feeding or struggling to breastfeed, '*that it had come too easy*.'

After being discharged from hospital, Louise valued the reassurance she received from the midwives. She appreciated the '*reminder*' of the acronym '*CHIN*'⁴¹ as this '*checklist*' helped her get her son in '*the right position*' for breastfeeding. Confirming her son was having '*good nappies*' and was '*putting weight on*' helped her to know that breastfeeding was '*going well*'. Louise also appreciated the '*tips and tricks*' she received from her family, especially her mother and mother-in-law who had both breastfed.

Louise was '*surprised*' when her health visitor, at 6 weeks, advised this would be the last visit until her son was nine months old. Although she felt able to contact her to '*double check anything*', she did not '*feel prepared*' for the '*new information*' about introducing solid foods she received. Louise was considering introducing formula milk but spoke of her uncertainty as she had eczema when she was a child.

Although her health visitor reassured her that her son's skin '*had been alright*', she was not surprised when she did not get the information she needed, blaming herself for asking a '*difficult question*'.

Louise introduced her son '*by the book*' to solids at five and a half months, despite her family encouraging her to '*get him on solids*' sooner. Although she breastfed exclusively, she admitted if she had struggled, she would not have '*known what to do*'. When reflecting on her '*journey*', Louise allowed herself to realise how important

⁴¹ The *CHIN* (*Close, head free, in line, nose free*) acronym is used to help staff to support mothers to effectively position their baby for breastfeeding.

breastfeeding was to her. She felt if she had other children, she would have the 'confidence' to do 'anything' to ensure she could breastfeed again.

Table 20: Key findings for 'Having the resources that matter'.

System Levels	Key Factors	Example (s) illustrating key factor
Individual Level	Confidence	Louise proactively looked for information and had the confidence necessary to ask questions.
Individual Level	Having the necessary resources to access information	For Louise the ability to pay enabled her to attend in-person antenatal classes.
Dyadic Level	Normal birth and being able to breastfeed	Louise had a normal birth and no breastfeeding challenges in the immediate postnatal period.
Significant Other Level	Significant others provided support.	Louise received breastfeeding tips and tricks from family.
Significant Other Level	Others positive vicarious experiences	Positive breastfeeding experiences positively influenced Louise's perceptions of breastfeeding.
Organisational Level	Support to Breastfeed	Health professionals confirmed for Louise breastfeeding looked correct, reminded of different breastfeeding positions, observed feeds, used the CHIN acronym, checked re: number of wet and dirty nappies.
Organisational Level	Lack of responsive care	Lack of antenatal information Lack of timely information about introducing solid foods.

Critical summary for 'Having the resources that matter.'

This meta-narrative illustrates how Louise (of higher socio-economic status) used her personal and material resources to both achieve her infant feeding goals and counterbalance a lack of infant feeding information.

Despite Louise's confidence, ability to ask questions and proactively look for information and pay to attend in-person antenatal classes, Louise would have welcomed opportunities antenatally to discuss feeding and relationship building with her midwife.

Louise had a straightforward birth and after having her baby, was supported by midwives to get breastfeeding off to a good start. Louise felt that the support and information she received from her midwives and health visitors was sufficient to reassure her that her baby was feeding effectively. Additionally, Louise received a combination of practical and informational support from her family which encouraged her to breastfeed. Although Louise did not experience any breastfeeding challenges, she was not aware of any additional support available for breastfeeding in her local area. It is therefore possible that Louise would not have been able to achieve her breastfeeding goals if she had experienced any difficulties.

Despite a lack of timely information about introducing solid foods and a lack of relevant information from her health visitor about breastfeeding and eczema, Louise's motivation to breastfeed as per current guidance enabled her to introduce

her son to solids around six months and ignore the contradictory advice she received from her family.

7.5 Meta-narrative: 'Tipping the balance to positive.'

This meta-narrative includes Anna's narrative 'I've had a lot of support' which appeared to underscore her positive perception of her experience of infant feeding.

This meta-narrative illustrates the importance of personalising infant feeding care for positive infant feeding outcomes and experiences.

Case-study for Anna (high income): 'I've had a lot of support from everyone':

Anna aged 32 years, of White ethnicity, lived with her partner. As Anna saw the same midwife antenatally, she had developed a '*good relationship*' with her and believed she knew '*some of her thoughts and feelings*.' She particularly liked the way her midwife recognised she was a first-time mum and '*drip-fed*' rather than '*bombarded*' her with information and included her partner in conversations. Even though she wanted her midwife to provide her with information, she did her '*own research*.' She felt this enabled her to have an '*informed opinion*' and provided time to think of questions. As her health visitor had put her '*at ease*' she was able to explore her concerns about breastfeeding. She wanted to '*try*' [to breastfeed] but was aware that '*a lot of*' her friends had '*given up quite quickly*.' However, she felt '*more confident*' to give breastfeeding '*a go*' when her health visitor told her there were '*people*' she could ask for support. Unfortunately, she was unable to attend a face-to-face antenatal class '*due to Covid*.' She also wished she could have attended a

breastfeeding group *'to hear from other breastfeeding mums about their experiences.'*

When Anna breastfed her daughter for the first time, she knew *'the signs to look for.'* She felt the support and *'necessary information'* she had received enabled her to *'properly latch'* her daughter on. She felt that midwives made sure she was *'happy with feeding'* before discharge, describing how *'there was no rush'* to leave the hospital. Anna particularly liked, as she was *'in a shared ward'*, that the midwives were *'saying the same stuff'* to the other women.

On day four, Anna found feeding painful after her milk *'came in.'* When she rang the FAB team for help with expressing, the lady she spoke to *'laughed'* at her and told her she was *'not to express until six weeks.'* As she felt *'told off,'* she refused a home visit: an experience she described as *'disappointing.'* However, her partner looked online for information and the midwife who visited on day five spoke about expressing including *'different ways of expressing and hand expressing'* which Anna found *'really good.'* Anna explained how she was provided with extra visits after this experience for her *'piece of mind.'*

Anna introduced solids to her daughter when she was 5.5 months old. She continued to breastfeed and express her milk so *'her partner could feed'* and for when they were outside the home environment. She felt *'lucky'* that she had been able to attend a webinar pre-recorded by the health visiting service about *'moving on to solids'*

before *'she had started to do anything.'* She found the webinar *'straight to the point'* and told her what she *'needed to know,'* without *'overloading'* her with information.

When reflecting on her care, Anna felt it would have been a struggle if she *'didn't have the midwives and health visitors.'* She felt lucky that she had received *'support with expressing as well as breastfeeding.'* Despite wanting to *'try'* breastfeeding antenatally, Anna was *'really pleased'* that she had breastfed for as long as she had, especially as her mum had advised her *'every day is beneficial.'* Overall, Anna felt the care she had received had been *'good.'* In the absence of information antenatally about what to expect she reminded herself of her work colleague's advice that *'the first six weeks are the hardest the whole way through.'* However, Anna would have liked to have had guidance about expressing and what to expect antenatally as this would have helped her feel *'more prepared and more normal.'*

Table 21: Key findings for 'Tipping the balance to positive'.

System Levels	Key Factors	Example (s) illustrating key factor
Individual Level	Confidence	Anna could find and process information confidently.
Dyadic Level	Normal birth and feeding difficulties resolved quickly.	Anna's initial feeding difficulties were resolved quickly.
Significant Other Level	Sufficient practical, emotional and informational support	Anna's partner provided practical help. Family and work colleague provided emotional and informational support.
Significant Other Level	Positive vicarious experiences	Family shared positive breastfeeding experiences.
Organisational Level	Personalised care	The midwife involved Anna's partner in conversations. Anna felt her midwife understood her thoughts, feelings, and views.
Organisational Level	Providing practical information that enabled effective breastfeeding	Anna was taught how to feed and attach her baby. Anna used the leaflets she had been given antenatally to reinforce information. Information provided antenatally enabled identification of feeding cues.
Organisational Level	Timely information and infant feeding help	Midwife drip fed information antenatally. Anna provided help to overcome initial infant feeding challenges. Anna attended a pre-recorded weaning session which did not overload her with information.

Organisational Level	Supportive health professionals	<p>Health professionals explored Anna's concerns about breastfeeding and reassured her about the help available postnatally for breastfeeding. Postnatally Health professionals checked and confirmed breastfeeding was going well.</p> <p>Anna felt she had a good relationship with both her midwife and health visitor. Health professionals checked postnatally that everything was going okay.</p>
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Critical summary for 'Tipping the balance to positive.'

This meta-narrative indicates the importance of health professional support for positive infant feeding experiences and outcomes. The findings suggest that Anna's ability to achieve her infant feeding goals resulted from a combination of factors. First, Anna appeared confident and to have the ability to obtain and understand information. Second, she received practical support from her partner. Third, her mother's and work colleague's beliefs about breastfeeding appeared to not only influence how she responded when she found breastfeeding challenging but counteracted the potential influence of the negative infant feeding experiences of friends. Finally, she felt she received information and infant feeding help from her midwife and health visitor which was supportive and personalised to her individual needs.

In a similar way to the other women in this study, Anna wanted sufficient information to prepare her for breastfeeding and to introduce her baby to solid foods. Despite Anna having midwifery continuity of carer antenatally, it was not until she faced challenges postnatally that she realised her antenatal conversations had not been as helpful as she had initially perceived. However, Anna appeared to receive the care she needed in the immediate postnatal period to help her learn to breastfeed. Despite a negative experience with the FAB team, findings suggest that responsive help from her midwives and health visitor, and support from her partner counteracted this negative experience and enabled her to make informed choices about expressing. The session recorded by the health visiting service appeared to emphasise key messages about introducing her baby to solid food and provided her with what she considered to be an appropriate amount of relevant information. It was

this information which appeared to enable Anna to introduce solids to her baby confidently and in line with current guidelines.

7.6 Conclusion

The meta-narratives presented in this chapter have illustrated how organisational factors interact with the other level factors in women's lives to influence their infant feeding experiences and outcomes. The meta-narratives illustrate how supportive health professionals who personalise infant feeding care according to the woman's individual circumstances and needs can positively influence infant feeding experiences and outcomes. In the next chapter, the meta-narratives are considered in relation to the revised BFI standards to answer my research question.

Chapter 8 - Considering the meta-narratives in relation to the revised BFI standards.

8.1 Introduction

The previous chapter presented four meta-narratives which showed how factors at the different levels of the SEM interacted to influence the women experiences and outcomes both positively and negatively. In this chapter, the meta-narratives are considered in relation to the revised BFI standards to achieve my research objectives:

To explore how professionals trained in implementing the BFI revised standards have influenced women's experiences and perceptions of infant feeding care during pregnancy up until introducing solid food (around six months postnatal).

To explore whether there are any variations in experiences amongst a diverse sample of women and what influences these.

I begin this chapter by presenting tables where I have drawn out evidence from the women's stories to suggest where their infant feeding care provides evidence of the BFI standards⁴². I then discuss how the infant feeding care health professionals provided appeared to influence the women's experiences and outcomes, highlighting

⁴² Although I did not ask the women any specific questions in relation to the BFI standards, I have done this to gain a deeper understanding of how professionals influenced the women's experiences and perceptions.

any variations in experience. A visual metaphor which was designed to represent my research findings is introduced at the end of the chapter.

8.2 Understanding where infant feeding care provides evidence of the BFI standards

The following tables suggest where the infant feeding care provided by the midwifery and health visiting services provide evidence of the revised BFI standards. Table 21 relates to the infant feeding care provided by midwives and Table 22 relates to the infant feeding care provided by health visitors. The table in appendix 18 provides the rationale for these decisions.

Table 22: Comparing women's stories to the BFI Maternity standards

Meta-narrative	Women	Standard 1 – Antenatal conversations. Services and information available		Standard 2 – Closeness and feeding after birth	Standard 3 -Breastfeeding off to a good start		Standard 4 - Informed decisions about other foods for babies		Standard 5 – Close and loving relationships	
		Antenatal conversations	Services and information	Skin to skin	Effective, timely care	Understanding responsive feeding	Support to formula feed	Support to maximise breastmilk	Recognising baby's needs	Enhancing mother-baby relationship
An insurmountable level of challenge	Michelle	No data	No data	√	No data	No data	No data	No data	No data	No data
	Ashleigh	In part	√	√	No data	No data	No data	No data	No data	√
Too many missed opportunities to identify needs	Irene	In part	√	√	√	No data	NA	No data	No data	√
	Isabella	No data	No data	√	No data	No data	No data	No data	No data	No data
	Catherine	No data	No data	NA	√	No data	√	√	No data	No data
	Charlotte	In part	No data	√	No data	No data	No data	√	No data	√
Having the resources that matter	Louise	No data	No data	√	√	No data	NA	NA	No data	No data
Tipping the balance to positive	Anna	√	√	√	√	√	NA	NA	√	No data

Table 23: Comparing women's stories to the BFI Health Visiting standards

Meta-narrative	Women	Standard 1 – Support for pregnant women		Standard 2 – Continued breastfeeding		Standard 3 – Informed decisions about other foods for babies		Standard 4 – Close and loving relationships	
		Antenatal conversations	Services and information	Support with problem solving	Support for ongoing breastfeeding	Supported to formula feed	Supported to introduce solid foods	Skin to skin	Supporting parents to be responsive
An insurmountable level of challenge	Michelle	No data	No data	No data	No data	No data	No data	No data	No data
	Ashleigh	√	No data	No data	No data	No data	No data	√	No data
Too many missed opportunities to identify needs	Irene	In part	√	No data	No data	No data	No data	√	No data
	Isabella	No data	No data	No data	In part	No data	No data	No data	No data
	Catherine	No data	No data	No data	No data	√	√	No data	No data
	Charlotte	In part	No data	No data	No data	No data	In part	In part	No data
Having the resources that matter	Louise	No data	No data	NA	√	NA	In part	√	No data
Tipping the balance to positive	Anna	√	√	√	√	NA	√	√	√

In the following section I consider how a diverse sample of women experienced infant feeding care from midwives and health visitors working in UNICEF UK BFI Gold accredited services, highlighting any variations in experience. I provide examples from the women's narratives to suggest how the implementation of the standards influenced their experiences and outcomes.

8.3 Antenatal care

Antenatal conversations

The antenatal care standard requires midwives and health visitors to have conversations with women and their families about feeding during pregnancy to meet their needs (UNICEF UK BFI, 2017a). However, when conversations focused on identifying whether the women wanted to breastfeed, there was no evidence to suggest that health professionals were able to provide relevant information or understand who the women had available to support them and how their experiences and attitudes would influence infant feeding decision making.

Providing relevant information

Most of the women, antenatally, felt that their health professionals did not explore what they already knew about breastfeeding and provided insufficient information about the practicalities of breastfeeding. Moreover, when women had discussions about breastfeeding these discussions focused on colostrum harvesting or the benefits of breastfeeding. As a result, health professionals appeared not to either provide or acknowledge relevant information. For example, health professionals did not identify Irene's lack of information about the realities of breastfeeding or acknowledge Catherine's relevant knowledge from rearing animals. Additionally, most of the women felt that the BadgerNet⁴³ app did not provide sufficient information about breastfeeding. Despite online antenatal sessions enabling women to access information at a time which was convenient for them, women felt that these sessions did not provide sufficient practical information to help them get breastfeeding off to a good start. Whilst Anna felt that written information provided by her midwife had helped her to learn how to breastfeed independently, with hindsight, she realised that a lack of information about feeding challenges in the postnatal period was unhelpful, supporting wider evidence of the rhetoric-reality gap.

Health professionals also appeared not to consider the women's individual circumstances and needs and tailor infant feeding information accordingly. For example, Michelle's midwife did not address her challenging individual circumstances which included a restricted maternity leave and how this would influence her ability to achieve her breastfeeding goals.

⁴³ In the study area midwives used the BadgerNet app antenatally to provide women with information, including leaflets. Please see section 5.3 for further information about the app.

Identifying the role of significant others

There was no evidence to suggest that health professionals provided the women with opportunities to either identify the support they had available to them and whether this was sufficient for breastfeeding continuation or understand how their significant others' experiences and attitudes would influence their infant feeding decision-making. For example, Michelle's midwife did not acknowledge her single parent status and a lack of practical and emotional resource. For Charlotte, health professionals did not identify ways that her wife could have supported breastfeeding. This is significant as it was her wife's support of breastfeeding which enabled her to feel confident in her decision to breastfeed their baby. Moreover, health professionals appeared not to identify Irene's mother's experiences of breastfeeding which would lead to the introduction of commercial milk formula.

Ability to access infant feeding information and local services.

For the antenatal care standard to be met, information provided antenatally should be helpful and enabling (UNICEF UK BFI, 2017a). However, for most of the women in this research, health professionals did not appear to consider whether the women could access infant feeding information which met their needs. All the women of lower socio-economic status identified difficulties accessing digital-based information, which included the written information on the BadgerNet app. For Catherine, her limited material resource made it difficult for her to access digital information on the app. Whereas, both Michelle and Ashleigh struggled to understand and retain written information on the app. These women expressed a preference for visual information, including videos that were realistic and relatable.

Moreover, women reported how they had wanted their midwife to give them more opportunities to discuss the information presented in the app.

For Irene conversations, which provided her with information about local postnatal support, did not appear to consider whether she could access this. Whilst women of a higher socio-economic status (Louise and Isabella), could pay to attend antenatal classes which facilitated access to in-person antenatal classes, these classes were not sufficient to create positive breastfeeding experiences.

Importance of continuity of carer antenatally

Some of the women described how continuity of midwife antenatally had enabled their thoughts and feelings to be considered. For Ashleigh (of lower socio-economic status) seeing the same midwife antenatally enabled her to explore her feelings about her mental health. This helped her to obtain the information she needed to support her decision making about breastfeeding and skin-to-skin contact. Anna (higher socio-economic status) perceived that continuity of midwife had helped her to develop a relationship with her midwife which had enabled her midwife to consider her thoughts and feelings. In contrast, some of the women recounted how a lack of continuity of carer had prevented them from developing relationships with their midwife antenatally or had eroded their trust in the information provided by their health visitor postnatally. This situation appeared to be magnified for Michelle (of lower socio-economic status) where a lack of continuity of midwife amplified her challenging individual situation. For example, when Michelle states that she stops telling her story and says she is 'fine' she is referring to how she decides to stop sharing information about her challenges with different midwives.

8.4 Close and loving relationships.

This standard relates to care provided by midwives and health visitors both antenatally and postnatally.

Skin to skin contact

All the women who participated in this study were given the opportunity to hold their baby in skin-to-skin contact as soon as possible after birth. Furthermore, most of the women discussed antenatal conversations during pregnancy which encouraged them to have skin-to-skin contact with their babies past the immediate postnatal period. For example, both Ashleigh and Charlotte articulated how information they had received about the benefits of skin-to-skin had facilitated ongoing skin-to-skin contact.

Feeding and responding to baby's needs

Whilst Anna discussed how information she had received from her midwife antenatally had helped her to understand her newborn baby's feeding cues which had facilitated her ability to breastfeed, there is no evidence to suggest that she had any conversations about relationship building. Moreover, most of the women in this study did not identify information they have received about ways to develop a close mother-baby relationship or feed responsively. Despite Louise instigating a conversation with her midwife about responsive parenting, she appeared not to have been provided with the opportunity to discuss how she would recognise and respond to her baby's needs.

Safe-sleep conversations.

Whilst receiving information about safe sleep has only recently become a required component of the standards (UNICEF UK BFI, 2024a) all women reported receiving information about how to keep their baby safe whilst asleep. However, several women commented that safe-sleep conversations were not helpful and closed the opportunity for further discussion. For example, for Isabella safe sleep conversations led to her feeling she was being assessed.

8.5 Mothers initiate feeding soon after birth and get breastfeeding off to a good start.

This standard relates to the care provided by midwives in the immediate postnatal period. Most of the women identified infant feeding care and information provided by their midwives in the immediate postnatal period which helped them initiate feeding soon after birth. However, only half of the women received the effective timely care they needed to get breastfeeding off to a good start.

Support to position and attach for breastfeeding.

When women received care from their midwives to get breastfeeding off to a good start, they received support to effectively position and attach their babies themselves. For Louise the use of the CHIN acronym (see section 7.4) along with a rationale she understood, boosted her confidence. For Anna, practical help provided on the postnatal ward helped her to learn how to breastfeed independently. Despite Anna reporting a disappointing experience with the FAB team, this was outweighed by the timely care she received from her midwives. In contrast, when there was no evidence to suggest that feeding challenges were identified or women received appropriate infant feeding help, women appeared not to receive care which met their needs. For example, neither Isabella nor Michelle appeared to have been supported to achieve effective feeding.

For mothers with complex breastfeeding challenges, the standards require health services to provide specialist support, with an appropriate referral pathway. Whilst

Isabella felt satisfied with the help, she received from the Infant Feeding Team; she received this help too late for breastfeeding continuation.

8.6 Enable mothers to continue breastfeeding for as long as they wish.

This standard relates to postnatal care provided by health visitors. Out of the eight women who participated in this study, only Louise and Anna exclusively breastfed for as long as they wished. However, four out of the eight women in this study appeared not to receive support they needed for breastfeeding continuation which resulted in guilt and disappointment. Moreover, there was no evidence to suggest that these women had the opportunity to discuss their options for continued breastfeeding according to their individual need. For women of a lower socio-economic status this meant that health professionals appeared not to help the women explore how their individual circumstances would influence their ability to breastfeed longer term.

Importance of responsive help.

Whilst Michelle internalised the failure she felt for not exclusively breastfeeding when she returned to work, responsive help could have enabled her to achieve effective breastfeeding. Additionally, for Catherine a lack of responsive help from the FAB team prevented her from returning to full breastfeeding.

Support for ongoing breastfeeding

Despite Irene receiving help from her midwife to achieve effective breastfeeding, she believed that her inability to access community breastfeeding support led to early breastfeeding cessation. Whilst Michelle and Catherine of lower socio-economic status knew that they would have restricted maternity leave, health professionals did not appear to explore their options for continued breastfeeding. Health professionals did not appear to recognise the severity of Ashleigh's mental health issues and identify the help she would need to breastfeed longer-term. However, it is unclear whether information about Ashleigh's individual circumstances was communicated to her health visitor.

Maximising breastmilk

All women felt that they were encouraged and supported to provide their babies with breastmilk and ensure their babies received the maximum amount of breastmilk possible. For example, Catherine was supported to express her breastmilk whilst waiting for her baby's tongue tie procedure.

8.7 Supporting informed decisions about other foods for babies.

This standard relates to the care provided by midwives and health visitors in relation to the introduction of commercial milk formula and for health visitors in relation to the introduction of solid foods.

Support to make informed decisions.

There was evidence to suggest that women felt supported to make informed decisions about the introduction of commercial milk formula. For example, Charlotte's health visitor appeared to understand the reasons she wanted to introduce commercial milk formula and supported her to continue to partially breastfeed. However, this contrasted with Irene's experience where health professionals appeared not to explore her reasons for introducing commercial milk formula which prevented her from understanding that mixed feeding would not help her baby sleep better.

Sufficient information to give commercial formula milk responsively and safely.

For this standard to be met, midwives and health visitors need to provide mothers with the information necessary to understand how to bottle feed their babies as safely as possible (UNICEF UK BFI, 2017a). However, most women in this study who introduced commercial milk formula perceived that health professionals had not provided them with sufficient information. For example, Michelle believed she had received a lack of practical information about how to feed her baby formula and only had conversations about feeding her baby upright. Despite Ashleigh's health visitor

providing her with information about the type of commercial milk formula she should use, there were no discussions about responsive bottle-feeding, sterilizing or how to make up feeds. As Michelle reported she did not have any conversations with her midwife or health visitor about introducing commercial milk formula, her health professionals were not able to provide her with the opportunity to discuss how to make up milk safely or provide her with information about the dangers of using a formula preparation machine⁴⁴.

⁴⁴ Concerns about using formula preparation machine are outlined in the report 'The bacterial contamination of powdered infant formula' published by First Steps Nutrition Trust in 2022.

8.8 Mothers supported to introduce solid foods.

This standard refers to the care provided by health visitors.

Receiving relevant information at a time which meets needs.

The BFI standard in relation to introducing solid foods requires mothers to receive relevant information about introducing their babies to solid foods at a time which meets their needs (UNICEF UK BFI, 2017a). There is evidence to suggest that the health visiting service provided Anna and Catherine with the timely and helpful information they needed to introduce solids as per current guidance. Moreover, the importance of keeping information simple helped Anna to obtain the relevant information she needed. The care Louise received in relation to introducing solid foods appeared to reflect this standard in part. Although health visitors provided her with the practical information she wanted, the timing of this information did not appear to meet her needs. Furthermore, some of the conversations health visitors had about introducing solid foods appeared not to be aligned with the women's needs. As Irene did not receive any support to introduce solid foods, she appeared to lack confidence about introducing solid foods and questioned whether her son was developmentally ready. For Ashleigh, an inability to access online support due to her mental health issues meant that she did not get the additional information she perceived she needed to introduce solid foods for her baby who had a milk allergy.

Additionally, when women were not provided with opportunities to discuss and understand the signs that would indicate readiness for solid foods this appeared to lead to uncertainty about current guidance and the introduction of solid food earlier

than recommended. For example, whilst Charlotte believed she had been given information about introducing solid foods, a lack of understanding about the signs that would indicate readiness for solid foods resulted in the introduction of solid foods earlier than recommended. Moreover, although women were able to find information on-line about introducing solid foods, they reported that information was either conflicting or too generic which increased their reliance on friends for information. For example, for Michelle, the contradictory advice she received from her friends and family led her to question whether the guidance she had received from her health visitor had been trustworthy and introduced solids for reasons not supported by available evidence. Additionally, Isabella, who was looking for specific information about introducing solids for her baby who had reflux, felt that on-line information was too generic.

8.9 Importance of BFI relational approach

All the women identified how the communication skills used by health professionals either facilitated or hindered their ability to breastfeed, thereby illustrating the importance of compassionate care for successful implementation of all the standards including the sustainability standard which relates to positive culture.

Importance of communication

Women identified the importance of health professionals using effective and sensitive communication skills when communicating infant feeding care messages.

All the participants perceived that health professionals who encouraged them increased their confidence and helped them to continue to breastfeed. Although Louise believed that luck had enabled her to achieve her breastfeeding goal, it could be suggested that it was the confirmation she received from health professionals that her latch and her baby's outputs were signs of positive breastfeeding which helped her to understand that her baby was feeding effectively. Despite several women identifying the value of health professionals observing a full feed, only Ashleigh described the impact of being observed feeding in a non-judgmental way.

Additionally, Ashleigh described how a relational approach helped her to feel comfortable and understand information even when she was sleep deprived. Conversely, insensitive communication had a negative impact on her mental health and how she perceived the infant feeding care she had received. Furthermore, although the FAB team had reassured her about her positioning for breastfeeding, when they were judgmental about commercial milk formula this prevented her from contacting the team for help when she was considering introducing commercial milk formula for fear of further judgment.

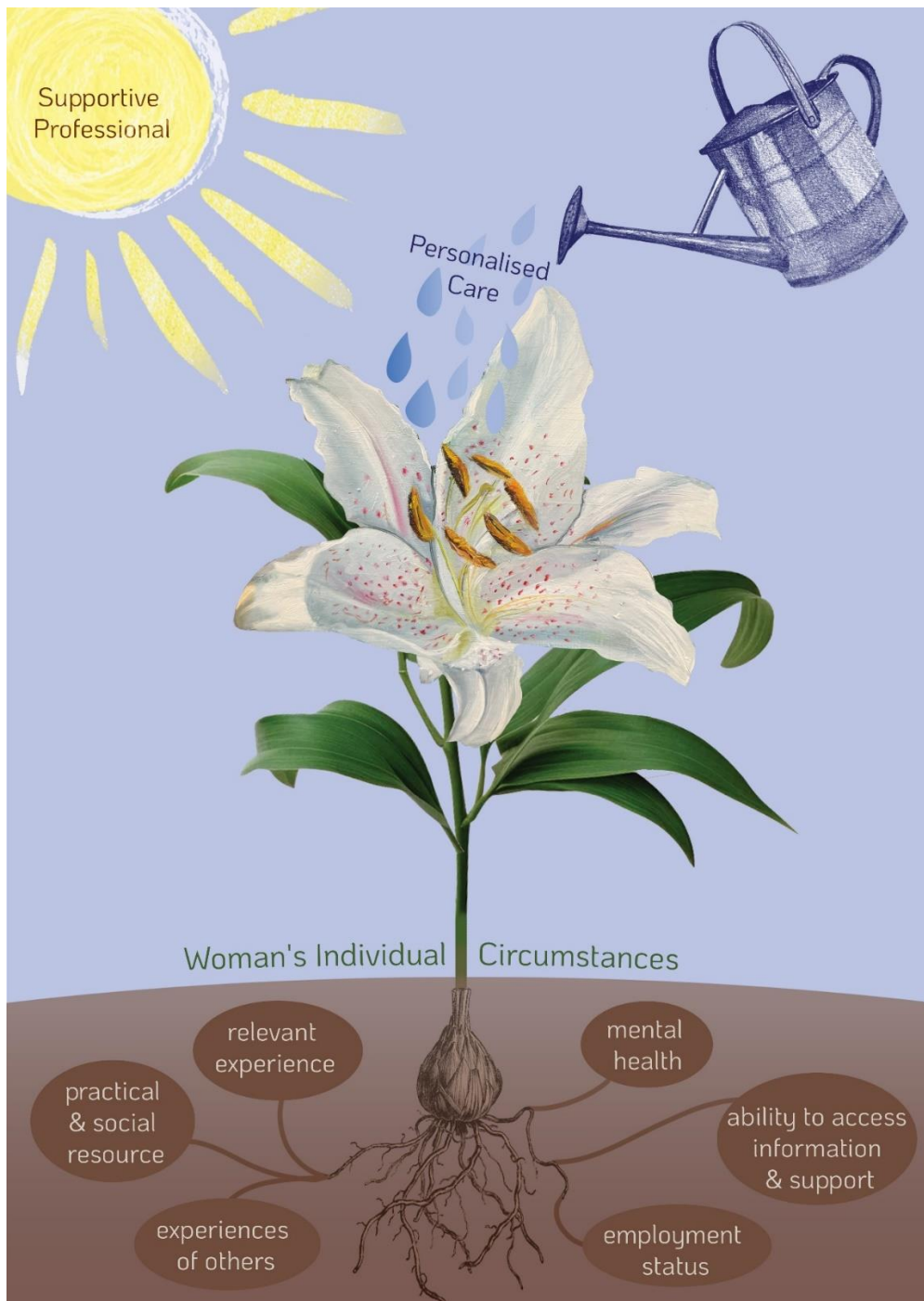
8.10 Visual metaphor of research findings

I developed the visual metaphor (Figure 8) to enable organisations and health professionals implementing the BFI standards to make sense of the research findings. It was whilst I was considering the meta-narratives in relation to the revised BFI standards that I decided that I wanted to emphasise the importance of health professionals facilitating supportive interactions underscored by an understanding of individual factors but also focuses on equity and the provision of personalised care to positively influence mother's experiences and infant feeding outcomes. The decision to use a plant metaphor was influenced by the BFI training slide which uses a flowering bush, watering can and pruning shears to illustrate the influence of oxytocin and cortisol on a baby's brain development. I felt that using a plant metaphor would provide conceptual clarity but also illustrate the connection between the various components which could be discussed and reinforced through BFI training. I involved the members of my advisory group and my public advisors when developing and revising this visual metaphor to ensure it both represented the research findings accurately, was easy to understand and would help health professionals implementing the standards with a meaningful framework to help women and their families achieve positive infant feeding experiences and outcomes.

In the metaphor, the plant represents the woman, the plant stem reflects her infant feeding journey and the flowers on the plant symbolise her infant feeding experiences and outcomes. When a plant is provided with the conditions it needs (sufficient sunlight and water) and the appropriate nutrients (in the soil) it will grow and produce flowers. In a similar way a woman requires the necessary internal and external resources (for example ability to access information and support, positive

mental well-being, practical and informational support), support from health professionals and personalised infant feeding care to achieve her infant feeding goals and have positive infant feeding experiences. The metaphor illustrates the different factors which health professionals implementing the BFI standards need to consider to enable positive infant feeding care. It also illustrates the importance of health professionals understanding how meaningful conversations during a woman's infant feeding journey are essential to identify whether a woman has the necessary resource (nutrients in the soil), or further support needs to be put in place to mitigate inequalities.

Figure 9: Visual metaphor of research findings



8.11 Conclusion

This chapter has identified how infant feeding care provided by health professionals (midwives and health visitors) trained in implementing the revised BFI standards influenced women's experiences and perceptions of infant feeding care throughout their infant feeding journey, highlighting any variations in experience due to socio-economic status. A visual metaphor has also been presented in this chapter to illustrate the different factors which health professionals implementing the BFI standards could consider enabling positive infant feeding care. The importance of personalisation is explored further in the next chapter, the discussion chapter, using the SEM and the visual metaphor, to suggest how health professionals can enable the provision of equitable infant feeding care.

Chapter 9: Discussion chapter

9.1 Introduction

In the previous chapter I considered my meta-narratives in relation to the UNICEF UK BFI standards to identify how the women experienced infant feeding care provided by UNICEF UK BFI Gold accredited maternity and health visiting services. In this chapter I first provide a summary of my findings. Second, I use a combination of the version of the SEM (used in chapters 6 and 7) and my visual metaphor to both contextualise my meta-narratives with wider theory and literature and consider how a focus on a woman's individual circumstances within the revised BFI standards could facilitate more equitable Baby Friendly care. Third, I discuss the implications of my research for further research, policy, and practice. Fourth, I identify the strengths and limitations of my research and consider the study's unique contribution to knowledge. Finally, I conclude my thesis with a conclusion and a reflection.

9.2 Summary of findings

This research employed narrative research methodology to understand how a diverse sample of women experience infant feeding care from UNICEF UK BFI Gold accredited maternity and community services. From the women's stories, four meta-narratives were identified: 'an insurmountable level of challenge;' 'too many missed opportunities to identify needs;' 'finding the resources that matter;' 'tipping the balance to positive,' illustrating a range of experiences and outcomes from negative to positive. Considering the findings in relation to the revised BFI standards emphasised three constructs (illustrated visually by Figure 7) which emphasise the importance of: the supportive health professional, personalised care, and an

understanding of the woman's individual circumstances to enable positive infant feeding care. Whilst all eight of the women in this study stated during pregnancy that they wanted to breastfeed, only two women of a higher socio-economic status breastfed for as long as they wanted and only one of these women had an overall positive care experience. Out of the remaining six women who did not meet their breastfeeding goals, four were of lower socio-economic status. All the participants from a lower socio-economic background reported less care relative to their needs and poorer experiences of BFI care. Therefore, from the stories of the women who participated in my research it could be concluded that the current delivery of Baby Friendly care does not go far enough to facilitate the supportive and personalised infant feeding care necessary to both consider what women need to achieve their infant feeding goals as well as acknowledge the equity issues they face. Whilst my meta-ethnography (see chapter 3) did not focus on women's experiences and perceptions of Baby Friendly care, the findings identify how women want health professionals to both prioritise connections and understand their individual context and circumstances to facilitate more personalised and equitable infant feeding care, therefore providing further support for the meta-narratives identified in my empirical research.

9.3 Discussing the meta-narratives in relation to wider evidence using the SEM.

I will now use the SEM (version used in chapters 6 and 7), and the constructs illustrated in my metaphor to discuss my meta-narratives in relation to current evidence about Baby Friendly practices and the wider health inequality literature.

Individual factors (factors 'hidden in the soil')

The meta-narratives identified several individual factors (self-agency, mental health, ability to access information and infant feeding care, income, employment status) which influenced both the women's experiences of BFI accredited care and their infant feeding outcomes. Whilst the revised BFI standards encourage health professionals to provide infant feeding information and help according to individual needs, health professionals often appeared to be unaware of the women's individual factors. This finding could suggest that the current conversations health professionals have with women throughout their infant feeding journeys are not sufficient to understand not only what women need to achieve their infant feeding goals but how to personalise care according to the equity issues they face. Therefore, within the visual metaphor these factors are shown as being hidden within the soil.

Self-agency

The meta-narratives provide an insight into how socio-economic status influences self-agency which has not previously been described. According to Ryan et al. (2017), who developed the construct of agency in relation to breastfeeding, agency is a woman's ability to make decisions in relation to breastfeeding and to work towards her breastfeeding goal. Whilst Thomson and Balaam (2024) suggest that women of a higher socio-economic status are more likely to experience self-agency, the meta-narratives challenge this notion and rather suggest that being a first-time mother was more likely to inhibit agency. Although individual factors, for example, ability to access information and help compounded the women's vulnerability, as highlighted by Heys et al. (2021), the meta-narratives also provide evidence to

suggest ways in which women of a lower socio-economic status were able to restore their sense of agency. This finding is important because when women were able to exercise their own agency this led to improved infant feeding experiences and outcomes. For example, for Michelle her ability to obtain information from social media compensated for inadequate infant feeding help to effectively breastfeed her baby. For Catherine, her prior knowledge of lactation compensated for a lack of information about breastfeeding from health professionals. These findings corroborate those of Ryan et al. (2017) who explored women's experiences of breastfeeding and their related information and support needs in the UK. Some women in this study felt that they had been the sole agent of their infant's feeding which enhanced their sense of agency. However, these findings are contrary to those of MacGregor and Hughes (2010) who described how mothers of a lower socio-economic status may require more, confidence building and reassurance to overcome any difficulties they may encounter.

Surprisingly, negative breastfeeding experiences did not influence how women felt about breastfeeding a future baby. The meta-narratives demonstrate how most of the women who discontinued breastfeeding before they wanted to, believed they would feed a future baby, a finding supported by Thomson et al. (2022). This finding is contrary to previous studies which have suggested that negative previous breastfeeding experience negatively influences future breastfeeding. Most of the women interviewed in a study by Palmér (2019) felt that previous experiences of breastfeeding difficulties resulted in doubt about whether to try to breastfeed again. Similarly, the systematic review by Huang et al. (2019) which explored how unsuccessful previous breastfeeding experience affects subsequent breastfeeding

outcomes found that previous short breastfeeding duration and negative previous breastfeeding experience negatively influenced future breastfeeding.

Maternal mental health and breastfeeding

Most of the women described 'the emotional rollercoaster' (Hinsliff-Smith et al., 2014) that has been associated with breastfeeding and discussed stress associated with being a first-time mother. The meta-narratives suggest that fatigue associated with a lack of sleep contributed to maternal stress, corroborating research by Fraser et al. (2019) and Prendergast and James (2016). This finding is important as stress has been confirmed in the literature as one of the most important psychological factors influencing breastfeeding duration (Hass et al., 2022; O'Brien et al., 2009).

The meta-narratives illustrate how positive attitudes towards breastfeeding and positive breastfeeding experiences motivated women of a lower socio-economic status to breastfeed. For example, Ashleigh identified how information about the benefits of breastfeeding for both mother and baby motivated her to breastfeed. Moreover, Ashleigh felt this information had increased her confidence and had a positive impact on her mental wellbeing. Similarly, Billings et al. (2024) in their systematic review of breastfeeding experiences of women with perinatal mental health problems highlighted how adequate breastfeeding education can positively impact breastfeeding choices. For Michelle (of lower socio-economic status) the enjoyment she felt when she breastfed created positive attitudes about breastfeeding. This finding is contrary to that of Cook et al. (2021) who found that white British mothers were not able to outline any benefits of breastfeeding for either

mother or baby. When women had positive attitudes towards breastfeeding this both influenced help-seeking behaviours and facilitated strategies to overcome ineffective support, findings also documented by Thomson et al. (2022). This result supports research by Cook et al. (2021) which explored the breastfeeding experiences of mothers living in a deprived and culturally diverse community and showed mothers who held positive attitudes about breastfeeding were more likely to breastfeed and possess the motivation to persevere with breastfeeding.

The meta-narratives provide additional evidence of the feelings of guilt, failure and sadness women experience when they stop breastfeeding before they want to, supporting the wider literature (Brown, 2019; Cook et al., 2021; Fahlquist, 2016). Although only Ashleigh, of lower socio-economic status, had a diagnosed mental health issue, her story highlights how anxiety and concerns about bonding difficulties may negatively affect self-efficacy and confidence, supporting research by Aksoy et al. (2022) and Entwistle et al. (2010). Additionally, the systematic review by Segura-Pérez et al. (2022) describes how poor maternal physical and mental health increases the incidence of self-reported insufficient milk supply which can lead to the discontinuation of breastfeeding. This finding therefore provides evidence to support the recommendation in the revised guidance for the standards (UNICEF UK BFI, 2024a) for staff to discuss the emotional impacts of feeding challenges on emotional well-being.

Ability to access infant feeding information and support.

As might be expected, women believed information provision should play a key role in their antenatal care and placed significant value on being provided with information which met their needs. Additionally, the meta-narratives identify how mothers wanted opportunities to go to classes or groups while they were pregnant. However, at the time of the study (see section 5.3), in-person antenatal classes were only available for those women who were able to pay to attend private classes. This finding therefore provides evidence to suggest that only those women of a higher socio-economic status who were able to pay were able to access antenatal education which they felt met their needs. However, as suggested by nurses in the study by Cunningham et al. (2018), which explored perceptions of implementing the 'Ten Steps', educated mothers may have received more information because they knew how to ask for it.

The meta-narratives provide evidence to suggest women of lower socio-economic status experienced inequities which included a lack of material resource to access antenatal information. Most striking was the substantial difficulty women of a lower socio-economic status experienced accessing local infant feeding services when they were unable to drive, further contributing to health inequalities. My meta-narratives build on the findings of other studies (Fair et al., 2024; Furman et al., 2023; Thomson et al., 2022) which identify how transportation problems can be a barrier to accessing support, illustrating an inequity in access to community support services. This is significant because evidence relating to the importance of community support underscores the BFI standards due to its role in the long-term sustainability of breastfeeding (Pérez -Escamilla et al., 2016). An implication of this is

that services should ensure breastfeeding groups are within 'pram pushing' distance (Garbers et al., 2006). Moreover, according to Hunt et al. (2021), health services need to ensure they consider the specific needs and circumstances of those who are socio-economically deprived to improve access.

The meta-narratives provide evidence to suggest that the standards do not encourage health professionals to consider equity and the way in which information should be communicated to meet individual needs and enable women to use information themselves. The integrative review by Gallagher and McKechnie (2024) suggest the existence of inequities in breastfeeding care and underscore the need to address and eliminate infant feeding inequalities. The meta-narratives provide evidence to suggest that health professionals should discuss breastfeeding with women rather than relying on leaflets, corroborating the results of research by Fraser et al. (2019), McFadden and Toole (2006) and Thomson and Dykes (2011). Research by Shortt et al. (2013) also found that low-income women can find leaflets about breastfeeding difficult to understand with women preferring practical information during pregnancy about breastfeeding to enable them to make an informed choice. Additionally, women of a lower socio-economic status required relatable information to increase understanding, with videos being identified as being particularly useful. Previous research by Metin and Baltaci (2024) provides evidence of the link between video-supported breastfeeding education and increased breastfeeding self-efficacy. Whilst Feinstein et al. (2021) argue that virtual feeding support can be beneficial for many mothers as telehealth services can be more convenient and Tomori et al. (2022) identify a growing body of evidence to suggest that digital interventions provide opportunities for improving breastfeeding outcomes,

the meta-narratives propose that on-line information, and help can be inaccessible for women of a lower socio-economic status therefore suggesting that digital interventions do not consider these women's needs. To be accessible, NICE guidance (2021) confirms the importance of tailoring the content and delivery of information to needs and preferences. Similarly, Neely and Reed (2023) suggest that to be equitable and accessible, care should be mother-centred. Furthermore, research by Page et al. (2021) suggests that the delivery of informational support is dependent on its delivery, thus providing further evidence for services implementing the standards to consider what women need to ensure information is accessible. As my meta-narratives illustrate that women require written information in a variety of formats, it could be suggested that the revised guidance to the standards (UNICEF UK BFI, 2024a) which state that information should be provided in a digital or written format does not go far enough to ensure women receive accessible information which they can understand and use. Furthermore, participants in the study by Fair et al. (2024) which considered stakeholders' views of the impact and implementation of the BFI felt antenatal education should be provided in a variety of formats due to women having different learning styles. However, the meta-narrative 'an insurmountable level of challenge' provides evidence to support Fraser et al. (2019) finding that social media can be helpful to help women make sense of their own situation. The meta-narratives also identify the importance of tailoring the timing and content of information. Whilst some mothers wished they had been provided with more information others commented on information overload reflecting the results of the study by Fraser et al. (2019).

My meta-narratives therefore provide evidence to suggest that an increased focus in the BFI standards on increasing health literacy could promote equity and reduce inequalities. This is in line with recommendations made in the Marmot Review (Marmot et al., 2020) which highlights how improving health literacy is likely to reduce health inequalities.

Employment status

The meta-narratives provide evidence to support the growing body of evidence which identifies the link between returning to work and early breastfeeding cessation and the specific barriers women in self-employment face in relation to the availability of paid maternity leave (Alianmoghaddam et al., 2018; Chang et al., 2021; Dagher et al., 2016; Scott et al., 2019, Tomori et al., 2022). Findings reported within the meta-narratives ('an insurmountable level of challenge' and 'too many missed opportunities to identify needs') identify how self-employed women from a lower socio-economic background, either must return to work earlier than they want due to a restricted maternity leave or find difficulty finding time to express breastmilk whilst working. Building on the work of Dozier et al. (2012) the meta-narratives identify how a restricted maternity leave and associated financial issues and stress affect breastfeeding. Furthermore, the recent survey by Maternity Action (2024) confirms an increasing number of women are returning to work earlier than they want due to the significant financial impact of maternity leave. The findings of this survey are consistent with the experiences of the two self-employed women in this study of lower socio-economic status who identified how their employment status had influenced their ability to achieve their breastfeeding goals.

While, Roll and Cheater (2016) in their systematic review of expectant parents' views of factors influencing infant feeding decisions in the antenatal period, found lifestyle factors which included women's considerations of future work positively influenced the decision to commercially formula feed, these women decided to breastfeed antenatally despite being aware that they would only have limited maternity leave and would need to express their breastmilk when returning to work. Although it is unclear whether their health professionals were aware of their limited maternity leave, this finding provides evidence to suggest health professionals provide relevant information antenatally about expressing and ways to continue to breastfeed when going back to work, in line with the BFI standard for continued breastfeeding (UNICEF UK BFI, 2017a). Additionally, the meta-narratives provide evidence to support the view that BFI staff training should be updated to ensure that staff understand the importance of tailoring information relating to the expression of breastmilk for women with limited maternity leave who may need to express their breastmilk before six weeks postnatal to continue to give breastmilk to their baby.

Moreover, Spaeth et al. (2018) undertook a cross-sectional study in Switzerland to explore whether BFH designation had a sustained impact on continued breastfeeding. Whilst this study concluded that BFH designation had a positive effect on continued breastfeeding, the effects were only evident in the short-term on exclusive breastfeeding due to maternal employment impacting women's ability to breastfeed. Their study suggested that whilst reinforcing the accreditation of hospitals as Baby Friendly and ensuring compliance with the best breastfeeding practices are the best way to increase both the initiation and continuation of breastfeeding, other strategies are needed to support breastfeeding longer term.

Dyadic level – mother and infant factors – influence on growth of plant and flower

Birth experiences, infant feeding challenges and infant feeding outcomes.

The meta-narratives illustrate how both birth experiences and postnatal infant feeding challenges, identified in the wider literature (Fraser et al., 2019; Jackson & Hallam, 2022; Thomson et al., 2022) influence women's infant feeding experiences and outcomes. In the visual metaphor mother and infant factors which facilitate positive infant feeding experiences and outcomes are illustrated by the ability of the plant to flower. However, the meta-narratives suggest that women of a lower socio-economic status can experience poorer infant feeding experiences and outcomes. Whilst the meta-narratives do not show significantly different birth experiences, the meta-narratives illustrate how women of a lower socio-economic status were more likely to experience infant feeding challenges in the postnatal period. Likewise, Gallagher and McKechnie (2024) identified missed opportunities for health professionals to provide equitable breastfeeding support which influenced whether mothers were provided with support and whether that support had an influence on breastfeeding. These challenges included concern about insufficient milk supply due to unidentified feeding challenges (n=1), infant feeding challenges caused by tongue tie (n=2) and milk allergy (n=1). Whilst two women of higher socio-economic status experienced breastfeeding challenges in the postnatal period (tongue tie (n=1)), unidentified feeding challenge (n=1), the other two women either did not experience any breastfeeding problems in the immediate postnatal period or feeding difficulties were resolved quickly.

Significant others level

The meta-narratives provide evidence to suggest that health professionals implementing the BFI standards need to understand how the practical and emotional resource of significant others and the experiences of family and friends, influence breastfeeding continuation. However, in the visual metaphor, factors related to significant others (practical and social support and the experiences of others) have been illustrated as being hidden factors (in the soil) to reflect the important role health professionals have in identifying how significant others can influence infant feeding outcomes and experiences.

Practical and emotional resource

The meta-narratives highlighted the importance of health professionals understanding how a woman's informal support network will influence breastfeeding experiences and outcomes. All the meta-narratives support research which shows how supportive partners (Roll & Cheater, 2016; Ogbo et al., 2020) and family members (Synder et al., 2021; Thomson et al., 2022) who provide general household support and ongoing encouragement positively influence women's breastfeeding experiences and facilitate breastfeeding self-efficacy (Aksoy et al., 2022). Whilst only one woman was in a same sex relationship, the meta-narrative 'too many missed opportunities to identify needs' increases our understanding of the essential support provided by the non-gestational parent, as highlighted by research by Juntereal and Spatz (2020). However, this meta-narrative also identifies the opportunities missed by health professionals to build on this support. For example, the provision of information antenatally in relation to breastfeeding and co-nursing could have helped this mother to share responsibility for feeding. Whilst the research

by Cook et al. (2021) focused on the experiences of mothers who live in a deprived and culturally diverse community, their study highlights the importance of understanding how flexible approaches to feeding help mothers to share responsibilities for feeding. Cook et al. (2021) proposed that by using formula fathers could take a more active role in feeding their infant and to support the mother. Moreover, Schnell (2022) suggests that inducing lactation in the non-gestational parent provides opportunities for parents to share breastfeeding equally which can help to maintain or increase lactation.

Although only one participant of a lower socio-economic status was a single parent, the meta-narrative 'an insurmountable level of challenge' emphasises the importance of both understanding what support mothers have available and need. However, Brown (2023) suggests looking at the bigger picture and cautions against focusing on relationship status. For example, Michelle's narrative ('an insurmountable level of challenge') illustrates how various aspects of her situation made things difficult in addition to her single parent status. An implication of this, as supported by this meta-narrative, is that single parents may need more support when trying to balance work and childcare. Similarly, Kim and Gallien (2016) in their study which examined childcare arrangements and infant feeding practices by family structure (single mother vs two parent households) and household income in the US found that single mothers, regardless of income, needed support with childcare for breastfeeding continuation.

Whilst the revised guide to the standards require staff to explore possible sources of social support available in the local community (UNICEF UK BFI, 2024), the meta-narratives provide evidence to suggest that health professionals do not currently consider antenatally whether women have access to a support network that will meet their needs. This finding is important because the BFI standards encourage staff to recognise that mothers feed their babies within the context of their families and close friends (UNICEF UK BFI, 2017a). Moreover, the study by Groleau et al. (2016) found that when staff who worked in BFI services encouraged mothers to include their partners in breastfeeding decisions, they were able to empower mothers and ‘transform’ their partners into sources of emotional and domestic support. Thomson et al. (2020) have identified the positive use of a genogram to identify people/services that can provide support to women in the intervention group of their ABA randomised feasibility trial. However, the importance of training infant feeding supporters to use the genogram was highlighted.

Family and friends’ experiences

The meta-narratives identified how the vicarious experiences of others, including family, peers and work colleagues influenced infant feeding decision making positively and negatively. When women had been breastfed themselves, this positively influenced decision making. However negative vicarious experiences of friends or if the woman had not been breastfed, negatively influenced the ability of women of a lower socio-economic status to breastfeed postnatally, supporting the findings of previous studies (Ward et al., 2017). Thomson et al. (2022) identify how the vicarious experiences of friends or whether the woman had received breastmilk as a child affected attitudes and behaviours positively and negatively. Likewise,

Fraser et al. (2019) identified how a woman's social network conveyed both negative and positive influences, highlighting how information and advice including suggestions that are inconsistent with health recommendations can influence women's infant feeding outcomes negatively. Cultural beliefs of mothers, their family members and others were also seen as important across studies included in the scoping review undertaken by Walsh et al. (2023) to consider the wider context for the implementation of the Baby Friendly Hospital and Community Initiatives. The results of the study by Ward et al. (2017) included in this review support the view that understanding how others influence infant feeding decision making is particularly important for women of a lower socio-economic status.

Organisational level

The meta-narratives illustrate how organisational factors and the way in which health professionals interpreted and implemented the revised BFI standards influenced women's experiences of infant feeding care both positively and negatively.

Importance of personalised care

The importance of personalising care is illustrated by the watering can in the visual image. The meta-narrative 'tipping the balance to positive' illustrates how health professionals who personalise Baby Friendly care can improve infant feeding outcomes for mothers and babies. This is because this meta-narrative demonstrates how the personalisation of Baby Friendly care plays a key role in supporting women with aspects of care that are important to them. Therefore, it could be suggested that a lack of personalisation of Baby Friendly care negatively influences women's infant

feeding experiences and outcomes. This finding is consistent with those of Fallon et al. (2019) who suggest that the BFI standards use a 'one size fits all approach' and do not facilitate care that either considers the woman's individual situation or is responsive to their personal needs. Likewise, the meta-narratives provide evidence to support the study by Hadjiona et al. (2016) which focused on breastfeeding self-efficacy in relation to BFHI implementation in maternity units in Cyprus. This study which included women of both high and low socio-economic status suggested that women possessed low levels of breastfeeding self-efficacy and better implementation of the BFHI steps was necessary to improve breastfeeding outcomes. However, the meta-narratives emphasise that it is possible for health professionals implementing the BFI standards to personalise care. Therefore, suggesting that health professionals could mitigate the inequities women of a lower socio-economic status face if Baby Friendly care is personalised accordingly.

Meaningful antenatal conversations

The meta-narratives identified missed opportunities for meaningful antenatal conversations, particularly for women of lower socio-economic status. This finding highlights the importance of staff implementing the BFI standards both understanding what constitutes a meaningful conversation and possessing the appropriate skills to facilitate meaningful conversations in practice. Whilst recommendations outlined in the revised guide to the standards requires those who are pregnant to understand the evidence for breastfeeding on health and well-being (UNICEF UK BFI, 2024a), an implication of this is the possibility that staff will continue to have antenatal conversations which focus exclusively on the health benefits of breastfeeding and prevent women from having conversations that could

enable them to achieve their infant feeding goals. Likewise, Hamnøy et al. (2024) who explored mothers' experiences of breastfeeding counselling in Norway identified that mothers wished health professionals had explored their motivations and expectations relating to breastfeeding and wanted conversations adapted to their needs.

Supportive professional (sunshine)

In the plant metaphor, the sun illustrates the value women placed in all the meta-narratives of having a supportive health professional, thus demonstrating the role professional support plays in women's experiences of BFI care to facilitate positive infant feeding outcomes and experiences.

Importance of relationships

Women valued supportive health professionals who built relationships with them as previously found in several studies (Burns et al., 2013; Byrom et al., 2021; Fraser et al., 2019; Schmied et al., 2011) including my systematic review (see chapter 3).

Additionally, the meta-narratives indicated that most of the women felt staff created a welcoming atmosphere for breastfeeding as advocated in the standards (UNICEF UK BFI, 2017a). This encouraged rather than pressurised mothers to breastfeed. Therefore, the meta-narratives provide evidence to support and extend our understanding of how the 'BFI way' described by Byrom et al. (2021) enables staff to embed the standards within their practice. In Byrom et al.'s study which explored service users' perceptions and experiences of maternity care, they explain how

women and families felt 'cared for' which helped them to feel reassured and confident in relation to feeding and caring for their baby. Likewise in the study by Hamnøy et al. (2024), breastfeeding mothers highlighted the importance of having midwives and public health nurses who were interested in helping and supporting them. Whilst Hamnøy et al.'s (2024) study was undertaken in Norway where breastfeeding counselling has been integrated into routine community child health services as part of the implementation of the BFHI, this study highlights the importance of mothers having a strong relationship with health care professionals to enable them to seek support and help with breastfeeding when needed.

When mothers received information from a health professional they trusted and had a supportive relationship with, evidence-based information about the introduction of solid foods was accepted more readily. Likewise, findings from the study by Walsh et al. (2015) which explored the factors influencing first-time mothers' introduction of complementary foods identified that mothers who had a supportive health professional were more likely to wait until six months before introducing solid foods. Additionally, the systematic review by Spurlock et al. (2023) highlighted that parents were more likely to accept information about introducing solid foods if a rapport was built and a non-judgmental approach was used.

Importance of informational and practical support to breastfeed

The meta-narratives support research by Thomson et al. (2022) and the results of my systematic review which highlight the importance of providing women with personalised care which provides both positive practical and informational support which helps them to learn how to breastfeed and emotional support to reassure and boost confidence. Additionally, Aksoy et al. (2022) highlight that mothers value practical support provided by health professionals in relation to positioning and attachment. Likewise in the study by Cook et al. (2021) which considered the experiences of mothers of a lower socio-economic status, the additional practical advice and support the mothers received when they experienced breastfeeding challenges encouraged them to continue which included being signposted to services which could support them. Similarly, Munn et al.'s (2016) integrative literature review whilst identifying that step 10 of the Ten Steps to Successful Breastfeeding⁴⁵ (WHO/UNICEF, 1989) is one of the most difficult steps to implement highlights how influential this step can be in relation to maternal breastfeeding decisions.

The meta-narratives suggest that women of a lower socio-economic status experienced poorer care experiences related to a lack of personalised support to breastfeed. For example, the meta-narrative 'an insurmountable level of challenge' identifies how missed opportunities to personalise infant feeding care and communicate effectively negatively impacted on women's infant feeding experiences.

⁴⁵ Step 10 of the Ten Steps to Successful Breastfeeding refers to the establishment of breastfeeding support groups and the referral of mothers to them on discharge from the hospital or clinic.

This finding reflects those of Gallagher and McKechnie (2024) in their integrative review of exposure to in-hospital care by patient characteristics and breastfeeding outcomes. This review contextualises differences in exposure to best practices for breastfeeding support, such as the BFHI and 'Ten Steps' as 'missed care.' This review highlights inequitable access to breastfeeding support within the hospital environment, suggesting the importance of individualised support according to needs. Moreover, the meta-narratives illustrate further consequences of a lack of support. When women's infant feeding care needs were not met this eroded their confidence and undermined future care provision which increased their reliance on information from other sources.

The meta-narratives suggest an association between antenatal preparation which meets a woman's needs and breastfeeding self-efficacy. This finding highlights the importance of health professionals implementing the standards understanding what women know about breastfeeding and what they need to know to provide them with practical information which could increase breastfeeding self-efficacy. The qualitative research study by Fraser et al. (2019) which explored mother's experiences of support in the first 6-8 weeks supports the importance of breastfeeding preparation to meet needs. Additionally, this finding is consistent with those of Lewkowitz et al. (2019). In their study which examined outcomes among WIC-participating infants and the relationship to Baby Friendly hospital practices, those parents who breastfed and used commercial milk formula felt that more education and support would have helped them to exclusively breastfeed. However, this study also noted that participants receiving WIC were more likely to be giving formula on postpartum day 2 despite similar rates of prenatal education across all groups of participants in the

study. Whilst Munn et al. (2016) suggest prenatal education (step 3 of the Ten Steps to successful breastfeeding) is most likely to impact maternal breastfeeding decisions they propose that this step is difficult to implement which could explain why none of the women in my study received antenatal information which met their needs. On the other hand, 18 out of the 20 women who participated in the study by Miller et al. (2018) which explored African American women's experiences in a newly accredited Baby-Friendly hospital to understand the inequities they faced reported being satisfied with the information they received about breastfeeding at their prenatal appointments.

Despite the meta-narratives highlighting how women found information about the benefits of breastfeeding useful, all women described how they did not feel prepared for the realities of breastfeeding or the potential challenges they would face, a finding supported by available literature (Ryan et al., 2017; Shortt et al., 2013) and the results of my systematic review (see chapter 3). This finding is contrary to research by Groleau et al. (2016) who found that many women who used hospital and community services with BFI accreditation in Canada seemed prepared to deal with potential breastfeeding difficulties. However, a study undertaken by Chu et al. (2019) which explored Taiwanese mother's breastfeeding experiences in certified Baby-Friendly Hospitals revealed that mothers whose infant was diagnosed with neonatal jaundice felt that the breastfeeding information provided by the professionals focused mainly on the positive aspects of breastfeeding and possible problems were not discussed in advance.

Comparison of my meta-narratives with the findings of the study by Miller et al. (2018) confirms mothers required more support from health professionals to address positioning and attachment concerns and ineffective attachment which led to breastfeeding pain. Additionally, the maternal perception of insufficient milk supply was not addressed. This finding is significant because missed opportunities to provide adequate and appropriate support for breastfeeding resulted in the introduction of commercial milk formula and the unintended cessation of breastfeeding. Whilst the review by McFadden et al. (2017) did not focus on the implementation of the BFI standards, findings confirm the association between interventions to support breastfeeding and the reduced risk of women stopping any breastfeeding before six weeks.

However, the integrative review conducted by Lojander et al. (2022) which examined maternal perceptions of breastfeeding support in a maternity hospital before and after designation to the BFHI found that BFHI designation had a positive impact on mother's perspective of breastfeeding support. In relation to breastfeeding problems, nearly all mothers (93 %) in the study included in this review by Marinelli et al. (2019) reported receiving counselling from healthcare professional for their problems. This is significant because practical help may help avoid unnecessary supplementation with commercial milk formula (Bookhart et al., 2021). However, the differences in original studies were not always statistically significant. Furthermore, only three studies included in this review focused on low-income mothers (Ducharme-Smith et al., 2022; Jung et al., 2019; Lewkowitz et al., 2019) with two of the studies relating to mothers participating in the US Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) (Ducharme-Smith et al., 2022; Jung et al., 2019).

Moreover, these three qualitative studies indicated that mothers were mainly satisfied with the breastfeeding support in the Baby-Friendly hospitals, although they also reported inconsistent and inadequate support. However, my meta-narratives are broadly consistent with the results observed by Lewkowitz et al. (2019), whose study was also included in this review. Whilst exclusively breastfeeding mothers in their study were more likely to receive support compared to mothers who supplemented with commercial milk formula, breastfeeding information and support provided to these mothers did not always address the breastfeeding problems mothers encountered such as insufficient milk supply or breastfeeding challenges.

Breastfeeding assessments

The meta-narratives demonstrate how unidentified breastfeeding challenges associated with ineffective positioning and attachment or a lack of understanding of issues with the baby which would affect feeding, reduced ability to breastfeed long term. This finding would suggest that health professionals either did not undertake a full assessment of breastfeeding as per the BFI breastfeeding assessment form or had not discussed positioning, attachment, and hand expressing, according to the woman's need. For example, for Michelle ('an insurmountable level of challenge') a formal breastfeeding assessment and acknowledgement of her concerns could have resulted in early help to achieve effective breastfeeding.

This finding is significant because the BFI standards suggest where a mother is having any breastfeeding difficulties, breastfeeding support should be offered, and a plan of care developed with the mother. The meta-narratives also provide evidence

to support the association between the provision of skilled and appropriate support for the continuation of breastfeeding. For example, both Isabella and Catherine were offered help from breastfeeding peer supporters which did not provide the infant feeding help they needed. A possible explanation for this might be that these women required both peer support and breastfeeding help from skilled practitioners to help them overcome their breastfeeding challenges. Whilst the systematic review by Yang et al. (2024) identifies how breastfeeding peer support can have a positive impact on breastfeeding, they also suggest it is important to consider the individual needs of each mother. Moreover, the WBTi UK (2016) highlights the importance of staff trained to BFI standards understanding the unique characteristics of their roles within the infant feeding support workforce to ensure mothers receive appropriate support.

Supporting parents to have close and loving relationships

Despite the focus in the BFI standards on the importance of supporting parents to have a close and loving relationship with their baby, the meta-narratives identified a lack of conversations for most of the women about early relationship building and how they could develop a relationship with their baby. Whilst skin-to-skin was implemented for all the babies in my research, the meta-narratives identify how women were given a lack of information about other ways they could develop close and loving relationships with their baby. My meta-narratives therefore provide evidence to support the recommendation in the revised guide to the BFI standards (UNICEF UK BFI, 2024a) for services to find new ways of supporting parents in relation to relationship building such as helping parents to understand their baby's emotional and social development.

Whilst the revised standards (UNICEF UK BFI, 2017a) do not require staff to support parents to keep their baby safe when asleep, the meta-narratives identified how postnatal conversations provided information about safe-sleep messaging. Although conversations provided information on the key actions parents should take to reduce the risk of sudden infant death syndrome as per UNICEF UK BFI (2019), The Lullaby Trust (2025) and Public Health Agency (2019) guidance, mothers were not provided with information appropriate to their needs. Mothers felt that conversations repeatedly told them what to do rather than provide them with opportunities to have open, non-judgmental conversations. The qualitative study by Pease et al. (2017) which explored the factors influencing whether mothers adhered to safe-sleep messages with mothers from deprived areas of the UK found that when mothers felt they were being lectured this gave little time for mothers to absorb the information or ask questions. The meta-narratives support the findings of Pease et al.'s (2017) study that mothers would have preferred a more individual approach. This is significant because the updated standards for early years (UNICEF UK BFI, 2024a) require staff to have conversations with parents to support them to keep their baby safe when asleep.

Supporting parents to introduce other foods

The meta-narratives identified how women who were using commercial formula milk were not given the information they needed to do so safely or to maximise the amount of breastmilk their baby received. For example, for Irene a lack of information to maximise her breast milk when she introduced commercial milk formula led to breastfeeding discontinuation. For Michelle, an open conversation

based on the best available evidence could have enabled her to make an informed decision about using a perfect prep machine to prepare her baby's milk.

Most of the mothers participating in this study did not receive relevant information regarding the introduction of solid foods, which left them feeling confused about current guidelines. Likewise, research by Walsh et al. (2015), found that first-time mothers did not understand the rationale behind the WHO recommendations or did not fully understand the signs of readiness of infants to commence solid foods. The systematic review undertaken by Spurlock et al. (2023) found that accessibility of information about introducing solid foods was important to parents as information sources were not always in an understandable format, preferring to obtain information online. Therefore, the meta-narratives provide evidence to support the recommendations in the revised guide to the standards (UNICEF UK BFI, 2024a), for continued support for parents around formula feeding and the introduction of solid foods to ensure parents receive the information they need to feed safely and responsively.

Importance of appropriate communication skills

When health professionals used appropriate and sensitive communication skills women perceived their feeding experiences more positively, supporting previous research by Hinsliff-Smith et al. (2014), Lagan (2014) and Ryan et al. (2017). The meta-narratives demonstrate how this was of particular importance when identifying breastfeeding concerns as it was the way these were communicated which influenced the mother's well-being, as discussed by Leeming (2018). The meta-

narratives emphasise the importance of effective, woman-centred communication. Women valued positive feedback that affirmed their ability to breastfeed (Thomson et al., 2012) and confirmed that feeding was successful (Taylor et al., 2019; Thomson & Crossland, 2019; Thomson et al., 2012). Similarly, achieving BFI sustainability standards (UNICEF UK BFI, 2018) recognise the significance of a kind culture for mothers and families (UNICEF UK BFI, 2018) to facilitate effective infant feeding care provision.

Conversely, the meta-narratives identify negative experiences of support which occurred when health professionals were not able to provide the support that women required (Hoddinott et al., 2012b) or used language which was believed to be inappropriate or judgmental as this undermined feeding self-efficacy and decreased confidence in breastfeeding (Hinsliff-Smith et al., 2014; Ryan et al., 2017). Similarly, the integrative review by Gallagher and McKechnie (2024) identified inequities in relation to women's exposure to best practices such as the BFHI, underscoring the importance of addressing and eliminating breastfeeding disparities.

Collaborative approach across services for all standards

My meta-narratives resonate with current research that highlights the importance of infant feeding interventions spanning the continuum of a woman's infant feeding journey (Tomori, 2023). Despite the BFI standards recommending services work together across disciplines to ensure effective implementation of the standards (UNICEF UK BFI, 2017) the meta-narratives identify a lack of collaborative working between midwives and health visitors. This is significant because when midwives did

not share information with health visitors this contributed to women's negative experiences of care. For example, for Ashleigh ('an insurmountable level of challenge') if there had been an effective handover of care between midwife and health visitor, it is possible that she could have received infant feeding help in the postnatal period which met her needs. This finding is consistent with those of Pramono et al. (2022). In their study which explored Australian midwives' experience of implementing the BFHI, a lack of continuity of information between the hospital midwives and community care was identified. The meta-narratives therefore provide additional evidence to support health visitors working with maternity services to ensure effective handover of care that puts the needs of families first.

The meta-narratives provide evidence consistent with other studies and the findings of my systematic review to show how continuity of carer positively influences women's infant feeding experiences. This is because continuity of carer provided women with opportunities to develop open and honest relationships with health professionals and share information about their individual circumstances. Conversely when women of a lower socio-economic status did not have continuity of midwifery care this prevented them from sharing information which could have helped their midwives personalise care. This finding supports those of Heys et al. (2021) who suggested in their meta-ethnography that explored continuity of midwifery care could enhance individualised care for disadvantaged women. Furthermore, the study by Miller et al. (2017) showed how women who had continuous relationships with their BFHI caregivers could discuss their breastfeeding plans which helped them make informed decisions before birth. However, it needs to be recognised, as suggested

by Pramono et al. (2022), that it takes time for midwives to build effective communication with women.

Considering the mother's infant feeding journey

The meta-narratives highlighted the importance of ongoing health professional support and how mothers felt more alone as their infants got older, supporting findings from studies by Cook et al. (2021) and Fraser et al. (2019). This finding further contributes to our understanding of the significance of continuation of care and the importance of breastfeeding support throughout the postnatal period and beyond.

The meta-narratives also point to the need to consider the mother's longitudinal infant feeding experience. Whilst many of the standards have been replicated for different settings, the standard "protect and support breastfeeding in all aspects of the service and enable mothers to continue breastfeeding for as long as they wish" currently only applies to health visiting and early years services. As maternity and health visiting/early years services progress the standards separately, a reasonable approach to support health professionals to map the wider issues which influence a mother's ability to achieve her breastfeeding goals over the course of her infant feeding journey, could be to add this standard to the antenatal standards for midwifery care.

Macro-level implications of the study.

In the following section, I consider the macro-level implications of the findings of my research for systemic change beyond the BFI standards to improve infant feeding outcomes and address health inequalities.

The Becoming Breastfeeding Friendly (BBF) toolkit which was developed by the BBF initiative (Merritt et al., 2023), identifies the systemic change necessary at a national level to strengthen the breastfeeding environment across England, Wales and Scotland. This toolkit, which is based on the Breastfeeding Gear Model (Pérez-Escamilla et al., 2012), is made up of eight simultaneous conditions or gears that need to work together to guide action to improve breastfeeding rates. These gears are advocacy; political will; legislation and policies; funding and resources; training and program delivery; promotion; research and evaluation and co-ordination, goals and monitoring. Therefore, in a similar way to the macro level of the SEM, this toolkit acknowledges the complex system in which mothers make decisions about infant feeding (Kendall et al., 2023). The BBF Gear model has been used globally to address the necessary structural and policy-level measures to promote, protect and support breastfeeding (Pérez-Escamilla et al., 2023).

Consistent with the findings of the BBF committees⁴⁶ (Kendall et al., 2023), the meta-narratives suggest gaps in the breastfeeding environment which need to change to

⁴⁶ BBF committees are groups of stakeholders (for example, policymakers, academics, practitioners, NGOs) formed in countries or regions to assess the breastfeeding environment using the BBF gears.

empower mothers to breastfeed. First, the meta-narratives provide evidence to suggest how gaps which relate to the legislation and policy BBF gear (Kendall et al., 2023) interfered with a woman's ability to breastfeed. For example, information contained within the meta-narratives suggest how in the absence of paid maternity leave, self-employed women from a lower socio-economic background needed to return to work soon after birth. This finding supports Brown (2017) who makes the case for extended maternity leave that is paid at a reasonable level to protect breastfeeding. Additionally, this finding is consistent with Baker et al. (2023) who write that the absence of paid maternity leave has increased women's reliance on commercial milk formula. This finding provides further evidence to suggest the need for governments to change the breastfeeding environment by providing the maternity benefits that enable and support breastfeeding continuation (detailed further in section 2.2.5.4).

Second, my findings suggest how gaps in the training and programme delivery BBF gear (Kendall et al., 2023) in relation to infant feeding service provision and health professional knowledge prevented women from breastfeeding for as long as they wanted and receiving care appropriate to their needs. This is important because the meta-narratives suggest that a lack of personalised support influenced both the women's experiences of BFI accredited care and their infant feeding outcomes. Furthermore, this finding supports the recommendation of the BBF committees (Kendall et al., 2023) to protect and extend evidence-based infant feeding support to ensure all families can access this when and how they need it. As my findings highlight inequities in breastfeeding care which lead to increased health inequalities,

they align with the BBF recommendation to improve the provision of accessible services at a local level (Kendall et al., 2023).

Third and in relation to the training of health professionals, my meta-narratives support the BBF recommendation that all professionals who provide breastfeeding support should be provided with role appropriate training, including the necessary knowledge and practical skills (Kendall et al., 2023). Additionally, my meta-narratives build on this BBF recommendation by providing evidence to suggest that health professionals need additional role-specific training to be able to consider how the mother's environment will influence her ability to breastfeed and understand the experiences of mothers that find breastfeeding difficult.

Finally, in relation to the funding and resources gear, my findings support the BBF recommendation to ensure long-term government funding for breastfeeding support (Kendall et al., 2023). National investment in breastfeeding could strengthen the breastfeeding environment by helping health professionals to understand the health inequalities which influence women's infant feeding decision making and ensure that infant feeding services are appropriately resourced. This could subsequently enable health professionals to provide women with personalised infant feeding care which meets their needs.

As the meta-narratives suggest gaps in the breastfeeding environment which need to change, it could be suggested that within the visual metaphor, the blue sky which provides the background to the flower, watering can, and sunshine represents the

wider systemic factors which can influence the provision of both health professional support and the provision of personalised infant feeding care.

In this section I have contextualised my meta-narratives by relating them to the wider theory and literature. In the following section I discuss the implications of my study for research, policy and practice and its strengths and limitations. I then consider my study's unique contribution to knowledge.

9.4 Implications of my research for research, policy, and practice.

In this section I consider the implications of my study for research and then for policy and practice.

Implications for research

Whilst the revised standards encourage health professionals to be mother-centred and think about what makes each woman unique to put her needs first (UNICEF UK BFI, 2017a), the meta-narratives suggest that the current implementation of the antenatal standard does not enable staff to identify the factors which will influence women's infant feeding outcomes and experiences both positively and negatively. Consequently, there is a need for further research to identify how health professionals could ask women antenatally about the factors which will influence their ability to breastfeed. Additionally, it would also be interesting to explore whether health visitors and midwives undertake antenatal conversations differently. This

would also help to identify whether a consistent approach across health services which focused on identifying resources and building support networks would be more effective.

Future research could explore health professionals' perceptions and experiences of delivering accredited Baby Friendly care to a diverse sample of women. Whilst this research identified variations in the way women from different socio-economic backgrounds experienced infant feeding care from BFI Gold accredited maternity and health visiting services, research is needed to identify what knowledge health professionals implementing the standards have about inequalities. This could identify whether health professionals perceive resource constraints and a resulting belief that they are unable to do anything about them prevents them from exploring inequities further.

As my research used a small sample of women there is a need for further research with more women in different settings.

As most of the studies included in my systematic review focused on mothers' and birthing peoples' experiences of breastfeeding, there is a need for further research to understand what mothers who commercially formula feed their babies want from infant feeding communication.

This study has challenged my stereotyped views about breastfeeding and my assumptions about the factors which are responsible for breastfeeding rates being lower among women from lower socio-economic backgrounds (see section 1.10). Therefore, further research could explore the role of bias and whether providing staff with opportunities to identify and challenge their own misconceptions would change how breastfeeding support is provided to specific population groups.

A future study could use the narratives obtained in this research to develop and then evaluate an augmented reality training tool for BFI staff training. This training tool could enable health professionals to understand the impact of the infant feeding care they provide and which in turn could enable more equitable care for mothers and babies in the future. Additionally, this training tool could provide health professionals with the opportunity to understand how women have interpreted the information they have received and whether this has been sufficient for their needs.

Research could also explore whether using the narratives in staff BFI training rather than the scenarios currently used⁴⁷ would enable staff to understand the factors which influence infant feeding decision making for a diverse sample of women.

Further research could also explore how staff implementing the standards interpret and deliver the standards in practice. For example, it would be interesting to

⁴⁷ Staff are provided with four scenarios during BFI training when discussing compassionate care and sensitive communication to promote further discussion.

understand why midwives have routine conversations about colostrum harvesting antenatally as these conversations are not currently advocated by the standards.

Implications for policy

My findings provide evidence to suggest what a diverse sample of women need in relation to their infant feeding care. Whilst there is a commitment in the NHS Long Term plan (NHS, 2019) for all maternity services to be baby friendly accredited, a commitment to the implementation of the BFI for health visiting services, would be one way to ensure consistency of infant feeding care across services.

Implications for practice

This work has generated several important implications to help inform and improve practice.

Continued efforts are necessary to ensure that both midwives and health visitors receive appropriate training in relation to infant and young child feeding. Despite a commitment in the NMC standards of proficiency for midwives (Nursing & Midwifery Council (NMC), 2019) and the updated standards for Specialist Community Public Health Nursing practice (SCPHN) (NMC, 2022) to provide equitable care, the meta-narratives and findings from the systematic review suggest that health professionals could benefit from specific infant feeding communication training with a focus on health equity to be able to communicate infant feeding messages effectively to different population groups. Ensuring this training uses a health equity lens could equip health professionals with the skills necessary to effectively adapt the communication style and language used when transmitting infant feeding care messages to be more inclusive of different groups.

The meta-narratives provide evidence to suggest that midwifery and health visiting curricula do not provide health professionals with the additional skills necessary to support women who face more complex challenges, supporting research by Spiro (2019). Additionally, the most recent WBTi UK report (WBTi UK, 2024) identified that health visiting curricula based solely on the updated standards for SCPHN practice (NMC, 2022) do not adequately prepare health visiting students to provide effective infant feeding care.

Maternity trusts, health visiting services and local support services need to be sufficiently funded and resourced to enable women to receive the personalised, supportive infant feeding care they need to achieve their infant feeding goals. Similarly, both Taren and Lutter (2017) and UNICEF UK BFI (2017b) call for continued resourcing for the implementation of the BFI standards in practice. However, data indicates that there is both a national shortage of around 5,000 health visitors in England (Institute of Health Visiting, 2025) and a shortage of 2,500 midwives (Royal College of Midwives, 2023). This is important because data from the survey undertaken by UNICEF UK BFI (2022) identified that a lack of resources and staff time to implement the standards can lead to the standards becoming deprioritised and harder to implement even in a Baby Friendly accredited service. Moreover, the meta-narratives have highlighted the importance of meaningful antenatal conversations. However, data from the UNICEF UK BFI (2022) survey also showed how antenatal conversations are 67% harder to facilitate in maternity and 69% harder in the community without sufficient resources and staff time. Biggs et al. (2018) also support the view that whilst the number of hospitals implementing the

BFI standards is on the rise, the real effectiveness of this programme could be limited due to the increasing number of staff shortages.

My meta-narratives support the views of some of the participants in the study by Fair et al. (2024) who felt that the BFI standards have the capacity to address the social and health inequalities that exist by allowing health professionals to consider women as individuals. Using the visual metaphor in BFI staff training to emphasise the pivotal role health professionals have during a mother's infant feeding journey to consider factors related to the women's individual circumstances could therefore positively influence experiences and outcomes and reduce current infant feeding inequalities.

Greater efforts are needed to ensure that antenatal education provides women with the practical and realistic information they need to breastfeed. Whilst it is encouraging that the revised guide to the UNICEF UK BFI standards (UNICEF UK BFI, 2024a) recognises the importance of enabling awareness of normal newborn behaviour, women also require information about the practicalities of breastfeeding and the potential challenges they can face. However, care needs to be taken when preparing women for breastfeeding to ensure information is communicated appropriately. Research by Stockdale et al. (2011) highlights the importance of advising women about normal breastfeeding challenges such as positioning and attachment difficulties rather than the potential problems they can face. They argue that this ensures women are prepared for difficult breastfeeding experiences whilst protecting their expectancy for success (Stockdale et al., 2011). In addition,

Stockdale et al. (2011), discuss the importance of considering whether women believe they will be able to breastfeed when placing value on breastfeeding as a behaviour. In the updated BFI community staff audit interview form, staff are required to demonstrate that they understand that women require information about the value of breastfeeding antenatally related to their situation. However, there is no specific guidance to facilitate antenatal conversations which could enable staff to understand women's theoretical and experiential experiences of breastfeeding.

My meta-narratives provide evidence to suggest that further changes to the UNICEF UK BFI standards are necessary to enable health professionals to have conversations with women which could help them to understand the resources women have available to them. One such way would be to incorporate an asset-based approach such as asset mapping within the BFI antenatal and postnatal conversation guides to enable health professionals to consider women's individual situations and the resources available to them. Supporting this, previous research (Cassetti et al., 2024; Harrison et al., 2019; McClean, 2011, Wreford et al., 2024) suggests the benefits of asset-based approaches to focus on what individuals have. Whereas the traditional deficit approach to health focuses on problems and deficiencies, asset-based approaches focus on identifying assets, protective factors or strengths that support health and well-being (Morgan & Ziglio, 2007). Thus, NICE (2016) recommends the use of this approach to positively influence care outcomes within social care. Moreover, my visual metaphor highlights the importance of health professionals developing relationships with women to facilitate person-centred conversations. Harrison et al. (2019) explain how asset-based approaches use a person-centred, strengths-based approach with an emphasis on relationships to

build capacity. Morgan and Ziglio (2007) and Cassetti et al. (2024) have identified how approaches which enable asset-based thinking could reduce disparities in public health by focusing on the positive capabilities of individuals and communities. These studies found that asset-based approaches can empower individuals by involving them to improve their health outcomes. Additionally, to improve maternal outcomes, Mollard and Cottrell (2023) suggest using a theory of maternal adaptive capacity to consider factors which make individuals more resilient to risk, reduce health disparities and improve maternal health outcomes. Furthermore, Thomson et al. (2021) argue how health professionals with a greater awareness of structural constraints faced by those from a lower socio-economic status are more likely to empower individuals to be more involved in decisions around their care and help reduce health inequalities in the long term. Although the ABA-feed study is currently using an asset-based approach to develop interventions to support infant feeding (Clarke et al., 2023), to my knowledge an assets-based approach is not currently part of the Baby Friendly standards or guidance. This is surprising as asset-based approaches offer opportunities to build on the guiding approach currently advocated as being key to implementation of the BFI standards (UNICEF UK BFI, 2018).

The meta-narratives also provide support for a change to the first question in the audit tool for staff implementing the BFI standards which relates to the information a pregnant person would need to help make an informed decision about whether to breastfeed. The meta-narratives suggest that antenatal conversations can be meaningful if they provide opportunities for health professionals to understand the realities of women's lives. Therefore, the current focus on the specific health benefits of breastfeeding could prevent women from having conversations which enable them

to identify what information they need and how breastfeeding will fit with their individual situation.

My meta-narratives support the recommendation in the revised guide to the UNICEF UK BFI Standards (2024a) for parents to be involved in the development of local infant feeding services to ensure they meet the needs of the local community. For example, ensuring breastfeeding groups are within pram pushing distance for those parents who are unable to drive. Caution should be used when providing information and care virtually to ensure that it is accessible and meets women's needs.

Furthermore, when using leaflets, health professionals need to ensure that these are used to support conversations and are tailored to individual needs. Whilst health services in East Lancashire do not currently have Start for Life, Family Hub funding (UNICEF UK BFI, 2024b) the service needs to continue to build on the Family Hub model currently being utilised to ensure infant feeding services are co-produced with local families and ensure these are tailored to local contexts.

Ensuring appropriate referral pathways, services, and support for mothers with babies with complex infant feeding issues should continue to be a priority. Whilst the revised guide to the UNICEF UK BFI standards (2024a) recommends that mothers should be made aware of the specialist support available for breastfeeding challenges when they need help, my meta-narratives indicate that this information should be more readily available. Providing information antenatally about the specialist help available could enable mothers to access services in a timelier way, facilitating breastfeeding continuation.

During the interviews women valued the opportunity to share their infant feeding stories. They felt the interviews provided them with opportunities to debrief and were at times cathartic. These reflections provide evidence to support the recommendation in the revised guide to the standards (UNICEF UK BFI, 2024a) for staff to discuss the impact of current or previous infant feeding challenges with parents and consider together whether they need further support to enhance their emotional wellbeing.

In addition, the meta-narratives support the view that staff implementing the standards should ask all breastfeeding women about their experiences to identify both what breastfeeding means to them and how breastfeeding has influenced their relationship with their baby both positively and negatively. This could enable staff implementing the standards to both support the developing relationship between mother and baby more effectively and identify experiences which motivate women to breastfeed.

9.5 Study strengths and limitations

A key strength of this study was the longitudinal, narrative approach which allowed for both an in-depth understanding of the women's experiences and outcomes and how these changed throughout their infant feeding journeys in relation to the UNICEF UK BFI revised standards.

Another key strength was the successful recruitment of a diverse sample of women which was necessary to answer the research question. This was achieved by using a range of recruitment methods which included a Qualtrics questionnaire, posters, social media, and in-person recruitment. Moreover, I retained all study participants once data collection had commenced. Retention was helped by continued contact with the participants and providing the participants with the option of undertaking interviews over the telephone or via Teams.

Combining diaries with interviews helped me to gain a deeper understanding of how the women constructed and interpreted their infant feeding realities. Orientating participants to their OneNote notebook and diary on Teams before data collection commenced was important to build rapport and establish relationships. Participants liked having the option of being able to undertake interviews on the phone or on Teams. Two participants who were of a lower socio-economic status felt they would have been unable to participate in the research if the option to undertake interviews over the phone had not been available. For one participant, Ashleigh, being able to undertake interviews over the phone had enabled her to take part in the study as her anxiety would have made it difficult for her to speak online. For another participant, Catherine, unreliable WIFI had influenced her decision to undertake interviews over the phone.

Using OneNote to collect diary entries was also a strength as OneNote automatically saved and synced information. This meant that diary entries could be reviewed even when they were completed on the same day as an interview. Moreover, when

participants were able to record their experiences in real time, this increased recall accuracy and reduced the potential for failed memory responses. For example, one participant, Anna stated:

'I typed up my thoughts straight away; I thought that was really good. I thought if I don't do it now, I'm going to forget' (Anna, interview 5, six months postnatal).

Trustworthiness (see section 5.6) of the study's findings were considered from the outset. Methods such as reflexive practice and discussions of interpretations with my advisory group, public advisors and supervisory team were essential to ensure that the meta-narratives were based on the women's stories.

This study has generated theoretical ideas about how the BFI standards influence women's experiences which are relevant to current evidence, policy, and practice. As my meta-narratives are consistent with previous research this provides further validation of their transferability.

However, several limitations need to be noted. I purposively framed this research in study documents as being about infant feeding rather than breastfeeding as I wanted to recruit women who would breastfeed, and formula feed their babies. However, all women who participated in this research stated during pregnancy that they wanted to breastfeed. Therefore, it is possible that purposefully framing the research this way excluded women who intended to formula feed from the outset due to them worrying

that they might be shamed for not wanting to breastfeed. As a result, it was not possible to explore how the standards supported those women who intended to formula feed from the outset. Whilst I could have used purposive sampling to get one or two women who intended to formula feed, I did not want to recruit to the study according to feeding intention. This is because I believe that women do not need to decide how they want to feed their baby until their baby is born.

It is also possible that the high time commitment required to participate in this study could have influenced who would be likely to participate. However, I did acknowledge the time participants invested in the study by giving shopping vouchers as a thank you.

This study was undertaken during the pandemic which had a significant impact on the ability of midwives to support recruitment. Although I was able to amend my ethics application and recruit women myself, this reduced the amount of time I had available for data collection. Whilst I had planned for a larger sample size and I did have additional women express interest in participating in the study when recruitment to the study closed, eight participants provided an appropriate sample size. If the sample size had been any larger, I would not have been able to manage analysis with the time I had available. Furthermore, I would not have had sufficient time to analyse the amount of data a larger sample size would have generated. Although I was not aiming to generalise from my results, with a small sample size, caution must be applied when considering the transferability of the findings. Moreover, it is possible that resource constraints due to the pandemic limited

opportunities for health professionals to provide infant feeding information and help. Results from a survey undertaken by UNICEF UK BFI relating to the impact of COVID-19 on infant feeding (2022) identified how the pandemic led to staff shortages, changes to service delivery and de-prioritisation of Baby Friendly implementation.

As I undertook most of my interviews over the phone, I was unable to capture facial expressions, body language and non-verbal signs which would have been possible with a video call or in-person interview (Saarijärvi & Bratt, 2021). However, as discussed in section 5.5.3, I was able to work with this limitation by actively listening to the women and building a rapport with them.

Despite the possibility of participant fatigue for the completion of diary entries, as suggested by Garcia et al. (2016), I did not find evidence of this. However, participants did find that limited time in the immediate postnatal period made it difficult to complete diary entries.

Although Green et al. (2017) suggest that studying intersectionality involves comparing various inequalities between groups, this research has focused on one intersectional group, socio-economic status, to the neglect of others. Whilst I promoted equity when recruiting my participants, as demonstrated by their diverse demographics, I was not able to recruit women who did not speak English limiting the generality of findings. This was due to not having the resource to pay for

interpreters or having the access to interpreting services. Additionally, despite recruiting a diverse sample of women, only one of the participants of a low socioeconomic status was in receipt of benefits, possibly making findings less transferable.

9.6 Methodological reflections

Both Oakley (2016) and Clandinin and Connelly (2016) discuss how ‘genuine familiarity’ and the friendships which develop between the researcher and the research participants during longitudinal studies can influence what stories are told as well as the meaning of what is told. Whilst Weiss and Johnson-Koenke (2023) explain how narrative inquiry encourages the use of a caring and relational approach, Clandinin (2016) argues that it is the rapport and relationships the researcher develops with participants when undertaking a narrative inquiry which can enable them to explore their experiences in ways that are meaningful to them.

I believe the relationships I developed with the women participating in the research facilitated the sharing of their stories. For example, the women expressed how they had enjoyed talking with me and reflected on the value of having me listen to their stories. One participant (Charlotte) stated:

‘I think in terms of the interviews they’ve been good just to get, sometimes it’s just like getting things off your chest with somebody that’s listening’ (Charlotte, interview five, six months postnatal).

Moreover, I believe that these relationships contributed to the core strength of my study which was that all my participants remained in the study.

To mirror how the participants in the study recorded and reflected on their experiences, I completed my reflections in a OneNote notebook. In addition, I completed a further reflexive interview with my Director of Studies when a participant's story triggered negative memories from practice as this enabled me to work through and manage my personal feelings. Whilst I was aware at the beginning of the study of the boundaries of my role as a researcher, I was naïve to think that not providing information or infant feeding help would have no personal effect on me. Reflexive writing was therefore particularly important, as discussed by Finefter-Rosenbluh (2017) for me to understand the personal impact of research. For example, here is the reflection I completed following the transcription of Isabella's third interview (first post-natal interview):

Transcription of interview:

'(baby name) was like feeding off me for like long periods, like really long periods with no breaks and sometimes I said I would notice that her latch would slip and obviously because of the weight gain issues we questioned it' (Isabella, interview three, five weeks postnatal).

Reflection:

I felt angry that nobody had taken the time to understand why her baby was breastfeeding for long periods (over an hour) and was not gaining weight. When listening to her story, I was reminded of a family I had supported in practice as a Specialist Health Visitor where a breastfeeding mother with a baby with a posterior tongue tie raised a concern about the care they had received. It had become apparent, when listening to this mother, that staff had not completed a full breastfeeding assessment and had not identified that her baby would feed for long periods and would never come off the breast spontaneously. I felt frustrated that her breastfeeding challenges had not been identified earlier as this had prevented her from accessing the infant feeding care she needed to continue breastfeeding.

I found it useful, when reflecting on the women's stories with my public advisors, to keep a record of any specific insights into my data or any gaps in my knowledge or thinking that were highlighted so I could refer to these when analysing my data. For example, when sharing Louise's story, one of the public advisors discussed how important verbal reassurance and being told 'you're doing great' had been for her during her breastfeeding journey:

'I loved the support because I was getting negative comments from family that I should start bottle-feeding and my decision to breastfeed was not taken very positively. There was a lot of pressure to start giving the bottle, like a lot of pressure.'

I was aware that for the women who participated in the research completing diary entries and talking to me during interviews influenced their experiences and perceptions. Participants were conscious during their appointments with a health professional that they would be recording their thoughts in a OneNote notebook and then discussing these with me during interviews. For example, one participant, Michelle waited to see if her health professional would discuss feeding and did not ask the questions she had about breastfeeding until this topic had been raised. Furthermore, another participant, Louise felt she had been conscious during appointments that she needed to be able to recall what had happened so that she could discuss it with me.

Although the participants could write, draw, or audio record their diary entries, all the participants in this study chose to write their entries. However, they did consider using the other options available to them. As Louise reported:

“I kept thinking the voice, I should do the voice one but I never, I just wrote. I think I’ve just been a writer, note taker” (Louise, interview five, six months postnatal).

All participants accessed their diary on a laptop or computer and highlighted difficulties accessing their OneNote notebook on the mobile phone app or when they did not have access to a computer. For example, Isabella and Louise initially accessed their diaries on their work laptops but had to use a family member’s computer or their iPad postnatally as they had to return their work laptops when starting maternity leave. When participants were unable to complete diary entries,

they would keep notes on their phone which they would then email or text to me. However, they would also use these during interviews to remind them of things to discuss which led to more accurate reporting of participants' experiences.

Although participants were encouraged to complete diary entries, this was not necessary to participate in the study. Therefore, there were occasions where interviews were undertaken where a participant had not completed a diary entry. However, when participants did not complete diary entries in their OneNote notebook, they were unable to access the diary prompts. An implication of this was the possibility that women would not reflect on the relevant experiences which were necessary to answer the research questions.

Where diary entries were provided, I reviewed these before the interview took place and pulled out sections of the entry that answered the research question to explore further. The following example illustrates how combining diaries and interviews helped me to gain a deeper understanding of the participants' experiences:

In Michelle's 32-week diary entry she wrote:

'I have only concern that each appointment I have is with a different person and have only met my allocated midwife once in seven months.'

During her interview when Michelle was asked to tell me more about this entry. She said:

'I can't even tell you when or if I have met my allocated midwife to be honest. It's never the same person so for example if I am struggling with something and I've confided in a midwife, I would have to go over that again and I just don't see what benefit that is, telling a different person the same story over and over again, so I don't now. I just say I'm fine.'

Women found the diary guide useful, particularly the sentence which asked them to reflect on the support they had received and whether this had influenced the way they would feed and care for their baby. One participant, Ashleigh, commented:

'I think I found it helpful the last bit in the tips for writing, I think it said how did it affect the care you will be giving kind of thing. I think that kind of helps you to reflect on what you've been told because it helps you to think how this will affect me looking after baby and what I wrote helped with that' (Ashleigh, interview 2, 36 weeks antenatal).

9.7 Unique contribution to knowledge

This is the first study which aimed to understand how a diverse sample of women experience infant feeding care from UNICEF UK BFI Gold accredited maternity and health visiting services. It is also the first study to simultaneously explore how women experience both the maternity and health visiting UNICEF BFI standards. As such, it makes several unique contributions to knowledge.

Whilst the revised BFI standards highlight the importance of considering a mother's individual situation, the meta-narratives identify infant feeding disparities in relation to outcomes and experiences of BFI accredited care for women of a lower socio-economic background. These disparities related to both the women's individual circumstances and context and lack of equitable infant feeding care.

This finding suggests that the Baby Friendly standards do not currently provide health professionals with opportunities to consider equity issues. Whilst it is possible that health professionals understand the disparities women face, my findings suggest that a better integration of equity issues into the BFI standards, could facilitate more equitable infant feeding care.

The meta-narratives identify how factors at the individual level and meso-level of the SEM (Bronfenbrenner, 1977) interact and influence women's infant feeding experiences and outcomes both positively and negatively. Using a plant metaphor to visually represent the findings of this research emphasises the importance of health professionals identifying the 'hidden' factors which influence women's experiences and outcomes. This is because identifying how individual circumstances and context could influence infant feeding experiences and outcomes has the potential to facilitate the personalisation of infant feeding care which could have mitigated some of the effects of social disadvantage that were experienced by the women. Moreover, the visual metaphor illustrates what health professionals implementing the standards do well and to illustrate what a meaningful conversation looks like to highlight that it is possible for health professionals to positively influence infant feeding experiences.

This helps to reinforce what good practice is in relation to the implementation of the BFI standards which could be used to inform the BFI conversation guides for antenatal and postnatal conversations.

The visual metaphor also suggests that my findings have important implications for staff implementing the standards in relation to the importance of facilitating supportive relationships to personalise infant feeding care. Moreover, for women of a lower socio-economic status my meta-narratives highlighted how a supportive relationship was essential to overcome disparities in relation to inequitable access. Whilst the current evidence for the BFI standards (Entwistle, 2013) identifies that women value health professionals who build relationships with them, the meta-narratives suggest that the importance of personalised, relationship-based care should be made more explicit in the standards to increase women's infant feeding capabilities. This finding supports and builds on the results of my systematic review which identifies the ways in which infant feeding messages can be communicated by health professionals equitably to prioritise connections and illustrates the barriers women face. However, organisations need to be sufficiently resourced to provide the care that women need. Therefore, for my recommendations to be implemented in practice the current resource constraints (see section 9.4) need to be recognised. Moreover, this research suggests that an assets-based approach to care which uses a public health approach rather than an approach which focuses on commissioning priorities could promote positive infant feeding outcomes and experiences and reduce inequalities.

Using a longitudinal approach in this study both provided the opportunity to consider the women's experiences in their entirety and identify how wider contextual factors influence women's experiences and outcomes. However, the BFI standards have been designed to be service specific. Therefore, I have suggested adding 'to protect and support breastfeeding in all aspects of the service and enable mothers to continue breastfeeding for as long as they wish' to the antenatal standards for midwifery care. This recommendation could provide all health professionals with the opportunity to facilitate conversations throughout a woman's infant feeding journey to consider infant feeding in relation to the reality of women's lives.

Finally, this has been the first study to use a OneNote notebook to explore women's infant feeding experiences. The OneNote notebook has provided a useful tool to capture real-time information about women's actual experience of infant feeding care provided by UNICEF UK BFI Gold accredited health services over the course of their infant feeding journey. An implication of this is the possibility that organisations implementing the revised UNICEF UK BFI standards in practice may find the OneNote notebook an effective way of obtaining feedback from women and evaluating Baby Friendly care.

9.8 Conclusions

My study achieved its aims of understanding how a diverse sample of women from experience infant feeding care from UNICEF UK BFI Gold accredited health services and whether there are any variations in experience amongst women from different socioeconomic backgrounds.

Women who participated in this research experienced disparities in experience related to their socio-economic status. These disparities included an inability to understand and retain information, being self-employed with a limited maternity leave and a lack of practical and emotional resource. However, the meta-narratives provided evidence to suggest that meaningful conversations which focus on identifying the resources women have available to them and the disparities experienced by women of a lower socio-economic status face could potentially mitigate some of the consequences of social disadvantage and promote equitable access to infant feeding care.

The longitudinal narrative approach used in this research contributed to the strength of this study. Involving both public advisors with lived experience and an advisory group with experience of leading on the revised BFI standards enhanced the confirmability and dependability of my results.

The visual metaphor that has been created to visually represent the findings could provide a useful way to help health professionals implementing the standards to understand the importance of developing supportive relationships and of understanding women's individual circumstances to personalise care accordingly. However, the challenges in implementing the standards and health professional's capacity to have the time to develop supportive relationships and facilitate meaningful conversations in the current context of underfunded maternity and public health services is acknowledged.

It is hoped that the findings from this study could be used by organisations when embedding the standards to improve care and reduce any inequalities mothers and babies experience when accessing infant feeding care in the future.

9.9 Concluding reflection.

Although I have wanted to undertake a PhD since my undergraduate days and obtaining a NIHR studentship felt like I had won the lottery, at times undertaking a PhD has pushed me to my limits. I have had to draw on my resilience and remind myself that I can and will complete this. As a health visitor and International Board-Certified Lactation Consultant (IBCLC) I valued having my own 'caseload' of research participants that I could build relationships with over the course of my research. I felt privileged to share their infant feeding journeys, an experience I will always remember. I also feel more positive about helping women, irrespective of their socio-economic background to meet their personal infant feeding goals. I have appreciated the input from both my public advisors and advisory group from the outset. I valued the way my public advisors were happy to participate in ongoing reflection and discussion about their involvement and role in this research. I believe we were able to develop meaningful and trusted relationships which enabled my public advisors to be both honest and able to challenge me when necessary.

Additional reflexivity meetings were essential when my participants faced complex infant feeding issues and I found it challenging to remain in my role as researcher. Despite these difficulties, I felt pleased that the women who participated in the study

felt positive about taking part and had valued the opportunity to think about the conversations they had had with health professionals as well as contribute to a study that might help others. One participant, Catherine commented:

“I kind of think it has made me more mindful of what I have been told, reminded me of things that people have said, so yeah, I do think it kind of enhanced the experience and it’s not just been a research project” (Catherine, Interview four, six months postnatal)

As a health visitor I felt sad when hearing how the service had eroded and there were reduced opportunities for women to receive information and care, particularly in relation to introducing solid food. However, through this research I have learnt more about health inequalities and the way in which services could provide care which is both equitable and effective.

My ability to influence the way in which health visitors implement the BFI standards has evolved since I started this research. Whilst I had only just started as a lecturer at the University of Lancashire shortly after starting my PhD, I am now the Health Visiting Lead for BFI at the University and in September 2023, became a full-time lecturer on the SCPHN course. I believe these roles have provided me with an excellent opportunity to both educate the health visitors of the future on the importance of relationship-based care that is personalised to women’s individual circumstances. I remain committed to giving every child the best possible start in life across all socio-economic groups and welcome opportunities to identify ways of

facilitating equitable infant feeding care for all mothers, babies, and families in the future.

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Appendix 1: The 'Ten Steps' to Successful Breastfeeding

1. Have a written breastfeeding policy that is routinely communicated to all healthcare staff.
2. Train all healthcare staff in the skills necessary to implement the breastfeeding policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.
4. Help mothers initiate breastfeeding soon after birth.
5. Show mothers how to breastfeed and how to maintain lactation even if they are separated from their babies.
6. Give newborn infants no food or drink other than breast milk, unless medically indicated.
7. Practice rooming-in, allowing mothers and infants to remain together 24 hours a day.
8. Encourage breastfeeding on demand.
9. Give no artificial teats or dummies to breastfeeding infants.
10. Identify sources of national and local support for breastfeeding and ensure that mothers know how to access these prior to discharge from hospital.

Appendix 2: The 'Seven Point Plan'

1. Have a written breastfeeding policy that is routinely communicated to all healthcare staff.
2. Train all staff involved in the care of mothers and babies in the skills necessary to implement the policy.
3. Inform all pregnant women about the benefits and management of breastfeeding.
4. Support mothers to initiate and maintain breastfeeding.
5. Encourage exclusive and continued breastfeeding, with appropriately timed introduction of complementary foods.
6. Provide a welcoming atmosphere for breastfeeding families.
7. Promote co-operation between healthcare staff, breastfeeding support groups and the local community.

Appendix 3: Health Inequalities Assessment Tool (HIAT)

Mapping inequalities related to your research

- What is the problem you plan to address, and which dimensions of social and health inequalities are relevant?
- What are the root causes of those inequalities beyond possible behavioural / lifestyle factors? Have you considered how they intersect?
- How have you involved members of the public and stakeholders in helping you identify the problem you want to tackle and the relevant dimensions of inequalities.

Designing and conducting research sensitive to inequalities

- Will your study design, data collection, and analytical methods enable you to capture the structural causes of inequalities and identify any differential impacts and experiences?
- How have you involved members of the public and other stakeholders in shaping the study design and in analysing and interpreting the data?

Prioritising findings relevant to action on inequalities in reporting and dissemination

- What are the most effective ways you can share your findings relevant to understanding and/or reducing health inequalities? Which audiences should you target and why?
- Have you considered whether your research findings and their dissemination could inadvertently contribute negatively to inequalities and how this could be avoided?
- How have you involved members of the public and other stakeholders in planning and disseminating your findings?

Principles and practice in equity sensitive research

- Have you considered whether you may be making implicit assumptions or have implicit biases that influence your research? How might you mitigate against these?
- Are the involvement processes in your work transparent to the members of the public and other stakeholders involved and is there a feedback/complaints process set up?

Appendix 4: Quality assessment

Paper	Are the aims clear?	Are the participants appropriate for the research question?	Is the design appropriate?	Is the method appropriate?	Is the sample size and sampling justified?	Does data analysis fit with the methodology?	Is Reflexivity present?	Is the study ethical? Conflict of interest? Funding information provided?	Does the data justify the findings?	Is the context described sufficiently?	Sufficient Evidence of rigour?	Quality grade
Hoddinott & Pill (2000)	Yes	Yes	Yes	Yes	Yes	Yes	Yes However, influence on recruitment discussed elsewhere	Yes No detail about consent process No Yes	Yes. However, data in tables.	No. Only detail provided is deprived inner London Health Authority	Yes	C
Dykes (2005)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes No Yes	Yes	Yes	Yes	A
Hauck et al. (2009)	Yes	Yes	Yes, but no theoretical framework discussed	Yes	Yes	Yes	No	Yes No Yes	Yes	Yes	Yes	B
Heinig et al. (2009)	Yes	Yes	Yes, but no theoretical framework discussed	Yes	Yes	Yes	No	Yes No No	Yes	Yes	Yes	B
Hoddinott et al. (2012)	Yes	Yes	Yes, but no theoretical framework discussed	Yes	Yes	Yes	No	Yes No Yes	Yes	No	Yes	B
Junteral & Spatz (2019)	Yes	Yes	Yes, but no theoretical framework discussed	Yes	Yes	Yes	No	Yes No Yes	Yes	No but authors did acknowledge	Yes	B
Raisler (2000)	Yes	Yes	Yes, but no information about theoretical perspective	Yes	Yes	Yes	Only identified researcher was a midwife. No	Yes No Yes	Yes	Yes but no table of specific demographic information	Yes	B
Wandel et al. (2016)	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	B

								No conflict of interest declared				
Andrews et al. (2021)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes No Yes	Yes	Yes	Yes	A
Bookhart et al. (2021)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes No Yes	Yes	Yes	Yes	A
Burns et al. (2015)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes No Yes	Yes	Yes	Yes	A
Burns et al. (2013)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes No Yes	Yes	Yes	Yes	A
Burns & Schmied (2017).	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes No Yes	Yes	Yes, but limited information	Yes	B
Rossiter (1998)	Yes	Yes	Yes	Yes	Yes	Yes	No but limitations of researcher only being able to speak English noted.	Yes No Yes	Yes	Yes but no table of specific demographic information	Yes	B
Simmons (2002)	No	Yes	Yes, but no theoretical framework discussed	Yes	Yes	Yes	No	Yes No Yes	Yes, but results discussed briefly	Yes	No	D
Fahlquist (2016)	Yes	Yes	Yes, but no information about theoretical perspective	No – used online surveys	No	Yes	No	No ethical approval No Yes	Yes	No	No	D
Coreil et al. (1995)	No	Yes	Limited information	Yes	Yes	Yes	No	No No Yes	Yes	Specific demographic information not provided	No	D

Appendix 5: Category descriptions

L1 Employers in large organisations – people who employ others and delegate managerial functions to salaried staff.

L2 Higher managerial and administrative occupations – positions where there is a service relationship with the employer and involves general planning and supervision of operations on behalf of the employer.

L3 Higher professional occupations - positions that cover all types of higher professional work.

L4 Lower professional and higher technical occupations – positions that cover lower professional and higher technical occupations.

L5 Lower managerial and administrative occupations – employees who plan and supervise operations on behalf of the employer under the supervision of senior managers.

L6 Higher supervisory occupations – positions that involve formal supervision of others.

L7 Intermediate occupations – positions in clerical, sales, service, or intermediate technical occupations.

L8 Employers in small organisations – non-professional and agriculture.

L9 Own account workers – self-employed positions in which people are employed in any trade.

L10 Lower Supervisory occupations - positions with a modified form of labour contract and involve formal and immediate supervision of others engaged in such occupations.

L11 Lower technical occupations – positions in which employees are engaged in lower technical and related occupations.

L12 Semi-routine occupations – employees are engaged in semi-routine occupations.

L13 Routine occupations – employees are engaged in routine occupations – routine sales and service occupations, routine production occupations, routine technical occupations, routine operative occupations, routine agricultural occupations.

L14 Never worked and long-term unemployed.

Appendix 6: Demographic questions

How old are you?

18-24 years old / 25-34 years old / 35-44 years old/ 45-54 years old.

Who do you live with?

How many adults?

How many children?

How would you describe your ethnicity?

White / Mixed or Multiple ethnic groups

Asian or Asian British

Black, Black British, Caribbean or African Caribbean

Another ethnic group.

Have you done any paid work in the last twelve months? Yes/No

If not, have you ever had any paid work?

If yes, are you employed or self-employed?

Do you work full time or part time?

What is your job title?

Do any other adults that you live with have paid work?

What is your total household income?

Between £8,000 and £14,000 a year

Between £15,000 and £25,000 a year

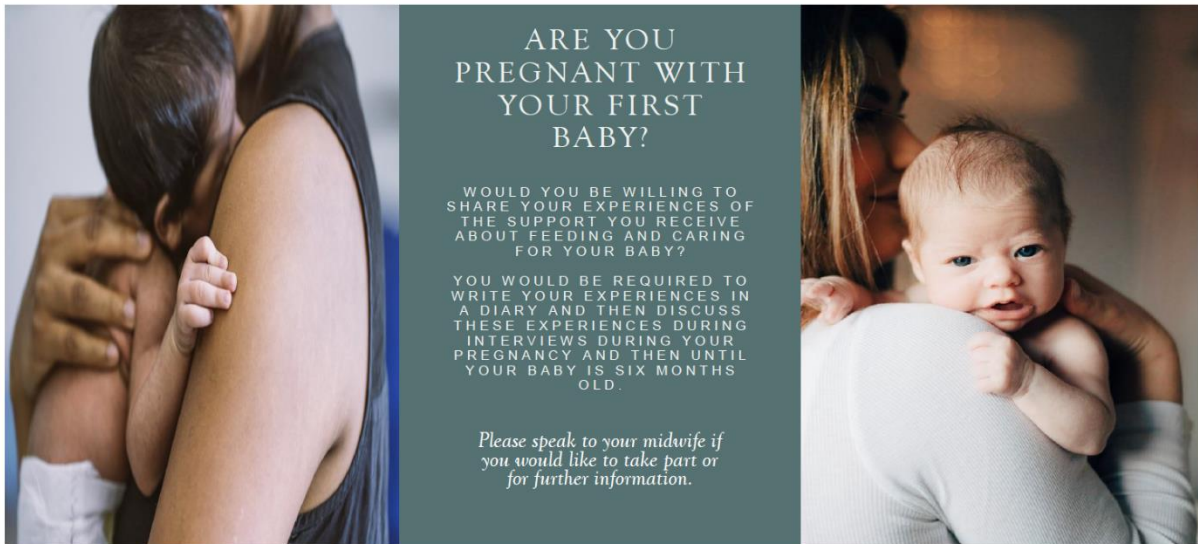
Between £26, 000 and £37,000 a year

Between £38, 000 and £49, 000 a year

Over £50, 000 a year.

Are you currently claiming Universal Credits? Yes/No

Appendix 7: Information flyer



The flyer features a central teal text box flanked by two photographs. The left photo shows a woman in a dark tank top being embraced from behind by a man. The right photo shows a woman in a light grey top holding a baby. The text in the center is white and reads:

**ARE YOU
PREGNANT WITH
YOUR FIRST
BABY?**

WOULD YOU BE WILLING TO
SHARE YOUR EXPERIENCES OF
THE SUPPORT YOU RECEIVE
ABOUT FEEDING AND CARING
FOR YOUR BABY?

YOU WOULD BE REQUIRED TO
WRITE YOUR EXPERIENCES IN
A DIARY AND THEN DISCUSS
THESE EXPERIENCES DURING
INTERVIEWS DURING YOUR
PREGNANCY AND THEN UNTIL
YOUR BABY IS SIX MONTHS
OLD.

*Please speak to your midwife if
you would like to take part or
for further information.*

Information Flyer Version 1.0 13/08/21. IRAS Number: 298819
This research is being undertaken as part of a PhD qualification and has ethics approval from the HRA and HCRW

Appendix 8: Recruitment poster



Version 1.0 IRAS Number 298819

This research is being undertaken as part of a PhD and has ethics approval from the HRA.



Are You Pregnant with your First Baby?



Would you be willing to share your experiences of the support you receive?

You would be asked to share your experiences in a diary and then discuss during interviews. Shopping vouchers will be given as a thank you for your time.

For more information contact Pippa Atkinson. Telephone/text 07375 639845 or email patkinson4@uclan.ac.uk



You can also scan this QR code to find out more

Pippa Atkinson
Tel: 07375 639845

Pippa Atkinson
Tel: 07375 639845

Pippa Atkinson
Tel: 07375 639845

Pippa Atkinson
Tel: 07375 639845

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Pippa Atkinson
Tel: 07375 639845

Pippa Atkinson
Tel: 07375 639845

Appendix 9: Social media advert

Experiences of the revised Baby Friendly Initiative standards.

Research study to find out women's experiences of the support they have received in relation to feeding and caring for their baby from pregnancy until six months after birth.

If you are pregnant with your first baby, having your maternity care at East Lancashire Hospitals Trust and are interested in taking part in this research please complete this online survey https://uclan.eu.qualtrics.com/jfe/form/SV_5inrLLwygg81vcW

If you would like more information about the study, please contact Pippa Atkinson patkinson4@uclan.ac.uk

Shopping vouchers will be given as a thank you for your time.

This research is being undertaken as part of a PhD qualification at the University of Central Lancashire and has ethics approval from the HRA and HCRW

Appendix 10: Screen shot of Facebook page.

The screenshot shows a mobile phone interface at the top with signal strength, 'EE WiFiCall', time '14:36', and battery '56%'. Below is a search bar containing 'Capturing Infant Feedin...' and a settings gear icon. A navigation bar includes 'Home', 'Services', 'Shop', 'Offers', and 'Photos'. The main content area features a post from 'Capturing Infant Feeding Journeys East Lancashire' dated '27 Feb'. The post text reads: 'Experiences of the revised Baby Friendly Initiative standards. Research study to find out women's experiences of the support they have received in relation to feeding and caring for their baby from pregnancy until six months after birth. If you are pregnant with your first baby, having your maternity care at East Lancashire Hospitals Trust and are interested in taking part in this research please complete this online survey https://uclan.eu.qualtrics.com/jfe/form/SV_5inrLLwygg81vcW'. Below the text is a promotional image for the survey, featuring a woman holding a baby and the University of Central Lancashire (UCLan) logo. The image text asks: 'Are you pregnant with your first baby? Having your maternity care at East Lancashire Hospitals Trust?'. At the bottom is a navigation bar with icons for Home, Marketplace, Groups, Pages, Notifications, and Menu (with a red notification badge).

Appendix 11: Diary guide



Diary Guide

You may find the following helps you to think about your appointment with your midwife/health visitor/professional providing your care.

What did you discuss about feeding and caring for your baby?

How did you feel?

Why do you think you felt this way?

Has this appointment influenced the way you will feed and care for your baby?

Appendix 12: Tips sheet

Tips for Completing Diary Entries

Find a way that suits you

Keep your notebook/phone close to you. Use it when you have a quiet moment. Some people find a regular time in the day that works for them like first thing in the morning or before bed.

Use the [instruction sheet](#) to find out the various options available for recording your experiences.

Use the [diary guide](#) to help you record and think about your experiences.

You may also find the following helpful:

Write freely. Writing or speaking the first thing that comes into your mind

Make a list. List your thoughts, feelings or describe what happened using bullet points.

Tell a story. Create a story based on your experiences.

Think about how you felt

Think about the conversations you had, the words that were spoken, memories that you have created.

You can record positive or negative experiences and memories or personal challenges and achievements

Be as creative as you would like

If you would like to you can add drawings or pictures to your diary.

You don't have to be an artist to do this.

This guide has been adapted from Maternal Journal's Top Tips with kind permission.

There are lots of other free resources on the Maternal Journal website

<https://www.maternaljournal.org> that you may also like to use

Appendix 13: Step by step instructions



Instruction Sheet

Find a way to record and think about your experiences that suits you. There are various ways you can document your thoughts and feelings in your diary.

To **type** in your diary:

Open the diary section you would like to write in. You will need to use the password you have been sent to open this.

Choose which untitled page you would like to write on.



Use this button to add further untitled pages:

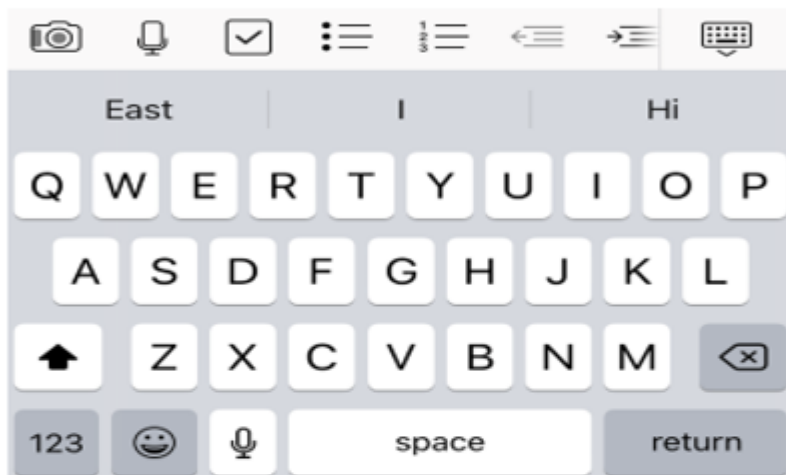




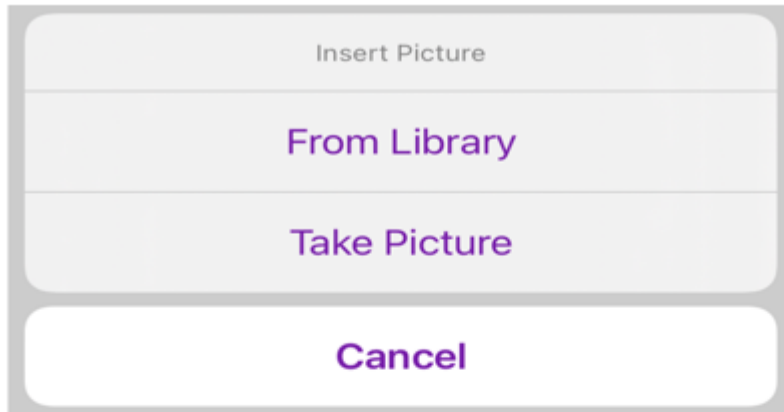
Press anywhere on the page to bring up the keyboard which will enable you to type on the page.

Above the keyboard you will see symbols for a microphone and for a camera.

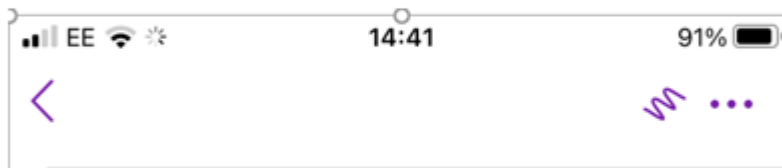
To record your voice press on the microphone:



To insert/take a photo of a drawing or a written diary entry press on the camera. Once you have pressed on the camera you will see the box below which will give you the option of inserting a picture from your library on your phone or enable you to take a photo.



If you would like to **draw a picture** in your diary press the wavy line (shown below):



Appendix 14: Approval letter



Dr Nicola Crossland
University of Central Lancashire
Preston
PR1 2HEN/A



Email: approvals@hra.nhs.uk

13 August 2021

Dear Dr Crossland,

**HRA and Health and Care
Research Wales (HCRW)
Approval Letter**

Study title: How the revised UNICEF UK Baby Friendly Initiative (BFI) standards influence the experiences of women from different socio-economic backgrounds.

IRAS project ID: 298819

Protocol number: Not applicable

REC reference: 21/NE/0160

Sponsor: University of Central Lancashire

I am pleased to confirm that [HRA and Health and Care Research Wales \(HCRW\) Approval](#) has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?

HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Please see [IRAS Help](#) for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?

HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to [obtain local agreement](#) in accordance with their procedures.

What are my notification responsibilities during the study?

The standard conditions document “[After Ethical Review – guidance for sponsors and investigators](#)”, issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The [HRA website](#) also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

Who should I contact for further information?

Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **298819**. Please quote this on all correspondence.

Yours sincerely,
Chris King

Approvals Specialist

Email: approvals@hra.nhs.uk

Copy to: Professor St John Crean, Sponsor's Representative

List of Documents

The final document set assessed and approved by HRA and HCRW Approval is listed below.

<i>Document</i>	<i>Version</i>	<i>Date</i>
Copies of materials calling attention of potential participants to the research [Information Flyer]	0.1	10 May 2021
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Insurance Certificate]	0.1	21 May 2021
Interview schedules or topic guides for participants [Diary Guide]	0.1	10 May 2021
IRAS Application Form [IRAS_Form_28072021]		28 July 2021
Organisation Information Document [Organisation Information Document]	0.1	15 June 2021
Other [Agreement to contact form]	0.2	07 July 2021
Other [Instruction sheet]	0.1	10 May 2021
Other [Tips for completing diary entries]	0.1	10 May 2021
Other [Demographic Information Question Sheet]	0.1	21 May 2021
Other [Response to conditions]	0.1	12 August 2021
Participant consent form [Consent Form]	0.1	24 February 2021
Participant information sheet (PIS) [Participant Information Sheet]	0.4	07 July 2021
Research protocol or project proposal [Research protocol]	0.3	06 July 2021
Schedule of Events or SoECAT [Schedule of Events]	0.1	15 June 2021
Summary CV for Chief Investigator (CI) [Nicola Crossland CV]	0.1	21 May 2021
Summary CV for student [Student CV]	0.1	07 July 2021
Summary CV for supervisor (student research) [Gill Thomson CV]	0.1	21 May 2021
Summary CV for supervisor (student research) [Anna Byrom CV]	0.1	07 July 2021
Summary CV for supervisor (student research) [Nicola Crossland CV]	0.1	21 May 2021

Appendix 15: Substantial amendment approval letter



North East - Tyne & Wear South Research Ethics Committee

NHSBT Newcastle Blood Donor Centre
Holland Drive
Newcastle upon Tyne
NE2 4NQ

Please note: This is the favourable opinion of the REC only and does not allow the amendment to be implemented at NHS sites in England until the outcome of the HRA assessment has been confirmed.

26 January 2022



Dear Ms Atkinson

Study title: How the revised UNICEF UK Baby Friendly Initiative (BFI) standards influence the experiences of women from different socio-economic backgrounds.
REC reference: 21/NE/0160
Protocol number: Not applicable
Amendment number: Substantial Amendment 1
Amendment date: 22 December 2021
IRAS project ID: 298819

The above amendment was reviewed by the Sub-Committee in correspondence.

Ethical opinion: Favourable Opinion

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

Approved documents

The documents reviewed and approved at the meeting were:

Document	Version	Date
Completed Amendment Tool [Amendment Tool]	1	22 December 2021
Copies of advertisement materials for research participants [Information Flyer (with comments)]	1.1	21 December 2021

Copies of materials calling attention of potential participants to the research [Wording for qualtrix]	0.1	21 December 2021
Copies of materials calling attention of potential participants to the research [Poster]	0.1	21 December 2021
Copies of materials calling attention of potential participants to the research [Advert for Social Media]	0.1	21 December 2021
Copies of materials calling attention of potential participants to the research [Text for Social Media Advert]	0.1	23 December 2021
Participant information sheet (PIS) [Participant Information Sheet]	1.1	21 December 2021
Participant information sheet (PIS) [Participant Information Sheet Tracked Changes]	1.1	21 December 2021

Membership of the Committee

The members of the Committee who took part in the review are listed on the attached sheet.

Working with NHS Care Organisations

Sponsors should ensure that they notify the R&D office for the relevant NHS care organisation of this amendment in line with the terms detailed in the categorisation email issued by the lead nation for the study.

Amendments related to COVID-19

We will update your research summary for the above study on the research summaries section of our website. During this public health emergency, it is vital that everyone can promptly identify all relevant research related to COVID-19 that is taking place globally. If you have not already done so, please register your study on a public registry as soon as possible and provide the HRA with the registration detail, which will be posted alongside other information relating to your project.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

HRA Learning

We are pleased to welcome researchers and research staff to our HRA Learning Events and online learning opportunities– see details at: <https://www.hra.nhs.uk/planning-and-improving-research/learning/>

IRAS Project ID - 298819:	Please quote this number on all correspondence
----------------------------------	---

Yours sincerely

PP.
Hayleigh Morris
Approvals Administrator

Mrs Debra J Lett
Chair

E-mail: tyneandwearsouth.rec@hra.nhs.uk

Appendix 16: Participant information sheet



Participant Information Sheet

Version 2.0 26/01/22

How the UNICEF UK Baby Friendly Initiative revised standards influence the experiences of mothers from different socio-economic backgrounds.

Thank you for taking the time to read this information sheet.

You are being invited to take part in a research study which will explore your thoughts and experiences about the support and information you will receive in relation to how you feed and care for your baby. Before you decide whether to take part, it is important that you understand why this research is being done and what taking part in this study will involve.

I (Pippa Atkinson) am the researcher for this study. I will be undertaking this research as part of a PhD qualification. The supervisors for my PhD are Nicola Crossland, Gill Thomson and Anna Byrom. I will be responsible for arranging the workshops for this study and for supporting participants to complete entries in their diaries. I will also be responsible for reviewing diary entries and undertaking the interviews. If you have any questions or would like further information, please contact me using the details provided on the last page of this information sheet.

What is the study about?

The UK Baby Friendly Initiative standards provide services and organisations with an opportunity to improve care for all babies, mothers, and their families

The aim of this study is to obtain detailed information from women about their experiences of being provided with infant feeding support (how they feed and care for their babies), from organisations that have been awarded Baby Friendly status.

This research aims to find out how the UK Baby Friendly Initiative standards make a difference to mothers. This study is particularly interested in understanding the experiences of women from different backgrounds to ensure appropriate support is available for all families.

Why have I been invited to take part?

We would like you to take part in this research because you are pregnant with your first baby and will be receiving antenatal and postnatal care from an organisation that has been awarded Baby Friendly status.

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What will the study involve?

You will be asked to record your thoughts and feelings about the information and support you have received about how to feed and care for your baby in a OneNote notebook during your pregnancy and then until you introduce your baby to solid foods (around 6 months after your baby has been born). You can either download the free OneNote app or access the OneNote notebook via an internet browser. You will have a choice as to whether you keep a written or audio diary. You will be asked to complete an entry after an appointment with your midwife, health visitor or other professional. We would like you to complete a minimum of four entries in your diary during this time, but you can write more than this if you wish to do so. You will be able to contact me if you have any questions or need any support with completing diary entries. You will also be invited to a workshop at the beginning of the study with other women also taking part in the study so that you can find out about the different ways you can record your experiences in your notebook.

The research team will be able to read the information you put in your diaries. You will have the opportunity to explore the thoughts and feelings you record in your notebook during interviews, two interviews before you have had your baby and two interviews after you have had your baby. These interviews can be undertaken either via video call online (Microsoft Teams) or by telephone. These interviews will be recorded if you are happy for me to do this, so that it will be easier for me to transcribe the conversation. However, I can take notes during these conversations if you would prefer. The interviews will be undertaken at a time and date to suit you and will last approximately 45 minutes each. You do not have to take part in both the interviews and diaries if you do not want to. You can just do the interviews if you would prefer this.

You will be invited to a second workshop towards the end of the study. This will give you the opportunity to discuss your experience of keeping a diary and to provide any further information that you think will be useful for the study.

Do I have to take part?

No - it is entirely up to you if you want to take part. If you do decide to take part, I will contact you to see if you have any questions before I ask you to give your verbal consent to take part in this study. I will obtain and record your verbal consent either during an online video call (Microsoft Teams) or during a telephone call. I will also check regularly that you are happy to continue to participate in the study. If you agree to take part in this study now, you can still change your mind at any point during the study without giving a reason and withdraw your consent to take part. Any data collected prior to this will be retained but no further data will be collected. During the interviews you also do not have to answer all the questions and can ask to stop the interview at any time.

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What are the benefits or risks to me of taking part?

There may not be any direct benefits to you of taking part. We hope that you may find it useful to think about your experiences and the information you give us will help us inform the infant feeding support that is provided to pregnant women and their babies in the future.

If you should experience any feeding difficulties or any discomfort (mental, emotional or physical) during the research I will signpost you to your Midwife/Health Visitor/Infant Feeding Team or other suitable local support service as appropriate.

We will speak to your care team if there are significant concerns about you or someone else's safety. We will take all possible steps to discuss this with you first, but ultimately, we have a duty of care to inform your care team of these concerns.

How will my data be used?

The University of Central Lancashire processes personal data as part of its research and teaching activities in accordance with the lawful basis of 'public task', and in accordance with the University's purpose of "advancing education, learning and research for the public benefit".

Under UK data protection legislation, the University acts as the Data Controller for personal data collected as part of the University's research. The University privacy notice for research participants can be found on the attached link https://www.uclan.ac.uk/data_protection/privacy-notice-research-participants.php

Further information on how your data will be used can be found in the table below:

How will my data be collected?	You will record your experiences in a OneNote notebook. You will be given a choice whether you write, or audio record your entries. You will also participate in interviews either via a video call (online via Microsoft Teams) or by telephone. The interviews will be recorded, with your agreement, so that it will be easier to transcribe the conversations. <u>Once interviews</u> have been transcribed, the recordings will be deleted.
How will my data be stored?	All information you provide will be kept confidential during and after the study. The personal details you provide will be kept <u>separate from other information you will</u>

Version 2.0 26/01/22. IRAS Number: 298819

	<p>provide (which cannot identify you). All information will be kept securely on the University of Central Lancashire's network in folders which are secure (password protected) and will only be available to the research team. You will have your own notebook on OneNote to use. The diary section of your notebook will be password protected.</p>
How long will my data be stored for?	<p>We are required to keep all primary data (which cannot identify you) for at least 5 years.</p>
What measures are in place to protect the security and confidentiality of my data?	<p>The research team has the responsibility to look after your personal data during the study.</p> <p>All information which is collected about you during this research will be kept strictly confidential and stored on the University of Central Lancashire's network which is password protected. The OneNote notebook you will use during this research will be stored on the University's One Drive for Business which is also password protected and encrypted. You will be provided with a password for the diary section of your notebook. The link to your diary and password will be emailed to you in separate emails.</p> <p>Once the study has finished your identifying details will be destroyed. All other data will be kept for at least 5 years. When the data is no longer required it will be disposed of securely.</p> <p>Should any member of the research team leave the University responsibility for the confidentiality of your information will be transferred to another member of the research team.</p> <p>We will not share your research data outside of the research team until it has been anonymised. Quotes from your diaries/interviews will be used in reports, publications, teaching and presentations, but we will remove identifying information so that you will not be identifiable.</p>
Will my data be anonymised?	<p>You will be given a unique number at the beginning of the study which will be used to link your personal details with the information you provide during the study. This will ensure the information you provide during the study is anonymised. When the interviews are transcribed any personal identifying information/names you provide will be removed. When we use any quotes from your diaries/interviews we will use your</p>

	unique number rather than your name or other identifying information.
How will my data be used?	Your contact details will be used, following the study, to share the results of the study with you. We will use anonymised quotes from the diaries and interviews in journal publications, teaching and presentations.
Who will have access to my data?	The research team (Nicola Crossland, Gill Thomson, Anna Byrom and I) have a responsibility to look after your personal data securely. Your personal data will not be shared with a data processor or any third-party organisations.
Will my data be archived for use in other research projects in the future?	The data from this research will not be archived for use in other research projects in the future.
How will my data be destroyed?	Your data will be disposed of securely when it is no longer required.

What will happen to the results of the study?

The results of the study will be published in professional journals or shared in conference presentations. You will not be identified in any report/publication.

If on completion of the study, you would like to receive a summary of the results of the study please let me know.

Expenses and / or payments

We will offer you a shopping voucher worth £10 at five points during the study to say thank you for taking part. A voucher can be given after each interview and after the workshop which will be held at the end of the study.

What do I do if I want to take part?

Please take time to read this information sheet carefully. I will contact you again to discuss with you whether you would like to be involved in the study and to answer any questions that you may have.

Who has reviewed this study?

Ethics approval for this study has been received from the HRA and HCRW.

What if I am unhappy or if there is a problem?

If you are unhappy, or if there is a problem at any point during the study, please feel free to let us know by contacting Nicola Crossland (my Director of Studies on ncrossland@uclan.ac.uk) and she will try to help. If you remain unhappy, or have a complaint which you feel you cannot come to us with, then please contact the Research Governance Unit at OfficerForEthics@uclan.ac.uk

The University of Lancashire strives to maintain the highest standards of rigour in the processing of your data. However, if you have any concerns about the way in which the University processes your personal data, it is important that you are aware of your right to lodge a complaint with the Information Commissioner's Office by calling 0303 123 1113.

Who can I contact if I have further questions?

Please contact me on patkinson4@uclan.ac.uk if you have any questions or would like further information about this study.

Contact details of research team:

Pippa Atkinson, PhD student, University of Central Lancashire patkinson4@uclan.ac.uk
Dr Nicola Crossland, Director of Studies, University of Central Lancashire
ncrossland@uclan.ac.uk
Dr Gill Thomson, PhD Supervisor, University of Central Lancashire gthomson@uclan.ac.uk
Dr Anna Byrom, PhD Supervisor, University of Central Lancashire abyrom@uclan.ac.uk

Appendix 17: Consent form



Participant Consent Form

Version 2.0 26th January 2022

IRAS project ID number: 298819

Participant Identification Number for this study: XX

Title of Project: How the UNICEF UK Baby Friendly Initiative revised standards influence the experiences of mothers from different socio-economic backgrounds.

Your verbal consent to take part in the study will be recorded once all the statements below have been read out to you.

The researcher will also initial each statement to record your consent.

1. I confirm that I have read and have understood the information sheet dated, 26th January 2022 (version 2.0) for the above study, or it has been read to me. I have had the opportunity to consider the information and ask any questions that I may have and have had these answered satisfactorily.
2. I understand that my participation is voluntary, and it is up to me whether I take part or not.
3. I understand that taking part in the study involves taking part in interviews. I am happy to take part in the interviews and for these to be recorded.
4. I understand that a OneNote notebook will be available to me to record my thoughts and feelings during the study. I am happy to record my thoughts and feelings in the notebook.
5. I understand I am free to stop taking part in the study at any time without giving any reason. In addition, I understand that I do not have to answer all the questions in the interviews, and may stop the interview at any time, without giving a reason.
6. I understand that if I withdraw from this study data collected prior to my withdrawal will be retained but no further data will be collected.
7. I understand that quotes from the diaries and interviews will be used in reports, publications, teaching and presentations, but that identifying information will be removed. I am happy for quotes to be used.

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8. I understand that the recording of consent, diary entries and recordings and transcripts of the interviews will be held securely in line with data protection requirements at the University of Central Lancashire. I understand that personal information collected about me that can identify me, such as my name or where I live, will not be shared beyond the study team.

9. I agree to take part in the above study and give my verbal consent.

Verbal consent obtained and recorded on xx/xx/202x at 0.00pm by researcher.

Statement to be completed by the researcher taking consent:

I have accurately read out the information sheet to the potential participant and, to the best of my ability, ensured that the participant understands to what they are consenting.

Name of researcher

Date

Signature

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Appendix 18: Table with rationale for the decisions made in Tables 21 and 22

Meta-narrative	Antenatal Care Standard
An insurmountable level of challenge	<p>No data to suggest conversations for either Michelle or Ashleigh considered how the women’s individual circumstances (such as available resources (employment status, mental health issues, relationship status, ability to access information) would influence ability to breastfeed.</p> <p>Women struggled to understand and retain digital written information. Difficulties accessing information on app.</p> <p>Both women appeared to receive a lack of information about realities/challenges/practicalities of breastfeeding. Information focused on colostrum harvesting and the benefits of breastfeeding. Data suggested a lack of continuity of care postnatally for both Ashleigh and Michelle and antenatally for Michelle.</p>
Too many missed opportunities to identify needs.	<p>No data to suggest conversations considered the women’s individual circumstances such as vicarious experiences and ability to access support.</p> <p>Irene – not able to drive. Isabella could pay to attend antenatal class.</p> <p>Data suggests that Isabella was unable to establish relationships with her health professionals or Irene’s relationship with health professionals was eroded postnatally when trust/confidence in health professional lost.</p> <p>Data suggests a lack of helpful conversations about infant feeding. Isabella reported she had no conversations. For Irene conversations appeared to focus on the benefits of breastfeeding rather than the practicalities and realities which she would need postnatally.</p> <p>Data suggests employment status/income influenced ability to access information.</p> <p>Charlotte - working full time and ability to prepare for breastfeeding.</p> <p>Catherine’s small phone and limited Wi-Fi (beginning of study) made it harder to access resources. Online antenatal classes important for fitting around life.</p>
Having the resources that matter	<p>Louise was able to pay to attend antenatal class.</p>

Tipping the balance to positive	Data suggests that antenatal conversations enabled Anna to identify feeding cues and provided information about postnatal support. However, did not provide information about the challenges she would face. Health professional appeared to involve partner in conversations. Antenatal information (especially leaflets) appeared helpful postnatally.
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Meta-narrative	Support parents to have a close and loving relationship with their baby.
An insurmountable level of challenge	Data suggests for Ashleigh skin to skin contact discussion facilitated skin-to-skin throughout postnatal period.
Too many missed opportunities to identify needs	Irene felt she discussed skin to skin antenatally and had skin to skin post birth as she had planned. Data suggests Charlotte's skin to skin contact discussion facilitated skin-to-skin throughout postnatal period. Both she and her wife had skin to skin post birth.
Having the resources that matter	Data suggests that health professionals did not talk about responsive parenting when she asked about routines.
Tipping the balance to positive	Conversations appeared to enable Anna to identify infant feeding cues.

Meta-narrative	Support all mothers to feed soon after birth and get breastfeeding off to a good start.
An insurmountable level of challenge	Data suggests a lack of assessments prevented challenges from being identified.
Too many missed opportunities to identify needs	Irene felt she received help to latch after birth and midwife checked her son was feeding well. Irene felt she received help from midwife with

	<p>positioning and attachment when she had sore nipples which enabled effective breastfeeding.</p> <p>Isabella felt the postnatal ward was too busy and she did not receive the help she needed. Data suggests a delay in the identification of challenges due to a lack of assessment. Data suggests mother-in-law identified baby's lack of tongue function.</p> <p>Catherine felt she received support to breastfeed and express breastmilk in hospital.</p>
Having the resources that matter	Louise felt that being reminded of the CHIN acronym useful.
Tipping the balance to positive	<p>Data suggests Anna was helped and taught how to feed and properly latch on.</p> <p>Anna felt she had the necessary information to feed on own.</p> <p>Data suggests her feeding difficulties were resolved quickly, despite disappointing experience with FAB team.</p> <p>Data suggests FAB team were not supportive with expressing.</p> <p>Anna felt she had a supportive midwife and was given helpful suggestions (including in relation to expressing)</p>

Meta-narrative	Enable mothers to continue to breastfeed for as long as they wish
An insurmountable level of challenge.	<p>Data suggests Michelle's feeding issues were not resolved which led to feelings of blame. Michelle reported a limited time to breastfeed when back at work/unable to breastfeed for as long as wanted/limited maternity leave.</p> <p>Data suggests a lack of appropriate care led to the unwanted introduction of formula.</p> <p>Data suggests that health professionals did not appear to recognise the severity of Ashleigh's mental health issues and identify the help she would need to breastfeed longer-term.</p>

<p>Too many missed opportunities to identify needs.</p>	<p>Data suggests for Isabella a delay in referral for specialist help reduced her ability to breastfeed/ led to cessation.</p> <p>Irene reported she introduced formula at 17 weeks after her mother told her that her son would sleep better. She wished that she had been given information about combination feeding as this 'killed' her milk supply.</p> <p>Irene felt that she would need to pay to access support postnatally. Irene was unable to drive to access groups for support.</p> <p>Catherine and Charlotte would have liked to have breastfed for longer.</p> <p>Catherine felt her unrealistic feeding plan made it harder to continue to breastfeed.</p> <p>Data suggests that Catherine's self-employment status and limited maternity leave was a barrier to breastfeeding.</p> <p>Data suggests Catherine did not receive the infant feeding help she needed after her daughter's tongue tie was cut.</p>
<p>Finding the resources that matter</p>	<p>Data suggests health professionals checked breastfeeding going well.</p> <p>Louise felt that checking the number of wet and dirty nappies helped to confirm breastfeeding was going well.</p>
<p>Tipping the balance to positive</p>	<p>Anna felt she had an overall positive experience and received timely and appropriate care.</p> <p>Data suggests that her health visitor checking baby was feeding well, being watched feeding, and given tips was helpful.</p> <p>Anna felt that everyone had checked that everything was okay and whether she needed any support.</p>

<p>Meta-narrative</p>	<p>Support to make informed decisions regarding the introduction of foods or fluids other than breastmilk. Includes introducing solid foods.</p>
<p>An insurmountable level of challenge</p>	<p>Data suggests Michelle received a lack of information about formula feeding.</p> <p>Data suggests Michelle received insufficient information about the timing of the introduction of solid food which led to uncertainty about current guidance.</p>

	Data suggests that Ashleigh's mental health issues meant that she was unable to access group support for introducing solid food which was provided online.
Too many opportunities to identify needs.	<p>Neither Irene nor Isabella felt they received information about introducing their babies to solid foods.</p> <p>Data suggests that they both wanted tailored information and guidance to navigate the introduction of solid foods/know when their baby was ready.</p> <p>Data suggests Charlotte received a lack of information about formula feeding when she started combination feeding. Charlotte felt health professionals lacked appreciation of her baby as an individual.</p>
Having the resources that matter	Data suggests that Louise was provided with information about introducing solid foods too early.
Tipping the balance to positive	<p>Anna felt she received sufficient information about introducing her baby to solid food without being overloaded.</p> <p>She attended a pre-recorded weaning session which she felt provided her with timely and helpful information.</p> <p>Anna introduced solids at 5.5 months.</p>