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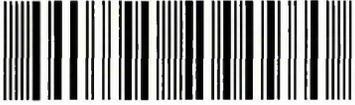
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Breastfeeding Peer Counsellors' Reflections on their Support Role in a Northern Town

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Contents

Abstract

This research study seeks to explore the personal reflections of mothers who had chosen to support other mothers to breastfeed in a northern town where the local tradition was one of bottle feeding. These mothers had made this commitment because they felt they had not received adequate breastfeeding support with their own babies. The project was based upon the favorable evidence that demonstrated the positive benefits of local mothers providing one to one breastfeeding support for women from disadvantaged groups.

A focus group consisting of seven breastfeeding peer counsellor mothers, using a semi structured interview schedule, enabled them to share their personal reflections on their experiences of becoming and being a breastfeeding peer counsellor. The data was analysed using principles of grounded theory and voice centered relational method (VCRM).

This study identified how these peer counsellors felt that they had a crucial role in reversing negative attitudes towards breastfeeding and examined the challenges of supporting women to breastfeed, as well as bridging the gap between health professionals and their community and discusses the different approaches of how mothers are supported to breastfeed.

Glossary

Association of Breastfeeding Mothers (ABM): A charity run by mothers for mothers, committed to giving support and supplying accurate information to all women wishing to breastfeed.

Breastfeeding Counsellors[1]: Women who have themselves breastfed and who have completed an accredited training with one of the four recognised UK volunteer organisations, namely, National Childbirth Trust (NCT), La Leche League (LLL), Breastfeeding Network (BfN), and Association of Breastfeeding Mothers (ABM). This training equips counselors with listening and counseling skills in line with counseling ethics to provide mother-centered support to breastfeeding women. Breastfeeding counselors fulfill a range of support and advocacy roles including breastfeeding counseling support to mothers, training of peer supporters and health professionals, and political lobbying to promote and protect breastfeeding.

Breastfeeding drop in: A place where mothers can go and receive support and information from skilled breastfeeding supporters and health professionals and is set in the community.

Breastfeeding Network (BfN): The Breastfeeding Network (BfN) aims to be an independent source of support and information for breastfeeding women and others. It aims to: promote breastfeeding and a greater understanding thereof in the United Kingdom, collect and disseminate information on breastfeeding and baby and infant nutrition, provide information and support to parents on the feeding of babies and infants, set, and encourage the acceptance of quality standards for breastfeeding support, and establish and publish codes of practice for such support. It is principally composed of mothers.

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[1] The American La Leche League spelling of 'counselor' however the UK La Leche League have adopted the English spelling of 'counsellor'.

Breastfeeding peer support: Support offered by women who have themselves breastfed, who are usually from similar socio-economic backgrounds and locality to the women they are supporting, and who have received minimal training to support breastfeeding women. Peer supporters may provide breastfeeding support services voluntarily.

Community Enablement: Enabling members of a community to be responsible for their own health.

Initiation of breastfeeding: The mother is defined as having initiated breastfeeding if, within the first 48 hours of birth, either she puts the baby to the breast or the baby is given any of the mother's breast milk (Department of Health).

La Leche League (LLL): La Leche League International strives to help mothers worldwide to breastfeed through mother-to-mother support, encouragement, information, and education, and to promote a better understanding of breastfeeding as an important element in the healthy development of the baby and mother. La Leche League GB works across the UK.

National Childbirth Trust (NCT): The NCT is UK's leading charity for parents. They support people through the life changing experience of pregnancy, birth and early parenthood. They provide breastfeeding counselors who are experienced in breastfeeding and trained to enable them to support and help new mothers to breastfeed. They can help with any difficulties with feeding babies, and can also listen to any worries and anxieties about breastfeeding.

Public health: The mission of public health is to "fulfill society's interest in assuring conditions in which people can be healthy" (Institute of Medicine, 1988).

Social Capital: Refers to the internal social and cultural coherence of society.

Sure Start: Sure Start is a government programme, which aims to achieve better outcomes for children, parents and communities by providing early education, childcare and health and family support.

Silo: Fragmentation of care, which occurs even within institutions. Care is often discontinuous, with knowledge, culture and activity being housed in separate 'silos'.

Volunteer support: Breastfeeding support offered by women who may or may not have breastfed themselves and who have received minimal training to support breastfeeding women.

World Class Commissioning: World class commissioning delivers a more strategic and long-term approach to commissioning services, with a clear focus on delivering improved health outcomes. Services are evidence-based and of the best quality. People have choice and control over the services that they use, so they become more personalised.

"What drives me is the fact that I struggled so much and there was no one there."
(Sophie Q114)

Chapter 1:Introduction

The purpose of this study was to listen to women who had breastfed their own babies and chosen to become peer counsellor/supporters[1]. I wanted to provide time and space for the peer counsellors to explore their experiences of working counter culturally, in terms of the local culture of bottle feeding. I also wanted to provide statutory organisations and health professionals with insights into the challenges women, who are trained as volunteers to support other mothers to breastfeed, face. The peer counsellors were mothers who fervently believed that every mother can breastfeed; this conflicted with the views of most of the community they lived in.

The group acted as a social 'spirit level', gauging current thinking concerning the reasons why mothers in their community did or did not breastfeed. They sought to provide maximum support to mothers who wanted to breastfeed and whose success would in turn inspire others and produce social change towards breastfeeding. They passionately wanted other mothers to successfully breastfeed and where these mothers had difficulties they wanted to fill knowledge gaps and be a 'friend' who could offer support in a non-judgemental, non-jargonised way. Predominantly women were socialised in the knowledge that their kin networks bottle feed and that breastfeeding is a struggle.

1.1 The Policy Context

Health policy has acknowledged the positive health outcomes of breastfeeding for mothers and babies and has sought to promote breastfeeding. It was recognised in the Acheson Independent Enquiry

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[2] The study will refer to the women as peer counsellors, although during the focus group they would interchange that and refer to them as peer supporters or volunteers.

(1998) which examined the impact of poverty on the health and nutritional status of women and children. The inquiry highlighted that women who are most disadvantaged are least likely to breastfeed and this is a strong indicator of social inequalities.

The NHS Plan (DH 2000) prioritised the reduction in inequalities in health including improved support for breastfeeding. Support for co-ordinated action across the UK built momentum. The DOH funded a three year infant feeding programme through the Public Health Development Fund (Dykes 2003). This resulted in 79 projects showing diverse ways of raising breastfeeding awareness and supporting women less likely to breastfeed, all improving interagency and interdisciplinary collaboration to achieve a coherent and cohesive infrastructure for breastfeeding women.

One of the first peer support projects I worked on was funded through the Public Health Development Fund (Dykes 2003) Breastfriends Doncaster 2000. It was successful in empowering local women to feel that their knowledge and skill in breastfeeding was highly valued (Curtis et al. 2001; Raine 2003; Renfrew et al. 2003). The NHS Priorities and Planning Framework 2003–2006 required all strategic health authorities and Trusts to 'deliver an increase of 2% points per year in breastfeeding initiation rates, focusing especially on women from disadvantaged groups' (DH 2002, p20). Progress is monitored by measuring the prevalence of breastfeeding at 6 to 8 weeks in all primary care trusts as a key indicator of the Child health and wellbeing PSA (public service agreement) target. In August 2008 the Government pledged an extra £2 million to help hospitals in low-income areas increase breastfeeding rates and achieve UNICEF Baby Friendly status. Clinical and public health guidelines are currently core standards, and performance against these standards are assessed by the Care Quality Commission in line with Standards for Better Health (2006).

A woman's diet during pregnancy and her views on infant feeding are influenced by many people including her partner, parents, grandparents, friends and peers. Initiatives such as Sure Start and Children's Centres have created more opportunities for multidisciplinary involvement outside

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traditional healthcare settings. This has been key in changing the way traditional services are offered to mothers and those who care for young children and offer nutritional advice (DH 2004a; DH 2004b; DfES 2004).

A National Indicator was set for 2008-11 (DCLG 2007) which reflects the Governments priorities for Local Area Agreements and includes an indicator of the prevalence of breastfeeding at 6-8weeks from birth. These agreements signal a new relationship between central and local government and are at the heart of the new national performance management framework. They bring together the governments national standards and priorities of an area to deliver innovation and improvements in all local partner services. Improving diet and nutrition of the local population was a key priority in narrowing health inequalities between the town and the rest of the country. There was a call for national, regional and local level action as set out in the Global Strategy for Infant and Young Child Feeding (WHO 2003). Multifaceted approaches had been shown to have a positive impact on increasing the breastfeeding rates (NICE 2008). The Child Health promotion programme set out to deliver a universal preventive service at the same time as focusing on vulnerable babies, children and families (DH 2009). These policy drivers and levers were vital in driving the integration of professional support services and informal support in communities.

My research gives a micro-view of women's experiences of the impact of the policy drivers, Sure Start targets and a community's response to the push to reverse the low breastfeeding rates up to 2004.

1.2 My Journey

I was a mother who had breastfed in a cultural setting very similar to that of the mothers in this study. I was born in the 1960s and although my mother had breastfed me she had difficulties and bottle fed me at 6 weeks of age. It was a very negative experience for her and an era of savage marketing tactics by formula companies to health professionals. I have two daughters, who I breastfed, and the cultural norm was still to bottle feed. It was still difficult to access support. I was in conflict with all my family who believed

'bottle is best'. I am pleased to say their attitudes have reversed, however this was quite a painful journey when my paternal Grandmother asked me 'can't you afford the bottle for her?' referring to my eldest daughter. That was 18 years ago; it appeared to be the same when I conducted this research study.

My experience was of a belief system that suppresses and sacrifices one's 'own' emotion for 'others'. My professional career had spanned 24 years. I am a 'product' of the NHS, nurtured by the ideologies of the NHS, partly in my childhood and definitely in my adult life. I had difficulty in thinking connectedly and outside of the boxes. I could empathise with the group as they spoke of mothers being undermined by some of the health professionals, relaying stories of how artificial feeding seems to be the normal answer to any challenges a mother faces when she experiences breastfeeding difficulties.

I became very focused on changing the 'world view' and decided to train as a midwife after having my first daughter and experiencing some of the health professionals' care of breastfeeding women. With passion and courage I made a vow to change the support that women received when they breastfed. I had very lengthy internal debates whether to be a midwife first, to achieve this, or to become a breastfeeding counsellor. I based my choice on what I thought would be the most influential role and a paid job rather than an unpaid volunteer, as I was the wage earner in the family. However I was motivated to become a breastfeeding counsellor because of the support I received from the National Childbirth Trust when I was struggling to breastfeed and was facing negative support from some of my family. I therefore trained for four years as a breastfeeding counsellor for the National Childbirth Trust after I felt I had become established as a midwife.

During my internal debates around the medical and non- medical approach to breastfeeding, I met Mary Smale, an experienced volunteer for the National Childbirth Trust. A breastfeeding counsellor and tutor for breastfeeding counsellors, Mary had written extensively on supporting women from a non medical perspective (Smale et al. 2006; Smale 1996; Trewick and Smale 2003). In my midwifery Infant Feeding Co-ordinator role

I began working with Mary Smale and Mavis Kirkham, a midwife and researcher who had conducted valuable research on women's experiences of childbirth and midwives being with women and listening to their stories. Mavis Kirkham had a joint post with Sheffield University and Doncaster and Bassetlaw NHS Trust; where a group of us were keen to develop an informal network of women supporting each other to breastfeed. This idea came to fruition when we successfully gained funding from the Department of Health Infant Feeding Practice projects and we all worked together on the local Doncaster Breastfriends peer support programme that recruited mothers to train to be breastfeeding peer supporters (Curtis et al. 2001). Mary developed an 'enablement model of training' (Smale 2004), it was a sheer joy to observe and be part of that first peer support training programme listening to how the local mothers felt empowered and reversing generations of under confidence around mothers being able to breastfeed. Mary felt strongly as we all did 'Remember to hear her story not take a history'.

I felt dissonance on how I could support mothers to breastfeed as my midwifery and breastfeeding counselling training were very different. As a midwife the focus was based on woman centred care; however in practice it seemed to be task orientated and risk focused, while as a breastfeeding counsellor it was person centred. These experiences made me aware that I had deconstructed my knowledge into boxes. Meeting with Mary and Mavis was a key milestone, developing my boxed thinking into integrated thoughts on supporting and listening to breastfeeding mothers' stories.

I went on several lecture tours with Mavis Kirkham and a team of maternity care researchers: midwives and non-midwives. Mary Smale was on the first tour I took part in. In Australia and New Zealand we recognised the cultural barriers towards breastfeeding that mothers were experiencing across the world. In a joint paper I presented with Mary in Sydney we spoke of,

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Making explicit previous cultural and personal learning about infant feeding during the training of those supporting breastfeeding mothers: like breaking down a jigsaw and putting it back together again

(Trewick and Smale 2005 p3)

We gave a space for midwives to reflect upon polarised thinking and difference in breastfeeding training models and the challenges this brought.

The breastfeeding peer support projects rolled successfully across Doncaster, however there were some difficulties in maintaining the projects, as it appeared that some of the health professionals did not have the capacity to take on the extra workload of co-ordinating a group of peer supporters. This tension was seen in many other projects and was the main reason I wanted to conduct the research to enable me to identify some of these challenges from the women's perspective and discover how they could truly be supported when they are facing immense barriers reversing the negative culture towards breastfeeding.

Breastfeeding peer support has been shown to be a way of addressing the low breastfeeding uptake particularly in groups of women who don't normally breastfeed (Curtis et al. 2001; Britton et al. 2006; Britton et al. 2007; Smale 2004; Battersby 2007). It has been shown to be extremely effective when women had difficulties with the medicalised approach. I felt in tune with this and wanted to understand how this approach could also be developed in health professionals' breastfeeding training.

In 2004 I started a new post as a Community Breastfeeding Co-ordinator for a Primary Care Trust to develop a co-ordinated approach, developing policy and training, to support teams across the town. This included a project employing women who had a passion for breastfeeding and had trained as breastfeeding peer supporters and counsellors, called Breastfeeding Link Workers. They were paid to facilitate breastfeeding-friendly awards across the town in children's centres, shops and workplaces to educate and raise awareness about supporting breastfeeding mothers and linking mothers with health professionals and

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peer supporters. This project was very successful and worked in collaboration with the breastfeeding education lead in the Primary Care Trust and the Infant Feeding Co-ordinator from the Hospital.

I had an excellent portfolio of experience and wanted to develop my own training programmes based on 'Training Breastfeeding Peer Supporters: An Enabling Approach' developed by Mary Smale (Smale 2004). When I commenced my post I found that the work had already began on a La Leche League programme. I had reservations about the way the La Leche League rolled out their training programmes through health professionals who may not have breastfed and the programme was very structured. I had been used to developing individual training programmes based on the group that I was working with at that time. I was pleasantly surprised as the peer administrators of the programme I had chosen to study were very innovative and creative trainers; a health visitor, a midwife and a community development worker. The training was very empowering for the group of women I studied.

As part of my understanding of breastfeeding peer support programmes I was fortunate to be involved with the La Leche League Breastfeeding Peer Counselling Programme[2] in my post as a Community Breastfeeding Co-ordinator. This was at the time when I was putting my proposal together for my MPhil and was an excellent opportunity to observe how an alternative model of peer support training worked for mothers and health professionals.

1.3 Background to the La Leche League Peer Counsellor Programme

The La Leche League Peer Counsellor Programme was established in 1956 in America, by a group of mothers who were friends and felt that they needed more support. It has grown and has 3,000 mother support groups worldwide in 60 countries. The programme reaches over 200,000 mothers monthly through a network of more than 6,700 accredited leaders, who work on a voluntary basis. The Peer Counsellor Programme was brought to

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[3] The La Leche League Peer Counsellor programme is referred to as La Leche League Peer Counsellor Programme GB in some texts, to maintain consistency with the peer counsellors I have referred to the programme as La Leche League Peer Counsellor Programme.

Great Britain in 1990 with the first projects piloted in Nottingham. It was developed to expand La Leche League's outreach work into resource-deprived communities worldwide (La Leche League 2003b). Program Administrators, usually health professionals, are trained over five days on how to administer the Peer Counsellor Programme locally and they are enabled to recruit, train and support mothers to become breastfeeding peer counsellors in their local areas. Peer counsellors receive training in effective mother-to-mother support and breastfeeding techniques. Peer counsellors support mothers in many diverse areas and ways, from working within health care systems to individualised support.

The Peer Counsellor Programme (PCP) team provides ongoing support to each programme for three years via telephone consultation, support visits, and regional and national Enrichment Days (La Leche League 2003d). The La Leche League Peer Counsellor Programme has been running in the UK since 1990 and there are 145 active programmes. I trained as a La Leche League Administrator to roll out local Peer Counsellor Programmes. Due to the strategic nature of my role as a Community Breastfeeding Co-ordinator I was unable to practice. However I met and worked with Sarah Gill the UK Peer Counsellor Programme Director, a strong voice for women-centred breastfeeding support and an advocate for mothers' knowledge of breastfeeding their babies.

1.4 Adapting the Program to Meet the Local Needs

The local health professionals identified the need for a breastfeeding PCP. Before I took up my post an application was made to the La Leche League organisation, which carried out a feasibility study by a PCP training co-ordinator. It considered the socio-demographics of the area and the future funding for the project along with the current breastfeeding rate figures, which were very low.

The programme trains health professionals to become administrators and then go into the community and deliver a 12 week training programme, training local women to become breastfeeding peer counsellors. The local programme recruited nine breastfeeding mothers to the project; the age

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range was 20 years to 28 years. Their socio-economic status was working class, two women were in paid employment.

One of the main criteria for becoming a peer counsellor was that they needed to have had a positive breastfeeding experience. The training sessions lasted two and a half hours and the peer counsellor curriculum covered topics such as the La Leche League organisation, communication skills, the benefits of breastfeeding, anatomy of the breast and hormones of human lactation, and examining attitudes towards other people. A crèche was provided and it was made clear that babes-in-arms were most welcome but toddlers, it was thought, could be quite distracting. After the training had been completed there was a graduation ceremony and the peer counsellors each received a certificate. The peer counsellors thoroughly enjoyed their training, because it was not in a classroom. The training was extremely important, allowing them space to speak honestly, remain silent if they wanted to, and listen.

After their initial training the women went on to support other local women in drop in sessions and provided a mobile telephone support service. They had a health professional providing ongoing support, had regular updates, and maintained log books on their contact time with the local mothers, sharing this on a regular basis in their group training sessions.

Respectfully, this thesis aims to share the stories of the seven mothers who took part in a focus group, out of the nine women on the first training programme, and candidly shared their experiences of supporting other mothers to breastfeed.

Chapter 2: Literature review

2.1 *Background*

Mothers who breastfeed their babies give them the best nutritional start in life (World Health Organization 2008).There is compounding evidence on the benefits of breastfeeding for both mother and baby. Nutrition is of fundamental importance for the growth, development and health of an infant during the first six months of life. Evidence shows that breastfeeding has a major role to play in public health, as it promotes health and prevents disease in both the short and long term, for both infant and mother. As well as providing complete nutrition for the development of healthy infants, human breast milk has an important role to play in protection against gastroenteritis and respiratory infection (Cesar et al.1999; Howie et al. 1990; Kramer et al. 2001; Wilson et al.1998). There are also strong indications that breastfeeding has an important role to play in the prevention of middle ear infection (Aniansson et al. 1994; Duncan et al. 1993), urinary tract infection (Marild et al.1990; Pisacane et al.1992), atopic disease (Burr et al. 1989; Fewtrell, 2004; Lucas et al.1990; Saarinen and Kajosaari, 1995), juvenile onset insulin-dependent diabetes mellitus (Mayer et al. 1988; Virtanen et al. 1991), raised blood pressure (Martin et al. 2004), and to a lesser degree, obesity (Dewey et al. 1992; Von Kries et al. 1999).

In addition to the nutritional and immunological superiority of breast milk over formula milk, formula feeding is associated with a number of specific health hazards to which breastfed babies are not exposed. These include the possibility of over or under concentrating formula milk during reconstitution, and the potential for infection introduced by using substitute milk products, bottles, teats, and other vessels (Renfrew et al. 2003). Breastfeeding is also beneficial to the mother's health. Women who do not breastfeed are significantly more likely to develop epithelial ovarian cancer (Rosenblatt and Thomas 1993) and breast cancer (Beral et al. 2002; Newcombe et al.1994) than women who breastfeed. There is an important public health question about the costs related to infant feeding, including broader issues such as absence from work because of childhood illness and the impact on the health of the population in the long term. Available

studies have clearly demonstrated the increased costs of formula feeding in terms of the costs of excess ill health on health services (Ball and Wright 1999; Hoey and Ware 1997; Riordan 1999). Despite the overwhelming health benefits and cost savings of breastfeeding, initiation rates in the UK are around the lowest in Europe, and worldwide, with rapid discontinuation rates for those who do start.

In the UK Infant Feeding Survey 2005 (Bolling et al. 2007) the breastfeeding initiation rates in 2005 were 78% in England and had shown an improvement from the last infant feeding survey in 2000. The highest incidence was found amongst mothers from managerial and professional occupations, those with the highest education levels, and those aged 30 or over.

In 2005, 48% of all mothers in the UK were breastfeeding at six weeks, while 25% were still breastfeeding at six months. Between 2000 and 2005 there was an increase in the prevalence of breastfeeding at all ages, up to nine months, in England, Wales and Northern Ireland. In Scotland, an increase in prevalence was seen only at ages up to six weeks. The UK figures for duration of breastfeeding contrast sharply with those of Norway where 80% of mothers breastfeed for the first 6 months (Lande et al. 2003).

2.2 *Mothers' Social Disadvantage Linked to Not Breastfeeding*

In the UK, women from disadvantaged communities are significantly less likely to start breastfeeding and more likely to discontinue breastfeeding prematurely when they do start (Renfrew 2007). There are complex psycho-social decisions mothers make when choosing to breastfeed their babies in communities where breastfeeding is a counter-cultural decision (Smale 2004; Battersby 2006; Kirkham 2006; Curtis et al. 2007; Hoddinott et al. 2008; Dykes 2006) Hamlyn et al. (2002) demonstrated that women from disadvantaged communities were less likely to breastfeed, 59% in fact breastfeed from manual occupations and 46% of mothers less than twenty, compared to 85% of women breastfeeding in higher social classes.

The Infant Feeding Survey 2005 (2007) has also shown that other factors, including low maternal age, educational attainment and socio-economic position, have an impact on patterns of infant feeding.

The lower a mother's socio-economic position and the shorter the duration of her education, the less likely she is to initiate and maintain breastfeeding (Bolling et al. 2007).

2.3 *Peer Support Programmes*

Battersby (2007) suggested professional efforts over recent years have done relatively little to change the breastfeeding rates in the UK. In addressing this issue other approaches have therefore been sought. A concern for the loss of community-based, woman-centred, embodied knowledge and skills around breastfeeding led to the development of a range of breastfeeding support organisations, some international, others national (Dykes 2006). The National Childbirth Trust, The Breastfeeding Network and health professionals have all been involved in devising peer support programmes. There have been recommendations made that peer or volunteer training schemes should be consistent and, where possible, based on nationally accredited training programmes (Dyson and Renfrew et al. 2006; Battersby 2007).

There was an upsurge of breastfeeding peer support programmes in the UK after the completion of an Infant Feeding Initiative; a report evaluating the Breastfeeding Practice Projects 1999-2002 (Dykes 2003). After three years of public health money for local projects, the Department of Health conducted an evaluation of the projects and evaluated these positively (Dykes 2003). The report was vital in informing policy makers of the evidence base of projects that could be used in each area.

There has been ample evidence, nationally and internationally, of the benefits of increasing the breastfeeding rates by utilising peer support/peer counsellor schemes (Battersby 2007; Britton et al. 2006; Hannula 2008; Dennis 2002; Meier 2007; Haider 2000). However there is a lack of

evidence regarding the experiences of how volunteers feel about being part of a government funded intervention to increase breastfeeding rates.

Curtis et al. (2001) clearly identified that there may be difficulties with the peer and professional interfaces and later discussed how health professionals controlled the peer supporters by gate keeping mothers and controlling the peer supporters' interactions with them. This study highlights the tensions that can arise between the professional and volunteer organisations.

2.4 *What is Peer Support?*

There have been various definitions of what peer support is:

> People outside of a professional capacity who have been trained in order to gain specialist knowledge of breastfeeding and who typically work in a voluntary capacity within the resident community.
> (Fairbank et al. 2000 pii)

> Peer counselling is a culturally sensitive approach to providing information and support while inspiring confidence.
> (Milligan et al. 2000, p249)

Peer support was defined by Dennis et al. (2002, p21) as:

> a specific type of social support that incorporates informational, appraisal (feedback) and emotional assistance. This lay assistance is provided by volunteers who are not part of the participant's family or immediate social network; instead, they possess experiential knowledge of the targeted behaviour (i.e. successful breastfeeding skills) and similar characteristics (e.g. age, socio-economic status, cultural background, location of residence).

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The La Leche League runs the largest international peer counsellor programme in the world. The evaluation report on their peer support projects in the UK identified peer support as follows:

> Breastfeeding peer support is when there is mother-to-mother support for children and who, with specialised training, act as role models sharing information and experiences and offer support to other women, who wish to breastfeed, in an atmosphere of trust and respect.
>
> (Battersby 2007, p7)

The La Leche League identified that they differ from other peer support/counsellor programmes in five ways Battersby (2007). One of the main differences is that they provide a national co-ordinated programme with follow up support for three years. There are other programmes, such as the National Childbirth Trust and Breastfeeding Network, however this is the most highly sophisticated business enterprise organisation providing peer counsellor programmes across the UK.

The peer counsellor project in this study is heavily influenced by the success of a local project funded by the Department of Health and one of many projects integrated within a Sure Start project and created to meet Sure Start aims (Department of Health 2007). These aims included a vision of making life better for children, parents and communities by bringing together early education, child care, health and family support, ensuring local services work well together and responding to the needs of parents and communities. The reason for this is to improve families' and children's well being so children are ready to perform at school. The Sure Start projects were phased out and replaced by children's centres after some years.

2.5 *Policy Context*
Medical and commercial practice has undermined the culture of breastfeeding for the past century. Ryan and Grace (2001) discussed in their study that women's knowledge was undermined by the increasing power of the infant formula industry that ensured a woman's dependence

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upon the doctor, for monitoring and surveillance of infant's growth. (Apple 1987; Greer and Apple, 1991). The hospitalisation of childbirth also resulted in surveillance of feeding behaviours and the development of practices and policies detrimental to breastfeeding (Silva and Buckfield 1978; Dykes 2006).

Recent initiatives, since 2000, have sought to improve this situation, and various policy measures have influenced the number and nature of settings at local level in which nutritional advice may be offered to mothers and others with responsibility for young children. These include the establishment of Sure Start initiatives and children's centres, with increased opportunity for multidisciplinary involvement outside the traditional healthcare setting, in order to achieve change that will also support the delivery of national policy set out in key documents (Department of Health 2004a; 2004b; Department for Education and Skills 2004).

Breastfeeding is a key strategy in tackling the fundamental policy goal of addressing inequalities in health (Department of Health 1998; 1999; 2000; 2004a). Breastfeeding contributes to several Public Service Agreement (DH 2007a) focusing especially on women from disadvantaged groups. (Department of Health 2003a) and was the impetus for this research study. Breastfeeding rates are one indicator of the quality and safety of maternity services, as highlighted in the National Service Framework for Children and the Maternity Services (Department for Health 2004b).

The promotion of breastfeeding has been included as an inspection criterion in the Every Child Matters Framework (Department for Education and Skills 2004). It is clear that the policy drivers are extremely supportive to the development of schemes that aim to increase breastfeeding rates, however the timescales and financial provision is short term and women's rights to breastfeeding have been neglected over several generations (Bromberg 2003; Renfrew 2007). It is clear that the peer counsellors are committed to turning the cultural tide towards breastfeeding but this is a tremendous task to lay upon volunteer mothers within projects with very limited funding.

2.6 *Breastfeeding Peer Support and its Effectiveness*

Industrial societies, on the whole, do not provide women with the opportunity to observe other breastfeeding women before they attempt breastfeeding themselves and many health professionals lack knowledge about breastfeeding (Enkin et al. 2000).

Women in areas where breastfeeding was a marginalised activity require consistency of support from health professionals but often do not receive it. At a time when a woman is considering stopping breastfeeding, peer support is a factor that keeps women going (Dykes 2003).

Protheroe et al. (2003) recognise that capturing quantitative outcomes alone is not sufficient in evaluating interventions that increase the initiation of breastfeeding. Breastfeeding promotion and support appears not to be embedded into the healthcare culture in the UK. The trend towards implementing breastfeeding peer support as a health intervention to tackle the low breastfeeding rates of women from the deprived areas has shown early signs of effectiveness. A systematic review of professional support interventions for breastfeeding from 2000-2006 concluded that the most effective interventions were home visits, telephone support, and breastfeeding centres, combined with peer support. A recommendation was made that an excellent way to increase the success of a programme is to include a peer support element (Britton 2007). Infant feeding knowledge in the community is based on bottle feeding and there is a lack of research that addresses the impact of these projects on the peer counsellors and their relationships with health professionals (Britton 2007; Curtis 2007; Hannula 2008).

2.7 *The Problems Associated with Peer Support*

There are many parallels with this work and that of Curtis (2007) who questioned that not all health professionals' considered empowerment a 'good thing' and continues:

> The narratives of some of the professionals in this study suggest that they were operating with a notion of finite power, fearing that they would lose some of their own authority if volunteers were given more authority in relation to breastfeeding mothers.
> (Curtis et al. 2007, p154)

Evaluations of breastfeeding peer support projects have demonstrated great diversity of professionals' response to peer supporters. Kaler (2001) discusses gains to volunteers are losses to health professionals. Other responses range from welcoming their help and clear, ongoing, two way communication, to ambivalence and even discouragement and 'negative rapport' (Curtis et al. 2001 p792-793; McInnes and Stone 2001). This appears to be linked, in some instances, with professionals seeing peer supporters as a threat rather than a help (Curtis et al. 2001; 2007).

2.8 *The Context*

A proactive approach was required locally because women are still choosing not to breastfeed, particularly in the most deprived local areas and initiation rates are as low as 37%. Interventions tailored to particular cultural or socio-economic groups and multifaceted interventions seem to be most effective (Dyson et al. 2006; Renfrew et al. 2005).

Peer support programmes were one of the key strategies that the Primary Care Trust, along with health professionals, identified as an initiative to reverse the negativity towards breastfeeding. Analysis was carried out through the mapping of postcodes of a geographical area such as an electoral ward of a neighbourhood.

This enabled organisations and healthcare professionals to understand the health needs of the population and to continue delivery of effective services/resources to those of greatest need and develop breastfeeding peer support programmes in the areas of lowest initiation of breastfeeding.

Curtis et al. (2007) identified that client empowerment is an aim in many areas of the healthcare system and is seen as a way to change a community's attitudes towards breastfeeding mothers and improve health outcomes. Curtis conducted thematic analysis of the peer/professional interface in a community-based breastfeeding peer support project and identified the complexity of the relationality of the peer/professional interface and recognised client empowerment requires sensitive handling.

Work by Smale (1996), in her analysis of women's contacts with a national breastfeeding counsellor in England 1979-1989, made the following observation:

> Women-centred literature may contribute to an understanding of the ways in which women's apparent choices in the maintenance of breastfeeding are limited by social meanings meditated by the health profession.
> (Smale 1996: abstract)

Smale continued to explore how the 'naturalness' of breastfeeding is scientifically quantified and breastfeeding knowledge lies predominantly with the health professionals:

> Breast milk is claimed as the birthright of all babies and breastfeeding as a natural part of motherhood. Scientific research confirms its feasibility for the majority of women and babies. The management of breastfeeding is accepted as a health professional role, but research suggests some reluctance on the part of the profession to abandon iatrogenic practice.
> (Smale 1996: abstract)

A decade later, Dykes (2006), in her research on breastfeeding in hospital, confirmed that the reluctance is not necessarily due to medical practices undermining breastfeeding mothers. Rather, midwives and health visitors are faced with staff shortages and are unable to attend catch-up training sessions and were not prepared in their initial professional training to support breastfeeding mothers. This has a devastating effect, particularly on new mothers, and she saw women breastfeeding in hospital as having a production line experience, thus she saw the hospital as similar to the factory and prison, observing frequently that first time mothers often felt unsupported in the medicalised surroundings of a maternity ward, staffed by overworked midwives. Kirkham (1999) focused her work on the culture of the National Health Service (NHS) and the difficulty for midwives thinking connectedly, implying they were oppressed by the organisations they were in.

2.9 Community Enablement; The Bigger Picture

The peer counsellors in this study came from a community that had, in years gone by, a superabundance of social capital, emanating from a proud tradition of social solidarity. However, just as the coal mining industry generated this social asset, so pit closures had helped to undermine it. The coal mining legacy of trust and ties was fading fast. In a study that looked at the intervention by the local health authorities to replenish social capital, it was noted that 'Public health is a goal of public policy, a basic value and hallmark of civilised society' (Gilbertson 2005, p1).

The author noted:

> The health of a community or a region's population also makes a vital contribution to social and economic regeneration. The symbiotic relationship was highlighted in the baseline study and is now an essential element of policy for the Yorkshire and Humber Region.
> (Gilbertson 2005, p1)

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An important characteristic of this type of community was that there was poorer health and much higher levels of long-term limiting illness and disability than the national average. Social capital is a useful concept in analysing such a situation. It is a newer addition to the other well-established capitals of physical, environmental and human capital (Gilbertson 2005). The survey identified that social capital – 'community spirit' contributes to health and prosperity both at a regional and neighbourhood level. Another clear message was that social capital is a vital element of any balanced regeneration programme.

In Gilbertson's (2005) study there was a balance of 'past pit villages', inner urban areas and mixed communities. The mining village exemplified enduring community bonds and respondents answered positively to survey questions in these topics and were more likely to think their neighbours would do them a favour or to think their neighbours would help each other, compared to some of the other communities. The community studied in this thesis was of lower socio-economic class, and is a market town with villages and areas of urban growth with a past history of mining. There is considerable social solidarity in this area, but with regard to infant feeding this is solidarity around bottle feeding. Wilkinson and Pickett (2009) demonstrated that unequal societies are bad for almost everyone in them. Identifying a balance of a friendlier and more collaborative society. Uslaner (2002), a political scientist at the University of Maryland, believes that we know people as friends and neighbours and that might increase our trust of people. Further work by Rothstein and Uslaner (2005) identified that economic equality is a key factor in gaining trust in an unequal World.

The peer counsellors were disadvantaged by their backgrounds and the lack of trust in local health professionals regarding breastfeeding and within their kin networks. There was a lack of trust and confidence in the community that women could breastfeed, it was a downward spiral amongst the majority of the community, as they lacked trust in themselves to breastfeed. It is interesting to note that in Wilkinson and Pickett's (2009) research they observed that the most important component in society is economic stability and economic equality in terms of health and reducing social inequalities.

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The local economy had been destabilised by pit closures and subsequent economic downturns.

The heavy marketing of breast milk substitutes in the 1960s had undermined breastfeeding when this area was relatively prosperous. As the industries declined, social upheavals made change to breastfeeding unlikely. Yet the peer counsellors, like warriors, went out to reverse this lack of confidence and build trust in mother's breastfeeding their babies, talking of risks of artificially feeding babies rather than the benefits of breastfeeding. Uslaner (2002) makes the point that trust leads to co-operation and discusses reciprocity between community citizens that intricately bonds these communities together and is sometimes forgotten and missed by the 'silo' mentalities of powerful governmental organisations. It was extremely difficult for the peer counsellors to break the cycle of lack of confidence in breastfeeding.

Returning to the evidence and how the peer counsellors responded to the lack of trust between them and the health professionals, it was clear to see that they were disadvantaged in those communities and it was an uphill struggle for them, unravelling years of social and economic decline represented in the everyday stories of women who had not been supported to breastfeed.

There is a lack of research around the lived experience of mothers supporting other mothers to breastfeed and the honesty of the peer counsellors in this research study was enlightening and humbling.

Chapter 3: Methodology

This research study sought to examine the experience and perceptions of breastfeeding peer counsellors since little research had been done in this area before. Its exploratory nature meant that the research had to be qualitative (Dyson and Brown 2006). The aim of examining how these women experience their world as peer supporters suggested a social constructionist perspective. Social constructionism sees social reality as continually constructed and sustained through language and discourse (Berger and Luckman 1966; Finlay 2008). Therefore, discourse is not simply a reflection of reality but functions to continually construct and create it. The context of speech is thus most important for understanding its meaning and context, in turn, is changed by how it is experienced and described (Berger and Luckman 1966).

3.1 Grounded Theory

I originally chose to use grounded theory (Strauss and Corbin 1990), which was developed in 1967 by Anselm Strauss and Barney Glaser. They developed a body of thought about analysis involving the whole research process, with the aim of generating theory, rather than simply providing mechanistic processes to undertake analysis. It focuses on the individual as a socially constructed being and social interaction is what helps people make sense of their world. Therefore grounded theory draws on the tenet that people make order and sense of their world, even when it appears to be disordered, which fits with my overall social constructionist approach. Grounded theory is an approach that works in an inductive fashion, to make sense of what people say about their experiences, and then to convert those statements into theoretical propositions (Roberts and Taylor 1998). As an approach it is particularly useful in areas where little is known about the phenomenon of interest or where there are few existing theories to explain an individual or group's behaviour. Glaser and Strauss, the two sociologists, began to differ on their approach to grounded theory and Strauss developed a version of grounded theory with Corbin (Strauss and Corbin 1990). This was criticised by Glaser, who argued it no longer constituted grounded theory (Glaser 1992). Other variations have been

described by Stern (1994) and Charmaz (2000). Glaser (1992) explains how the researcher using grounded theory brings no preconceived ideas to the study. This was problematic for me as I had worked with breastfeeding peer support for a number of years. Glaser (1992) believes that grounded theory should allow the relevant organisations and social psychological organisation of the participants to emerge in their own perspective, which did fit my questioning of the Straussian approach. Glaser (1999) discussed how grounded theory can be used in part or whole by the researchers and, when used in parts it is possible to 'adopt and adapt', with other research methods woven in. A grounded theory approach enabled me to use a thematic approach to explore the inter-relatedness of how the peer counsellors related to the world after their training.

3.2 *Reflexivity*

The research process was a reflexive journey; in research terms this can be translated as thoughtful, self-aware analysis of the intersubjective dynamics between researcher and the researched. Reflexivity requires critical self-reflection on the ways in which researchers' social background, assumptions, positioning and behaviour impact on the research process.

To enable a deepening of the reflexive journey I drew upon phenomenological psychology. Giorgi (1994) theorized around determining what an experience means for the persons who have had the experience and are able to provide a comprehensive description of it. He developed thought around the intertwining of subjective and objective knowledge, i.e. reality of representation is in truth a subjective reality. In other words, perception of the reality of an object is dependent on the subject.

As Giorgi (1994 p205) has firmly stated, 'nothing can be accomplished without subjectivity, so its elimination is not the solution. Rather how the subject is present is what matters, and objectivity itself is an achievement of subjectivity'. This exploration of my own subjectivity and that of the peer counsellors, experiences of providing breastfeeding support in terms of the individuals' descriptions or general meanings enabled a deepening of the reflexivity, the essence of structures of the experience.

Giorgi et al. (1994, p190) postulated that:

> greater theoretical clarity and consistency as well as deeper reflection or better utilization of imaginative possibilities still seem to be called for in order to bring better theoretical conceptualization and more consistent practices to qualitative research.

Finlay (2008) in her work discusses the researcher's own subjectivity, mirroring Giorgi on the impact of subjectivity in the research process.

She states that researchers need to bring a

> critical self-awareness of their own subjectivity, vested interests predilections and assumptions and to be conscious of how these might impact on the research process and findings.
> (Finlay 2008, p17)

Researcher reflexivity in this context becomes a 'process of continually reflecting upon our interpretations of both our experience and the phenomena being studied so as to move beyond the partiality of our previous understandings' (Finlay, 2003). Reflexivity permeates every aspect of the research process. Mauthner (2003, p413) classifies reflexivity as:

> Our deepening understanding of reflexivity – and the range of personal, interpersonal, institutional, pragmatic, emotional, theoretical, epistemological and ontological influences on our research has only come through emotional and intellectual distance from our projects.

This also provides the opportunity for unpicking the years of listening through a model of 'power and authority,' which is prevalent within the NHS. I continued with self-development techniques, to find my voice, working through my own story. I freed myself to explore my own voice and needed time to connect to my feelings and resonate authentically to what the women were saying to me. My long period of self-reflection equipped

me to interpret what it meant to this group of women to support women and families in their community to breastfeed.

I felt angry and emotional at how mothers and women were not respected for their knowledge around breastfeeding. This was a major factor for choosing this line of enquiry, enabling me to listen to the peer counsellors telling me their stories of the challenges they faced with the community and the health professionals. I was not separate to the peer counsellors and in many ways our boundary lines crossed. I found analysing the data difficult because relationally I was working in this field for the same reasons as the peer counsellors. However I made it clear to myself and the peer counsellors that I strived for impartiality.

Smale (1996) recognised and located herself in her study:

> I was rather an interested and involved observer, one with a conscious partiality.
> (Smale1996, p230)

Smale (1996) continued along the same theme using the work of Mishler (1991), who described the process as the way in which the meaning is grounded in and constructed through the discourse. Chesney (2001) and later Battersby (2006) debate the 'self' in the research and acknowledge how it helps to be transparent in the research process. In doing so Chesney (2001) recognised that this improved the credibility of the research. Mauthner (1998) expounded that Western philosophical tradition is that of a separate, self sufficient, independent, rational self, whereas Ruddick (1989) saw a relational being. This view of human beings as embedded in a complex web of intimate and larger social relations (Gilligan 1982) produced a way of seeing human beings as interdependent rather than independent (Tronto 1995). This approach felt appropriate for my study.

Reflexivity therefore, involves far more that an analytical approach to the role of the researcher within the research, crucial and constant though that is. The reflexive voice of respondents also needs to be captured Finlay (2008). Sometimes this was very evident, as when they discussed their

various 'battles'. The peer counsellors and I also shared some reactions and assumptions. These were challenging but important to analyse. For instance, I and the group exhibited rescuer tendencies springing from experiences of difficulty breastfeeding our babies because of our culture. This was evident even in group introductions. Eliza introduced herself as having difficulty breastfeeding and was now fully bottle feeding. My immediate reaction was to rescue her and I asked her if she wanted to talk about it, an immediate parallel with the group's aims in rescuing their peers who want to breastfeed. Eliza was exposed in the group, and reflecting back over the transcript, Eliza spoke more than other group members and was the main lead in the group. This made me question how peer counsellors are supported through their own story.

It was thus clear that reflexivity involved complex layers and was central to the whole project. A method of analysis was needed which had reflexivity at its heart. Reflexivity is a theme which permeates the rest of this chapter and resulted in the blend of research methods chosen.

3.3 *Research Methods*

I endeavoured to be transparent throughout my work and acknowledged that I was deeply involved as the strategic lead in breastfeeding with the local Primary Care Trust whilst conducting the research. Within the wider analytical framework of Grounded theory, I sort specific techniques to increase reflexivity. I was to find these in Voice Centred Relational Methodology (see cross ref p34, 3.5.2)

I took this into account by having regular group supervision and used a spreadsheet (see Appendix 2) which I developed, enabling me to listen, read and then respond with my own voice, and then listen to the peer counsellors' voices, developing objectiveness and allowing time to reflect and think reflexively. I endeavoured to explore their stories sensitively using semi structured questions (see Appendix 1) and at the same time gave myself time to reflect on my similar experiences as a mother who breastfed in a northern town and had the same cultural barriers.

The peer counsellors became involved in a complex web of governmental requirements and this was certainly not on their agenda when they initially volunteered. They were the first peer counsellor volunteers in their area and were therefore, to some extent, 'guinea pigs'. The peer counsellors' stories are emotionally charged; they are part of and different to their community and do not hold the same norms and values as the whole community group and do not work synergistically outside or inside the group:

> Spending this time carefully listening to the respondents creates a space between their way of speaking and seeing our own, so we can discover how she speaks of herself before we speak of her.
> (Brown and Gilligan 1992, p27-8)

Listening to how they spoke before I began interpreting their words gave them a space to speak of themselves; a space they appeared to value that they did not have elsewhere: the peer counsellors throughout the focus group battled with their culture. Eventually the group internalised the outside conflicts. The group was in a flight or fight mode and had fear of attack or assault on the psychological self. Destructive processes operate in all groups (Nitsun, 1996) and scapegoating is common here; 'bad' aspects are ascribed to one member for the group. Foulkes (1948) identified the anti-group phenomena; the destructive forces within groups are marked by high tension, low morale, negative attitudes and angry attacks. The peer counsellors thought in boxes too and wanted to compartmentalise and make order out of what was 'messy' and out of control. They wanted to flee the situation and were restraining their emotions. It appeared challenging for them to find the answers to how they could reverse this negativity towards breastfeeding.

Battersby (2006) discusses similar findings related to the emotional work of supporting mothers to breastfeed, as Deery (2003) did in her analysis of community midwives managing and performing emotions caring for mothers.

Insights from the midwives came to the following conclusion:

> Emotion work impinges not only on their (midwives) relationships with women but also with their peers and their relationships at home.
>
> (Hunter and Deery 2009, p87)

The peer counsellors appeared to be emotionally drained from the battle to be heard by some of the health professionals and disillusioned with the organisation they were in. Curtis (1991) and Murphy-Lawless (1991) identified doctors and midwives' relationships as a potential source of conflict. However Deery (2003) and Hunter (2004) identified recently that the problem lies within midwives themselves. This was similar for the peer counsellors who intuitively recognised that they were to some extent responsible for their powerless position suggesting they were victims of their own success in the community. There is an opportunity; a space for us to reverse the downward spiral and heal the battle wounds of what appears to be an oppressed workforce. Hunter and Deery (2009) discuss and provide a space to reflect on the emotional work in midwifery and reproduction, enabling a sense of connectivity through the disconnection of medicalised health care services. Curtis (2001) concluded in her study that the peer supporters had similar experiences around emotional work and felt they were doing more than if they were employed. The peer counsellors appeared to be catalysts in the forefront of healthcare dilemmas about where the peer counsellors place was in relation to the medical model.

Using mixed methods has become popular amongst midwifery researchers, not least in data analysis (Battersby 2006; Kirkham and Stapelton 2000). Shih (1998) observed that mixed methods were valuable when trying to describe and conceptualise the multifaceted complexities of the human response to various health care situations.

This seemed highly relevant to this study because Battersby (2007) conducted a study which had many parallels with mine but she studied the midwife perspective. Battersby found great complexity and multiple truths in midwifery experience of breastfeeding. Polit and Hungler (1993) identified

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the difficulties with establishing the truth about phenomena of interest to midwife researchers and the argument of the postmodernists that there is no such thing as objective truth that remains stable and unchanging regardless of time and circumstances (Edwards 2005).

Scott and Scott (2000) discuss the connections of the individuals and society through a nexus of roles and the work around the readings validated this thinking. I found myself assuming various roles throughout the focus groups: mother, midwife, breastfeeding counsellor, marathon runner and, importantly, me.

I have tried to create a space where we can deepen our understanding of how the peer counsellors perceived their role of supporting mothers to breastfeed and explore their thoughts on issues of truth around the social interplay and power struggles that they were involved in. Kirkham (1997) identified the importance of stories in her midwifery research and this resonated with the peer counsellors placing much importance on this.

I decided to combine the Voice Centred Relational Methodology (VCRM) (Mauthner et al. 1998) with a grounded theory approach. The grounding of the analysis in the peer counsellor experience was fundamental. Grounded theory gave me the fundamental concept of theming the data in the women's experience. Strauss (1987) unravels the elements of experience and defines grounded theory as a detailed grounding of the research inquiry by careful analysis of the data.

Initially I was concerned that the grounded theory would collide with the relational method as the grounded theory appeared to dissect and cut into the data whereas the VCRM was layered and felt more sensitive to the way the data was read and the peer counsellors' voices listened to. After discussing the divisions in my thought processes with my supervisor I concluded that it is impossible to completely remove myself. This combination of methods grounded theory and VCRM, increased my ability to focus on the different subjectivities involved.

3.4 Data Methods

In order to understand the experience of these women, I needed them to speak of their experience in some detail. No written accounts of their experience were available and I knew them to be much more fluent and comfortable in conversation that in writing. For the data collection, the options available were therefore individual interviews or a focus group. As the peer counsellors were already a group who had trained together and developed friendships and trust, as well as differences, I opted for a focus group.

3.4.1 *Focus Groups*

Kreuger (1994, p6) defines a focus group as a carefully planned discussion designed to obtain perceptions on a defined area of interest in a permissive non- threatening environment. It was a tool that market researchers used to guide advertising and image management and historically was first mentioned by Bogardus, who in 1926 described group interviews in social science research (Raymond 2008). Interestingly they were also used during the Second World War when Merton employed the method to examine people's reactions to wartime propaganda and the effectiveness of training materials for soldiers (Merton and Kendall 1946) and in social science research in the 1950's (Barbour and Kitzinger 1999). Focus groups are distinguished from group interviews by the explicit use of the group interactions as research data (Morgan 1998a, Krueger 1988; Krueger and Casey 2000; Putcha and Potter 2004). It remains a popular method in both market research and in the social sciences.

A focus group was thought to be particularly appropriate for this study as it enables the researcher to explore people's knowledge and experiences and can be used to find out what, why and how they feel (Kitzinger 1995). It is a suitable method for addressing 'sensitive' issues. Its use in research involving 'sensitive' populations 'gives a voice' to marginalised groups such as the poor, minority and ethnic groups, or those affected by AIDS/HIV, enabling researchers, policy makers and others to 'listen' to people who have little chance to express an opinion about their health needs. (Barbour

and Kitzinger 1999; Kitzinger 1995; Umana-Taylor and Bamaca 2004; Wilkinson 1999) A study conducted by McDonald (1999) discussed his struggle for subjectivity when conducting an engaged, political study that examined issues such as unemployment, growing up in a deprived neighbourhood, amid youth crime, and racism in Melbourne Australia. He made the following observations:

> The powerful tensions confronting and at times threatening these young people, emerging with compelling clarity and urgency. (McDonald1999, p108)

He described 'tension rather than coherence between opposing dimensions of their reality.' (McDonald 1999, p108). McDonald's work resonated with the peer counsellors, being in constant tension with their community. As key actors in their community, I saw the focus group as a means of empowering the group to speak out and share their interpretations around their opposing dimensions.

Kahn and Manderson (1992) observed that a focus group which creates an informal and relaxed setting will encourage participants to feel free from constraints. The group expressed how they were more powerful together. There were some who were more vocal, as noted by other researchers (Baker and Hinton 1999). Deery (2003), in her work, discussed the powerful forces that were evident in the work team and became exaggerated within the focus group setting. I felt this method would serve similarly to highlight the powerful issues experienced by breastfeeding peer supporters.

Focus groups have been seen as a 'soft option' by researchers outside qualitative disciplines (Stewart and Shamdasani 1990). However, Kitzinger (1995) believed focus groups can provide a window into the richness and complexity of social life in general and health behaviours.

The focus group enabled the peer counsellors to step back and reflect on what they were doing. Deery (2003) found, after conducting a focus group with midwives, that it acted as a catalyst for change; I hoped to achieve a similar result with peer counsellors.

3.4.2 The Practicalities of a Focus Group

I was an experienced group facilitator, and had trained many health professionals and peer supporters in my career as a midwife. A group theory course had enabled me to identify group dynamics. This focus group was a unique opportunity to listen to how peer counsellors felt about what they were involved with. I was particularly aware of the peer counsellor who did not join in as frequently, since Khan et al. (1991) identified that participants who shared common attitudes towards a particular subject would be able to talk more openly with each other. It served the research process well and utilising a mixed analytic approach served as an excellent way to listen to the peer counsellors.

3.4.3 Recruitment to the La Leche League Peer Counsellor Programme and the Study

I came into my post as a Community breastfeeding co-ordinator in May 2005. The local Sure Start had already commenced a La Leche League Peer Counsellor Programme. Originally the women had been recruited to the project by the local health professionals looking through their caseloads and then through local networks of women who knew someone who was breastfeeding. Once the women had been identified as possible peer counsellors, the project leads contacted them to explain the training and gave them an application form to complete. If the women fitted the criteria of having a positive breastfeeding experience and identified the reason why they would like to train as a peer counsellor, they were offered an informal interview. If considered suitable the women were offered a place on the training programme.

I was introduced to the group at the beginning of their peer counsellor training programme. I discussed the research explaining I wanted to listen to their experiences of being a breastfeeding peer counsellor. They all had a passion to support other women to breastfeed as it appeared that they had not been supported by their community or health professionals.

I requested verbal and written consent which was given by all members of the group after they had time to reflect and ask any further questions about their involvement in the study.

The peer counsellors had all breastfed their babies and seven of the group had chosen not to return to work because they wanted to devote their time to their babies and families. They had experienced either a breastfeeding problem or a lack of support, it was a great driver to them wanting to support other mothers in a similar position. Prior to the focus group being conducted I attended several of the weekly training sessions in my dual role as a health professional and researcher. I made extensive field notes, which I used when I had my research group supervision. The focus group was conducted two months post peer counsellor training, giving the peer counsellors time to consolidate and establish themselves within the community offering peer support.

3.4.4 Focus Group Experience

At times the focus group was difficult to facilitate and was an avenue for the peer counsellors to vent their frustration and anger about how they felt used by the Sure Start organisation as unpaid workers. Stewart and Shamdasani (1990) suggest that it is difficult to moderate a focus group. Morgan & Kreuger (1998) recommend that focus groups are conducted with a facilitator and an observer. I was fortunate to have my second research supervisor as an accompanying co-researcher, and it was extremely useful that she was able to take notes and help support the peer counsellors who had kept their babies in the room. Later, our reflection over how the focus group had gone was enlightening.

3.5 *Data analysis*

3.5.1 Voice Centred Relational Methodology

VCRM was developed by two researchers Natasha Mauthner and Andrea Doucet (Mauthner and Doucet, 1998) after they completed post-doctoral fellowship with Carol Gilligan at Harvard University (1994-95). The reading

method or listening guide was developed initially by Lyn Brown and Carol Gilligan at Harvard in the mid 1980's and has roots in relational theory. VCRM has been used on different research topics, different disciplines and different adaptions. Mauthner and Doucet (2003) developed and extended the listening guide over 10 years and it has been broadened within the context of feminist theory, and sociological and anthropological discussions on methodology and epistemology. It involved a multilayered approach to reading/listening and suggested four readings. Reading 1 comprised of two elements. First, the text is read for the overall plot and story told to the reader, and then the second reader-response element of this first reading enables the researcher to read for herself how she is located emotionally and theoretically.

The second reading traced the personal pronoun statements and was layered and concerned with reflection (Ribbens and Edwards 1998) whereas grounded theory was more concerned with action/interaction (Strauss and Corbin 1990). Reading 3 was for the interpersonal relationships that the peer counsellors had and Reading 4 was for the broader context; politically, culturally and structurally. This method successfully enabled me to theorise and place the peer counsellors within theoretical debates.

3.5.2 *The Practicalities of VCRM*

I had great difficulty when I began my first reading. I was very conscious of my technique, I was very self-absorbed, and found it hard to concentrate because my mind had many triggers from my many roles.

I had a lengthy discussion with Natasha Mauthner on the telephone when I recognised this conflict happening. I seemed to be immobilised on how to analyse the data when I was clearly relationally close to the women and the research field. I was drowned by my voice and felt a need to explore this whilst I read the first reading three times. I developed a spreadsheet that provided a framework to explore and listen to the peer counsellors' as well as being transparent with my own position of power. Opie (1992) pointed out ideology can obscure as well as enlighten. I would write triggers from

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what the peer counsellors said that evoked a response in me, since I was always aware of my response whilst doing the readings in a very open and transparent way. I wondered whether I was controlling and codifying myself so that I would not seep out into the data.

I was trying to 'clean' up what was not clean. It reminded me of the work I had read regarding the caste system and as the lower caste members are seen as the untouchables, ignored and not caste system as the lower caste members are seen as the untouchables, ignored and not credible (Bhatt, 1975), so too was my laying bare of my story in the world of some researchers. Chesney (2004) likened a woman's body of knowledge to something 'unclean', in the culture she studied. I drew a parallel with the way the knowledge of the peer counsellors laid them open to attack and how they felt breastfeeding was viewed in a negative light from their experiences in their community. Smale (1996) analysed calls to her as a National Childbirth Trust breastfeeding counsellor, acknowledged the impossibility of objectivity, the unavoidable involvement of the researcher in a personal way in women-centred work and acknowledged this feminist dilemma.

Mauthner and Doucet (1998) identified the issues around equating computer coding with qualitative data analysis:

> The use of technology confers an air of scientific objectivity onto
> what remains a fundamentally subjective, interpretive process.
> (Mauthner and Doucet 1998, p120)

Mauthner and Doucet (1998), after gathering immense amounts of data for PhD's, searched the literature for guidance on data analysis and found that little is written to support researchers in this area; that is the Achilles heel of the research.

They reflected:

> These neglects are surprising given that the robustness and validity of our research claims largely lie in the precise methods through which we transform people's private lives and stories into public categories, theories and texts.
> (Mauthner and Doucet 1998, p120)

Other researchers noted that the competence with which the qualitative data is analysed is central to the way the analysis is carried out (Miles and Huberman 1994). It was with great privilege that I listened to the stories of the peer counsellors who struggled with the dominant power of the health professionals within their community, and their voices, although a small group made public the social discourse of the day. Drawing parallels with the work of Davis-Floyd (1997), who recognised that midwifery lacked cultural authority, it what is it was mirrored by the peer counsellors and their relationships with the professionals not involved in the project and the Sure Start organisation.

3.5.3 *Layers of the First Reading; My Story of their Story*

To understand the complexity of where the peer counsellors and I were located, I read three times and devised a legend to identify how I was responding to their stories.

My first reading was made up of three in-depth readings. I analysed the data using the spreadsheet which enabled me to understand how I was listening and what role I was in. Eventually I was able to tune into my own story with guidance, through individual and group supervision support, which enabled me to listen reflexively to the women, respecting and understanding their lives on their own terms. A supervision group comprising of Mavis Kirkham my supervisor, Ruth Deery second supervisor and Jane Bloom midwife and group analyst established to discuss mine and the peer counsellors stories, this enabled me to raise sensitive concerns of how I had felt exposed in the supervision group and parallels to

the focus group on how they too may have felt exposed. I was aware not to sanitize and launder what the women were saying.

An extract from my field notes highlights how I felt doing the first reading after many months of thoughts:

> Felt easier for me to think clearer about how I was interpreting the data. I was trying to listen without bias, trying not to distort their voices with my voice.
> (Sherridan A in personal field notes, 2006)

After understanding that I was actually struggling to write up the readings I read with interest what Mauthner and Doucet (2003) wrote in their reflexive accounts:

> Our deepening understanding of reflexivity – and the range of personal, interpersonal, institutional, pragmatic, emotional, theoretical, epistemological and ontological influences on our research – has only come through emotional and intellectual distance from our projects.
> (Mauthner and Doucet 2003, p425)

I continued:

> I needed time and space to grow and heal from my disconnection.
> (Sherridan A in personal field notes 2006)

The situation was made more difficult with the clock ticking away. I was fortunate to have a very understanding midwifery research supervisor who did not subscribe to that school of thought. Mauthner and Doucett (1998) discuss reflecting on data collection. I was deconstructing my own epistemological, ontological, personal, institutional, and emotional knowledge. I continue to do so, and it is an ongoing journey. It is very time consuming. I am a woman from a working class background, I had experienced the stigma of breastfeeding my children in a bottle feeding community and supporting other mothers as a peer as well as in the

capacity of a health professional and highly skilled breastfeeding counsellor volunteer.

At times I disconnected when I found it painful searching for my own voice and then listening to what the women told me in the focus group and outside of the group. As a researcher I was silencing my own voice to listen to the peer counsellors' struggles in making sense of why women do or do not breastfeed in their community. They searched for the answer and how disconnected it appeared to be when they gave examples of women being taught how to breastfeed like robots or cyborgs, as discussed by Davis Floyds (2001). Belenky et al. (1986, p113) noted, about women's knowledge, 'their belief was connected knowing comes more easily to many women than does separate knowing.'

The woman in the focus group were reflecting back to me how the medical model separates and disconnects their knowledge, and breastfeeding becomes a mechanistic procedure with a policy manual of how to do it. I became very aware that the women had no formal mechanism to talk about their own experiences at length or other mother's experiences that they came across. The peer counsellors were in an extremely vulnerable position.

Other levels of loss emerged during the analysis. I felt I was able to analyse the data with an understanding of being a woman from a working class background, however this made it almost unbearable to write. I reflected on how these women breastfeeding in a bottle feeding community exposed them and marked them different and open to attack. I listened to the group's account of the struggle in their community to breastfeed their own babies; they were ostracised for championing their belief in a community that believed contrary to them, that breastfeeding was not normal.

Later in the focus group the women spoke for each other, speaking as one voice and completing each other's sentences. However later still the group became fractured and split, like the communities they lived in.

I had a personal experience of undermining health professionals and even though I was one myself I was on the sidelines looking in at the 'battle' that was being fought in the group regarding this. These social intricacies focused my attention on the complexity of the peer counsellors' understanding and use of reciprocity and that of their wider social circle. I acknowledge that future research will be required to explore this to the depth which I feel is warranted.

I drew upon Dalal's (1998) work:

> Psychoanalytic development theories start somewhere near birth and their greater part of their focus is on the internal state of the infant. In contrast, sociological theories, at least the ones that are of interest here, begin with environment, with society.
> (Dalal 1998, p78)

To understand the peer counsellors' words I moved fluidly between both psychoanalytical and sociological theories. I have not chosen a linear path but have acknowledged the great debate between the self and group, which is reflected in the ebb and flow of the group dynamic. This initially caused me great debate on how I would focus through these mediums; my dichotomous debate is internalised at the centre of the study.

Dalal (1998, p78) observed that:

> In Freudian theory the social is an epiphenomenon of the biological.

He continued:

> Through the sublimation, society and cultural life are constructed. This now gives birth to the second conflict this time between internalised rules of society and nature.
> (Dalal 1998, p78-79)

The conflict resonates with the intricate relationships the peer counsellors have in the group and their external social world. Whether the individual

makes the reciprocal rules or the group, we must question if somehow nature has become distorted and our biological makeup now has a faulty gene. Burman (2001) asserted that the mother-daughter relation is the dominant paradigm for thinking about relations between women. Freud's most powerful discoveries were about the earliest experiences of care, and the frustration that came at the hands of women.

I developed this thinking further and applied it to the lost generation of breastfeeding grandmothers and how the peer counsellors were reversing the damage of this lost generation. I concentrated on the word sublimation as it is probably the most useful and constructive of the defence mechanisms. It takes the energy of something that is potentially harmful and turns it into something good and useful, like the peer counsellors were doing by not taking the robotically taught 'health professional model', as mentioned earlier in the peer counsellors' reflections. The first readings were milestones in the development of my thought processes and understanding of how the peer counsellors saw their world in an embodied way. They helped me to deconstruct my own, powerful, health professional ideology.

3.5.4 Second Reading; Reading for Relationship

The second reading built on the richness of the first reading and focused on how the women were making sense of where they were located in relation to the world. Listening to the tape and reading their thoughts, I was able to interpret the meanings, processes, relationships and contradictions the women talked about. Mauthner and Doucet (1998) acknowledged that this was central to domestic life, listening to private lives through filters of psychology and sociology. This reading was for the personal pronoun and Mauthner and Doucet (1998) questioned at this point that grounded theory seems more concerned with action and interaction and less so with the processes of reflection and decision making. As with VCRM I had found the first reading at odds with grounded theory and believe this was a product of my boxed thinking process. Other researchers may find this difference at other points if they were to combine the two methods. However I was able to blend the methods eventually as my own thinking became more

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integrated. I used lots of coloured pencils for this reading; the transcripts became rainbows with the women's 'owned' words and meanings underlined.

The women spoke about their lives as 'I' and were interchanged respectfully for the group into 'we': the 'I' and 'we' was owned by the individual and group depending on the context. I realised that the second reading lent itself to group analytic perspectives and I spoke and gained support from Jane Bloom, a researcher and group analyst adopting an anthropological perspective. Bloom (2005) had written on the experiences of student midwives and the re-distribution of power by enabling students to decide the priorities for their own learning and writing on the socialisation of women. Eichenbaum and Orbach (1983) movingly demonstrate the complications women experience in learning to think about themselves. They suggest women have learnt from a very early age what is expected of them. They are required to ignore their own needs, defer to others and connect emotionally with them. Throughout this reading the women were deeply connected to helping other women, however there was recognition that the peer counsellors were resentful to the host organisation, that they felt used. I drew from the work of Raphael-Leff (1991) how women can enact and resonate unconsciously with each other, as symbolic mothers, both good and bad. Developing this notion, good and bad mother positions can be experienced in complicated ways and the analytic supervision enabled me to listen to the 'I', 'we' and 'you' and determine where the peer counsellors were placing themselves intellectually and emotionally around the organisation, which I identified as the bad mother, and the health professionals involved in the project, who were the good mothers.

This reading opened up the deeper subconscious issues that were present in the group, and how they were relating and controlling their emotions and interrelationships based on the notion of primitive survival to manage the complex relationships. The peer counsellors' words suggested that they had been violated and were understandably angry that someone had given women another inferior option of artificial feeding.

They positioned themselves as having authority and knowledge on breastfeeding their babies. The group tasked themselves with finding ways of gaining respect and channelling that knowledge in what appeared to be a hostile environment.

3.5.5 *Merging Readings 3 and 4*

Listening to the peer counsellors' relationships with each other and their community and placing them within cultural contexts and social structures, readings 3 and 4 merged. The group battled internally with external factors that impacted on their growth. The peer counsellors tried to make sense of their relationships, how they felt about themselves, and their relationships to others in their social network. They placed themselves in isolation, separated from their own community, because they breastfed their babies and that was not their community norm. Word of mouth, woman to woman, was the driver for recruitment, and a source of credibility, to the initial project.

The group appeared to battle between being an informal network and placing themselves in the context of structures where risk assessments were the norm. These tensions and talking of risks heightened fear in the group. They viewed themselves, rightly, as having authoritative knowledge and theirs was a story of battles to maintain and strengthen their position within their community, and Sure Start appeared not to benefit them. Their very being was shaken as they battled to be heard.

This was possibly an early socialisation issue. When I read Belenky et al. (1986) regarding power with and over, I remember clearly my parents had been told by their parents that children 'should be seen and not heard'. Later, as a nurse, how I was trained, initially with a stoic approach and not writing in the first person, made it very challenging for me to make this mental shift to embodiment when I had lived and worked in a split frame.

The readings were an incredible journey, emotionally, listening to my voice and simultaneously the peer counsellors'. There were deeper structural layers of society to reveal that separation rather than connections is the main organising concept (Belenky 1986). They related as one voice, the data was rich with how together the group felt strong. The health professionals that supported the project were held in high esteem by the group and other health professionals who did not have the same knowledge were dismissed and not seen as credible. They mirrored traits of the patriarchal system that they were trying to 'fight' against.

A boundary line was crossed as women were targeted via the Sure Start system, ad hoc and even on the streets, so that their private lives became public property. The peer counsellors raised concern about how they had been co-opted for their knowledge to be part of the government's targeted approach and how they were not getting paid for that. They appeared to have a duty to serve their community, however doing their duty in the community resulted in them being stigmatised.

3.6 *Ethical Approval*

Ethical approval was given in compliance with the NHS Research Governance Framework (Department of Health 2001a; 2001b). A full explanation of the study to all participants was given in written and verbal format and I maintained confidentiality and obtained written consent from all individuals involved in the research. Due to the data being collected in a focus group, it would be impossible to maintain confidentiality from other group members. However I took every opportunity to safeguard group confidentiality and names were changed and data were kept safe and secure in a locked cabinet. The study site had been anonymised and the group interaction was a valuable source of data that would not have been apparent with individual interviews.

3.7 *Credibility*

It was with respect that I addressed the issue of credibility of this work. One colleague said to another, whilst I was discussing my research work,

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that it is 'Mickey Mouse research', implying it lacked the robustness and credibility of quantitative work. At this point I had been extensively reading relevant literature and had taken part in intense self -analytical work to ensure that I was able to be as transparent as possible, regarding my history and subconscious and conscious thought processes. Mason (1996) observes that many researchers encounter crises of confidence about the validity of their own research, especially new researchers. Postmodernists have argued that there are no final grounds for accepting interpretations as 'accurate'; this does not mean that all interpretations are equal. One way interpretive rigour can be ensured is to demonstrate clearly how the interpretation was achieved, hence the development of the spreadsheet.

The research supervision team provided a framework that was fluid in the way that I could discuss my interpretations and acted as a mechanism that ensured I was reflexive and able to interpret the text from differing perspectives. There is debate around the notion of one objective and independent reality and researchers may still want to demonstrate that (their) interpretation is valid, without restoring to claims of ultimate truth and objectivity (Mason 1996, p150). Validity and reliability are not established through using procedures that ensure findings reliably reflect one 'reality' and the spreadsheet was not produced with this intention, rather as a way of sharing the dialogue as I conducted the readings and enabling me to share with peers and my research supervision team.

Atkinson et al. (1992) observed that knowledge is legitimised when external peers, the people studied, and other relevant audiences agree that interpretations and conclusions are accurate reflections of the phenomenon. It is with this in my mind that I used the VCRM and grounded theory. I constantly and consistently examined my interpretations, ensuring rigorous reflexive thinking.

In the next chapter I present the findings. I trust that those studied here and those who read this study will recognise their reality presented in my analysis.

Chapter 4: Peer Counsellor Training and Dilemmas of Supporting Mothers

The women's stories of training to become a peer counsellor are explored through their discussion around the ambivalences of embodied and relational knowledge and skills to breastfeed; acknowledging the limitations of health professional knowledge.

The peer counsellors identified the benefits of their training and made suggestions for improvement. They critically reviewed the health professionals' lack of breastfeeding training and offered suggestions for improvements, finally balancing the risks involved in becoming a peer counsellor with the benefits of feeling empowered and supporting mothers to breastfeed.

4.1 Peer Counsellor Training

Each program is adapted to meet the local needs of mothers:

> *"I enjoyed my training. I did, I enjoyed it."*
> *(All voices joined in, Q215)*

> *"But it weren't too sat down in a classroom though, was it? It was like relaxed and everybody join in if they wanted to. If they didn't want to join in they could stay quiet and just listen. It was really relaxed and friendly."*
> *(Eliza, Q218)*

They were enjoying this because it was a relaxed atmosphere and there was no pressure on them. They were encouraged to talk and use their own experiences, the organisational ethos held mothering skills and breastfeeding in high regard.

Other models of peer support/counselling training also had an underlying philosophy of motherhood being valued and shared (Anderson 2001;

Smale 2004). This seemed to inspire confidence in the peer counsellors. Sophie felt this was true, that there was no substitute to actually doing it:

> "I think sometimes as well there's no substitute for training other than the real thing because if you've experienced it yourself and you've done it then ..."
> (Sophie, Q149)

They had interwoven their own tacit learning into their skills as peer counsellors and compared how women's embodied experiences were different to health professional training models on breastfeeding. In the evaluation of Breastfriends Doncaster 2000 Initiative (Curtis et al. 2001) it was discussed how the peer supporters had to unlearn the powerful and seductive model of 'advice-giving', which they had been exposed to during their childbearing years:

> "Yeah, I think that all health professionals should have to go on La Leche training ... administrator training. A five-day course like Eliza said, because UNICEF training, although I agree with a lot o' UNICEF statements and things, but their training."
> (Ann, Q373.)

> "Is like making breastfeeding a medical procedure."
> (Ann, Q375)

> "Yeah, it does. It's too medicalised."
> (Ann, Q379)

> "But not, right, you need to sit with your back straight, and talking it through as if it's ... I were gunna say, how many times when you breastfed, did you actually make yourself think all that when you did it? Because I didn't. It was a case of put her on. There were no, "Right, I've got to sit like this and I've got to hold ... and I've got to do 'cos that's how I latch on properly."
> (Eliza, Q390)

"You do what's comfy because when you're tired and your baby wants feeding, you get however's comfy for you."
(Eliza, Q392)

The peer counsellors approached their support in an embodied way, their experience was respected and their knowledge was synthesised in their training. This was at odds with the scientific research-based philosophy and body of knowledge that has become so accepted and that it is part of the invisible, unquestioned, commonsense knowledge of the population (Olson and Shopes 1981).

Theorists such as Vygotsky (1978) believed that interactions between parents and children, led to intellectual development, took place in a specific way. He proposed the Zone of Proximal Development (ZPD) as a way of illustrating how social interactions between experienced members of the culture and less experienced children led to development as determined through problem solving under adult guidance or in collaboration with more capable peers. Similarly, because the health professionals who were involved in the project acknowledged the experience of the peer counsellors and used their knowledge and skills as a resource, the volunteers felt confident and enabled. They went on to set up drop-in sessions, alongside the health professionals. This gave the peer counsellors an opportunity to talk and share their experiences as breastfeeding mothers with other mothers. Bruner (1983) came up with scaffolding an interactive process in which adults adjust both the amount and type of support they offer leading to the eventual mastery of the skill being taught. The peer counsellors did this with considerable flexibility. This was a typical example of how the peer counsellor's knowledge was applied, for promoting breastfeeding to teenagers:

"You've got to teach the parents and everybody, they're not going to do it, are they because that makes them totally different."
(Q322, Ann)

"So, is talking to the kids the best thing to do? Is talking to their mothers a better idea and educating their mothers so that they're behind."
(Q324, Ann)

'Kids' refers to the teenagers that the group were discussing. The La Leche League ethos of training works on the premise that the peer counsellors already have the knowledge and skills to support other women and that their training complements their existing knowledge. This was different to the health professionals that the peer counsellors came into contact with, whose training, on the whole, had not valued and respected mothers' skills and knowledge on mothering and breastfeeding.

4.2 *Empowered Peer Counsellors and Health Professionals' Lack of Training*

The peer counsellor training was set up to empower mothers and it seemed to have the desired effect, making the peer counsellors feel valued for their breastfeeding skill and knowledge. Paradoxically women are encouraged to measure their importance through motherhood but, by the same token, motherhood has low value in our society (Goffman 1991). Eliza went on to discuss how the health professionals had a lack of infant feeding training in their professional training and how their La Leche League training had helped the health professionals, some who had only received a couple of hours training on breastfeeding support during their studies:

"Catriana admitted, didn't she, she did two hours breastfeeding training through all her nurse training and health visitor training."
(Eliza, Q177)

"That week we had with our Ryan, he'd have been on the bottle now. Well, he won't have 'cos I wunt have, but she said, "If I hadn't have done that training to do it, she would have advised us to bottle-feed him."
(Theresa, Q178)

The training seemed to give confidence in breastfeeding to the health professionals as well and saved Theresa's son from going on to artificial formula.

> *"And that's from her and because she'd done this training she says, "Oh no, we'll stick it out." (Referring to the health visitor)*
> *(Theresa, Q180)*

> *"Oh well, the midwives have been doing this, health visitors and they're both sat there like [inaudible], but they were fine about it and to me if Jackie and Catriana have done that training surely that's going to make them stronger and better for advise other people that's not doing the support group."*
> *(Eliza, Q226)*

Eliza suggested that the health professional training was far from adequate:

> *"They [health professionals] need more training on it."*
> *(Eliza and Theresa, Q173)*

> *"It should be fetched in [referring to health professional training] in the training for it, as a standard thing, not just two hours because I'm sorry, but I think that's pathetic."*
> *(Eliza, Q213)*

Eliza summed up her view of the lack of training for health professionals; this has been mirrored in other discussion regarding health professional's lack of training on breastfeeding.

There has been controversy over the past few years regarding the International Growth Charts because they are based on formula fed babies. In Sachs's (2005) Ethnographic Study she concluded that babies were weighed more often than officially recommended, with weighing and plotting as a form of surveillance under the medical gaze, and practice by health professionals was found to be more concerned with increasing weight rather than improving breastfeeding.

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There has been a mismatch between the training women felt health professionals needed and the kinds of training provided. In the University of Leeds training analysis women emphasised the basic skills required for breastfeeding and the importance of understanding women's feelings, but many practitioners said that this was not what they were taught (Smale 2006).

The peer counsellors found that the information they had contradicted the health professionals', particularly the information and support mothers were given when their babies had lost weight, and the peer counsellors felt that they were being ignorant.

> *"But I feel that everything that they La Leche League Training told us contradicts everything that I've heard before from the midwife and the health professionals."*
> *(Laura, Q219)*

> *"It's ignorance on the part of the health professionals not been given them the right training."*
> *(Sam, Q146)*

The peer counsellors offer suggestions why the health professionals are less knowledgeable: they assumed they had bottle-fed.

> *"They shut it out 'cause they bottle- fed."*
> *(Theresa, Q147)*

The literature suggests that the attitudes and beliefs of low-income women's social networks may be more influential than that of health professionals (Humphreys et al. 1998). Hoddinott (2000) identified that it may have been a result of differing agendas between mothers and health professionals. Oakley observed that the medical model of care has ignored the importance of talking. However, she argues that the telling of a story is important as it shows how the world is to be known and who knows it (Oakley 1992). She continues by advising there is a great need for women to articulate their skills, especially in regard to breastfeeding, as these skills

need to be passed on to other women to enable them to nurture their infants. For most health problems the success in prevention and disease management is not dependent on high–tech medical interventions but proactive community interventions that take place upstream from the point of cure. Preventative services, the education of community members, on self-care and behaviour change are key components to change the negative culture. The allies (peer counsellors) are instrumental in breaking through the barriers. Curtis et al. (2006) noted that both peer supporters and health professionals described gate keeping activities and surveillance behaviours practiced by health professionals.

The health professionals had expert authority status and their knowledge, whilst inadequate, carries that authority (Davis-Floyd 2001). Their practice warranted gate keeping because of their authority. Love et al. (1997 p501) describes the role of peer counsellors as serving as 'culture brokers'. The peer counsellors seemed to be an advocate for mothers and recognised that mothers still had confidence in health professionals who might be needed to keep mothers breastfeeding. Peer counsellor training appears to have an empowering effect and has been a component recognised in other peer counsellor and support programs (Curtis 2001; Battersby 2001a; McInnes et al. 2000; Morrow et al. 1999; Kistin et al. 1994; Schafer et al. 1998). The La Leche League training provided by the local health professionals in this study was an arena where the peer counsellors and health professionals could feel safe, be honest, and listen to one another about their own feeding experiences or vicarious experiences of breastfeeding.

4.3 The Peer Counsellors' Frustration with Health Professional Surveillance

Weighing breastfed babies has been the subject of some controversy as the previous International Growth Chart was largely based on data from infants fed infant formula (Sachs et al. 2006).

The peer counsellors knew that the charts were not based on the normal growth pattern of a breastfed baby and they were extremely frustrated when some health visitors they dealt with at the clinics lacked the confidence to support mothers when their breastfed babies lost weight and would automatically advise them to bottle-feed.

Theresa, Sam and Eliza talked about how the health professionals they knew needed more training and confidence in breastfeeding support:

> *"When you're going to the baby clinics and they're weighing your child, know you're breastfeeding they need to be aware, dun't they? They need ... health visitors need that training."*
> *(Theresa, Q182)*

> *"They need to be aware that breastfed babies do ... they need to look at it and they dun't work the same as bottle-fed babies. They're not automatically just going to straight away start putting weight on. Most breastfed babies lose more than that 10% weight and when they're saying it's all right for them to lose 10% weight, but then when you see their face when you start going past that 10% weight and they're like, "Oh, I don't know, looking rate sort of ... and that makes you lose confidence in yourself."*
> *(Sam, Q183)*

Sam identified the importance of the health professional's body language and how their faces tell another story from 'being all right'. Theresa shared her personal story with the group of when her breastfed son lost weight and the health visitor's response. The group used this experience and felt the health professionals lacked training and could avoid a first line measure of advising a mother to put her baby on a bottle (Dykes 2005b; Sachs et al. 2006):

> *"And that's from ... from her and because she'd done this training she says, "Oh no, we'll stick it out."*
> *(Theresa, Q180)*

"I think that's a lack of training on their part."
(Sam, Q184)

"And if they had that training then they'd know … yeah, so, we've lost more weight, fair enough."
(Eliza, Q185)

Eliza and the group were sensitively working through how they could help the health professionals when they lacked the confidence and knowledge on breast-feeding:

"We've lost a bit more, fair enough, but breastfeeding. How can they say that breastfeeding's best if they're not going to do the training to learn that yeah, it is the best, but yet they might have this little bit of period to start with and your baby might seem to not do nowt."
(Eliza, Q188)

"Or they're allowed so long for them to gain weight rather than just....."
(Theresa, Q189)

"Exactly and not straight away."
(Eliza, Q190)

"They should put that other bit of training, even if it's like a week intense course within it, so that it's not dragging it out the 12 week that we did. They have like say one week out of their training where they concentrate on breastfeeding and do it that way because it's not taking more of their time up that much is it and they'd be better informed and better … be able to serve the community."
(Eliza, Q207)

It was a sad fact that most of the local health professionals in their area were not confident with breastfeeding and the peer counsellors were supporting the mothers and the health professionals to preserve mother's breastfeeding. The peer counsellor's approach was to support mothers

alongside health professionals, instead of using the surveillance strategies that have been the norm with mothers and health professionals, noted in the work by Sachs et al. (2006). There is a suggestion by Bradfield (1995) that there is a history of negating women's knowledge developed on the basis of experience. She suggests, in the community situation, at least one sector (La Leche League) may be different, with evidence of the merging of women's experiential knowledge with the dominant biomedical discourse.

4.4 Peer Counsellors Assessing the Risks; Advocacy and when to Call for Help

In the previous sections I have explored how the peer counsellors were empowered by their training and realised that they were sometimes more knowledgeable about breastfeeding than most of the health professionals they dealt with.

The peer counsellors agreed their training was mother-centred compared to the health professional's distanced language and 'medical procedure' approach to supporting mothers to breastfeed. In this section the peer counsellors identified two areas that concerned them when they supported mothers. Ann continued to discuss how health professionals' language could medicalise and make it into a procedure. Firstly, in light of their experiences as peer counsellors, they discuss how their training had prepared them to support mothers alongside health professionals. Secondly, how they balanced the risk of how much information and support to give to a mother and when to make a judgement call to a health professional. The peers were advocates for mothers empowering them to make their own decisions. These mechanisms seemed to be part of a self-preservation strategy to protect their peer counsellor role and protect mothers from inappropriate advice from health professionals. (Renfrew et al. 2000; Fairbank et al. 2002)

I will conclude this section with a discussion on the possible emergence of peer counsellors as opinion leaders in their community.

4.4.1 After the Peer Counselling Training

The peer counsellor training evaluated well and Theresa summarised:

> *"When we did that training though, I dun't think anybody knew how it would take off. Even Jackie and Catriana and Andrea did not know how much this was gunna take off, so they'd not even considered purrin' that in the training before, where this one, they are going to do stuff aren't they, different to what they did with us because we hadn't got a clue."*
> *(Theresa, Q519)*

Sam's words suggested there were gaps and they needed more training on people's attitudes:

> *"I think maybe there ought to be more training for us on people's attitudes and how to approach people in all different situations."*
> *(Sam, Q508)*

In northern communities breastfeeding is not the norm and Hall (1997) describes, the taboos surrounding the breasts are deeply ingrained and emotionally charged. Battersby (1999; 2006) has addressed the cultural norms that affect midwives' decisions to breastfeed and concludes that they too need to develop professional training to address this lack of knowledge.

Theresa voiced that she felt unsure about what the group would do and Sam felt like they were guinea pigs on their training:

> *"When we finished that training I did not know what we were going to end up having to do."*
> *(Theresa, Q522)*

> *"We're guinea pigs, you know, aren't we?"*
> *(Sam, Q526)*

There was agreement and an acknowledgement that the next group would benefit from their learning and what the expectations would be when they

completed their training. The overall training evaluations were excellent; there were, however, areas that the peers felt needed to be ironed out for the next training courses.

4.4.2 *The Peer Counsellors Judging when to Call for Help*

It was difficult for the peer counsellors to find someone who they could trust to refer onto, as most of their community had bottle-fed. However, they were in a difficult situation as they talked about the risks of having the information about breastfeeding but found they may be sued if they give the wrong information to mothers.

Theresa thought they were better at giving advice although Eliza reminded the group about their training and this was a fine line they had to tread when making the judgement of when to call a health professional:

> *"Might be able to give them better advice than what a midwife can or a health visitor. (Lots of group agreement)"*
> *(Theresa, Q407)*

Sophie gave some pointers for mothers, in this instance a mother with a possible mastitis and then decides on medical attention:

> *"Like how to lay in bed, like putting a cushion under."*
> *(Sophie, Q408)*

> *"Yeah, but then if it's mastitis and it needs treatment you've still got that."*
> *(Eliza, Q409)*

> *"You ought to get medical advice."*
> *(Sophie, Q413)*

Ann gave an example of how she would handle a woman who has mastitis, showing the mutuality between her and the woman reading the leaflet together and not taking any responsibility other than being with the woman:

"So ... but in that really you dun't need training, do you, about mastitis. You dun't need to know everything ... you can have some information theya if you need it. So, like if a woman ... you think a woman's got mastitis and there's a leaflet or whatever (tear offs) that care plan for mastitis and you can look at it together, but it's not ... I dunt feel it's our place to take that on board because what if we did something wrong and it turns into a breast abscess."
(Ann, Q414)

Ann reinforces her point that the decision lies with the mother:

"But when you give out information it's ... the whole idea is you give them ...so you give them the information ... you give them care plan on mastitis. You maybe go through it, but she has to do it. She makes the decision and she does it."
(Ann, Q473)

"That we can ourselves and then say, go see a doctor, but not actually like you say, well, that's definitely mastitis, that you've got to do this and you've got to do that. We could do with a bit of training to actually make sure that we know and ... you know, like determine whether or not that is ... which way it's tending to go rather than just a blocked duct or something summat like that".
(Eliza, Q419)

"But if a woman wo saying that she were in pain in her breast and you could see it were red and things like that, I mean you would ... you'd ring Jackie wouldn't you?"
(Ann, Q420)

The peer counsellors debated their roles and boundaries; it was difficult and the debate continues of who to call, principally a health professional, and when.

> "But you can get that with a blocked duct, yeah. I'd automatically send for a health professional, yeah."
> (Eliza, Q421)

The group discuss liability, how difficult it is for health professionals, and that they are definitely not professionals themselves. However when they talk about taking risks and having public liability their speech has connotations of adopting a degree of professional language (Gaskin 2006a):

> "I were going to say, we haven't actually got liability insurance or 'owt like that so if anybody did want to sue us ..."
> (Eliza, Q439)

> "Exactly. It's like with first aid. If you do first aid on anybody and crack their rib, straight away they'll be theya for, you cracked my rib. Bugger that you were trying to save my life. You cracked my rib. I'm taking you to court."
> (Eliza, Q450)

These peer counsellors drew a clear distinction between their support and the work of the health professionals:

> "It's like if the other profession ... at the minute that's something else professionals are doing. Nurse training, they haven't got time to do breastfeeding training because they're having to spend time on doing training to fill paperwork in case anybody sues them."
> (Eliza, Q445)

> "They're health professionals and we're not."
> (Ann, Q446)

Their discussion led to what they saw themselves providing, and it was very simple: Ann thought it was a cushion, Sophie referred to themselves as the driving force, and Sonia, if pushed, may suggest a cabbage leaf (which is believed to help decrease engorgement as discussed in Renfrew et al. 2000).

> *"But we're not doing anything that's massive are we, because then if she doesn't like it she can shove the cushion back under and I think beyond anything like that, that's not ... our place."*
> *(Ann, Q466)*

I tried to understand the 'place' that Ann was referring to when supporting mothers and how it may have become invaded by the unnatural knowledge of breastfeeding through a medical approach. The peer counsellors appeared to be reclaiming the right to speak of embodied experience of breastfeeding their babies in that place.

Belenky et al. (1996) spoke of how this place had been lost with urbanisation and social isolation. The peer counsellors appeared to be exploring the space available and pushing the boundaries of the health professionals, though not claiming their expert role. Yet by claiming their place, the breastfeeding peer counsellors were stepping out of the private place into the public gaze.

Smale (2007) writes of the fear of embodied knowledge around breastfeeding leaking out into the health professional domain, when midwives have breastfed their babies and the silencing around that discussion.

> The silencing of discussion about embodied breastfeeding experience could be read as a way of constructing rules about the behaviour of health professionals.
> (Smale 2007, p136)

Reflecting on my own breastfeeding experience as a midwife and trained volunteer breastfeeding supporter, I examined how I was allowed to

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consider who I am, how I breastfed my children within both 'spaces' because they were different and as a health professional it was more about silence and control of that experience.

> 'I feel' was an alien phrase in my midwifery training. We were rather like observers in a cocoon who did not take part in what was happening around us – that's for the patient /client! I..... presume that this approach was used to keep the patient/client safe and not too personal.
> (Trewick and Smale 2005, p3)

The peer counsellors were a voice for women's embodied experience within professional spaces and were negotiating their rightful place for women's knowledge and skill of breastfeeding their babies, as opposed to authorative medical knowledge. By supporting women, they were giving a voice and an importance to embodied knowledge. Their voice was easy for local women to understand and they would not be silenced.

Ann (quote 466 cross ref p59) made it clear they were not there in an advisory capacity and that suggesting a mother move a cushion was not claiming any authority. She had already identified that some of the local health professionals talk like textbooks.

> *"It's just being there to give them that driving force to carry on, isn't it? " Good on you. Keep going. How many weeks now? How many months now? That's brilliant. Don't worry about his weight. He's coming on. Just being there."*
> *(Sophie, Q551)*

> *"Well I mean if they pushed it and wanted me to give them some advice, then I'd say, Well, you know, perhaps you could try a cabbage leaf, or something like that, doesn't always work for everyone, but it's worth a try."*
> *(Sonia, Q494)*

Certainly, they suggested the health professionals could learn from working side by side with them and benefit from the same training they had:

> "They need more training to do like what we've done so they can work alongside us and then we both know the understanding of what we both do."
> (Theresa, Q175)

Norway has taken an integrated approach to removing the barriers for health professionals learning from mothers and breastfeeding supporters. We all need to move forward in a positive way acknowledging each other for the skills that we have to support mothers and celebrating that breastfeeding is a skill passed from woman to woman. We have to listen sensitively and find a way of accepting differences to be able to move forward. One major difference was payment for breastfeeding support.

This peer counsellor was very aware of how different they were to health professionals in monetary terms:

> "Are two separate entities."
> (Unknown, Q459)

> "If you're a peer and you're paid, you're not a peer, are ya?"
> (Ann, Q554)

They made it clear that as a paid worker you were not a peer, the role was unequal. Peers were on the same level and with the role of the health professional came the responsibility, which could be litigious (Gaskin 2006b). The peer counsellors were seeking mutual relationships with mothers and health professionals, mirroring the relationships that had been forged in their La Leche League training. They were using an enabling approach and not seeking to adopt an authoritative role.

4.5 Peer Counsellors as Advocates and Emerging Opinion Leaders; Finding a Place

4.5.1 Advocates

I listened to how the peer counsellors were advocates for mothers and how they offered to accompany the mothers when they went to see the health professionals. It was a mutual relationship; the peer counsellors shared with the mothers.

> *"And see Jackie about it? You're not ... you're not doing anything, are you? You're just offering."*
> *(Theresa, Q594)*

The peer counsellors were offering friendship and were not aggressive; it was simply offering support to another woman if she needed it. Ann used very subtle, gentle language and offered suggestions of how the mother might be able to hold her baby. Ann's approach to mothers appears non-threatening.

> *"It's just sitting and having a cup of tea and saying, "Why don't you try just ... pulling him in a bit closer, or, Take that cushion out from under your arm and see if that makes it any better for ya."*
> *(Ann, Q464)*

Ann's suggestions were simple, supporting mothers to help their babies to breastfeed, and was defining what she felt as a peer counsellor's role was.

> *"What you've to remember is health professionals are like everybody else and out of the group you'll have so many that take on board what's said and can put it across in a nice term. But then there's going to be so many who read it like a text book and they're saying Right, so ... and if we've got ... and using big words and such..."*
> *(Ann, Q381)*

Ann counterbalanced her views and recognised not all health professionals spoke in jargon. Darby (2006) explored the dynamic properties of the personal social networks concerned with child health, constructed by primary carers of pre-school children, and examined their influence on the delivery of care to those children when they are ill. It was found that the knowledge from both lay persons and professionals were valued by the respondents.

> The specialist and expert knowledge gained from consulting a health care professional is supplemented by the expert lay knowledge supplied by the most trusted contacts found in the core networks of their personal social networks. Both are valuable to the respondents, complementing each other rather than being viewed as stark alternatives.
> (Darby 2006 p 319)

This was certainly true for the peer counsellors who relied upon the health professionals when they came across mothers they felt posed a risky situation. Sophie suggested they were extremely empowering to mothers. The peer counsellor was confident, knowledgeable and could inspire confidence in mothers.

4.5.2 Opinion Leaders

As the peer counsellors grew in confidence there was a natural progression for the peer counsellors to be seen as 'opinion leaders', whereby people adopt new ideas, strategies, and methods and are able to transmit them to others – to diffuse innovations (Rogers 1995). One of the main methods of this diffusion is the 'two-step flow model', which involves opinion leaders carrying information from its source (often the media) to other individuals (Burt 1999). Their influence is thought to be mainly between groups and not within them. Opinion leaders are not people at the top of things so much as people at the edge of things, not leaders within groups so much as brokers between groups (Burt 1999). This brokerage is conducted through having strong links between groups and being able to introduce new information into them. The information is diffused within each group by, what Burt

describes as, equivalence – group members having similarities in their links with each other.

> The first adoption within a group comes from converting a close contact, after which the opinion leader fades into the background to allow contagion by equivalence to have its effect; peers adopt not because of the opinion leader but because of the advantages that adoption gave to the person converted by an opinion leader.
> (Burt 1999, p40)

This concept could be applied to the peer counsellors who were diffusing information into their own natural networks and will hopefully become the knowledgeable grandmothers of their communities. The peer counsellors were converting mothers who became more confident and knowledgeable about breastfeeding and converted another mother.

One example of putting this into practice was the discussion on teenagers and how they could tackle the problem of them not breastfeeding by influencing their mothers and families about breastfeeding.

> *"I'm not saying that we're trying to get them to breastfeed. I'm just saying that we can look at their answers for things to look at ... areas to look at and approach and try and change attitudes because that's what it's supposed to be about."*
> *(Eliza, Q315)*

The peer counsellors were very aware that they had to think of multiple approaches and that they needed to collaborate and collude as necessary with the health professionals, to enable them to utilise the skills and knowledge they had to support other mothers in their community. It was a complex and difficult situation and one that the peers paid a high price to achieve. In the next chapter I will explore these complexities, through listening to the peer counsellors speak of their motivation for becoming and being a peer counsellor.

Chapter 5: Becoming and Being a Breastfeeding Peer Supporter

5.1 Motivation

To understand the experience of these breastfeeding peer counsellors, it is useful to start with motivation. They had all breastfed and experienced some difficulty, whether they perceived it to be physical, emotional or both or that it was not an option:

> *"I'm Sam. I'm a mum of three. I didn't breastfeed my first because I were only 17 when I had her and I didn't, I weren't given an option for breastfeeding."*
> *(Sam, Q18)*

Similar experiences were shared by the group regarding breastfeeding not being an option, and that they passionately wanted women to have the options that they had not.

> *"If I could help one person to successfully breastfeed their baby, I think it would be almost as rewarding as my own breastfeeding experience."*
> *(Ann, in: Sherridan A 2006)*

Sophie wanted to ensure that she supported other mothers and this was a very powerful motivator for her.

> *"What drives me is the fact that I struggled so much and there was no one there."*
> *(Sophie, Q114)*

Theresa wanted to be a midwife and peer counselling seemed to present a route into midwifery training. Eliza and Sam recognised this as her motivation and challenged her enthusiasm about wanting to be a midwife, which she seemed to think was different to being a peer counsellor.

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"But do you think you'd have had as much enthusiasm not have breastfed?"
(Eliza, Q194)

"Yeah, because I want to be a midwife, don't I? I want to do it."
(Theresa, Q195)

"Yeah, but she's saying because you want to be a midwife"
(Sam, Q198)

Theresa was using this as a stepping-stone into midwifery training and Eliza continues:

"Yeah, but I'm just saying though if you hadn't have breastfed and say you didn't want to have been a midwife or you hadn't considered it, would you still have had as much enthusiasm, if you hadn't breastfed, to do it?"
(Eliza, Q199)

"Maybe not." (Quieter voice)
(Theresa, Q200)

"Exactly". (Lower tone confirmation voice)
(Eliza, Q201)

Eliza questioned if Theresa's enthusiasm would be different because her motivation was not solely grounded in breastfeeding; most of the peer counsellors' motivation concerned breastfeeding and the reciprocity of relationships surrounding breastfeeding.

5.2 Reciprocity

Reciprocity generally refers to mutual giving and receiving (Hogan et al. 1993). Williams (1995, p401) presented a theory that rather than the reciprocal benefit going to the person who gave the support in the first place, she saw a trend that she classed as 'stepwise reciprocity'.

She likened this to a ladder or stairs, with someone who has been helped on one stair giving to another person in need on the next step. The peer counsellors wanted to help someone else though they had often not been helped themselves. Their stories were emotionally complex and I was able to identify three relational themes of reciprocity, which were dependent on the varying degrees of relationship dependence the peer counsellors were in at the time, to that person or group, as follows:

Relationships with mothers they were supporting.
Relationships with health professionals and the problems with reciprocity.
Relationships with each other as volunteers and the wider community.

This focused my attention on the complexity of the peer counsellors' understanding and use of reciprocity and that of their wider social circle. In the next section I will examine the identified reciprocal relationships the peer counsellors had.

5.3 *Relationships with Mothers' Peer Counsellors were Supporting*

Theresa felt a great sense of achievement when she helped mothers to breastfeed. The peer counsellors found supporting mothers a rewarding experience:

> *"You see them up at the doctors and they are feeding and you think, Oh great, yeah. Have I helped to do that?"*
> *(Theresa, Q265)*

> *"But everyone's different because I've approached some people at a health ... a different antenatal class and when I've gone up they've been really ... they couldn't be more appreciative and they really want your help."*
> *(Sam, Q260)*

Sam summed up the power of supporting another person and identified that it was a reciprocal experience for her:

> "It's only because you've done it and now you know you can do it that you've done it."
> (Sam, Q84)

> "They just wait for you to come over and see them. They don't want to come and talk to you, but they wait ... they're waiting for you to go and approach them and then they really want to listen and they're wanting to know everything that you've got to say."
> (Theresa, Q262)

There seems to be some reticence in mothers coming forward and seeking peer counsellor support. Yet it is clear that when mothers do receive the support it is appreciated and the peer counsellors find this empowering.

5.4 Relationships with Health Professionals and the Problems with Reciprocity

The peer counsellors had different relationships with local health professionals who were involved in their training as opposed to the health professionals who were not involved in the training and consequently were not as close to the peer counsellors.

5.4.1 Relationships with the health professionals involved in the training

The peer counsellors were close to the project midwife because she made extra effort and actively sought to support them. They displayed a mutual obligation to Jackie:

> "Jackie, she's even come into my house to deal with stuff, to weigh the baby mix and explain things that that we can try makes a difference. I mean she come out Boxing Day to my home to weigh Lauren."
> (Eliza, Q117)

"She [referring to the midwife] just goes out of her way. It doesn't matter where they are. Even if they're not in the community she still goes out."
(Theresa, Q118)

The group showed support to her because she had belief in them and had supported them with their own babies, even in her own time:

"And that's what makes you ... because if she's willing to put that much time and effort in, even when she's not getting paid for it on her days off, (unison talking saying the same thing) that makes me then think, Well."
(Eliza, Q19)

The peer counsellors spoke very supportively towards the professionals who had trained them and saw them as allies, and sometimes like a surrogate kin. They usually experienced negative attitudes from family, friends and 'other professionals' for their belief in breastfeeding. The health professionals that had set up the project and delivered the curriculum to the peer counsellors shared the same values and developed a 'peer relationship':

"It is something worth doing. If she's got that much belief and everything else in this."
(Eliza, Q121)

"Don't think she's got belief in this. I think she's got belief in us. I think she really believes."
(Ann, Q124)

"That we can ... the group can do it."
(Ann, Q126)

The group were supported by this midwife and felt empowered by the fact that she respected them for their skill and knowledge of breastfeeding their own babies.

5.4.2 Relationships with Health Professionals not involved with the Project

It was apparent that the health professionals who were not as closely involved in the project did not respect the peer counsellors as the health professionals who were closely involved with them did. The peer counsellors wanted to give something back to women because the system had let them down. The relationship between health professionals and the provider agency of the Peer Counsellor Programmes was often imbalanced owing to the complicated professional and socially constructed boundary of who owned the breastfeeding knowledge and services. The peer counsellors appeared to voice that they had been let down by the system. The health professionals tended to revert to the bottle-feeding default position when a breastfeeding mother's baby was not gaining weight.

There was talk of being victims and metaphorically using 'battle' language:

> *"A health visitor and a … what is it? Boyston she's just had a hell of a time with her health visitor because the bairn's underweight. Now he is thriving summat chronic and Jackie sees him three times out of week like baby massage, no clothes and he's thriving and she's like in doubt, "What do I duh?" and we can't be fayting against them. When we're theya … I see her more or less every day and she's doing a chuffing hell of a job. Why, when it says health visitor have they got to listen to them? It's them we're faytin against."*
> *(Theresa, Q141)*

The relationships of peer counsellors and mothers are delicately balanced around the health professional's power and control of care (Kirkham et al. 1997).These elements were evident in the work Curtis (2001) conducted when she looked at the tensions and the evidence suggested there was a lack of trust and equality between the peer supporters and health professionals in the study.

There appeared to be a similar pattern in my study although I did not gather data from health professionals themselves. Sophie expressed that if health professionals could learn from their own experience and train in the same way it would reduce conflict between health professionals and rebalance the relationships with them and with the mothers in the community:

> *"Just from their own experiences can put you in the right direction. We'd be able to work better and help people if the health professionals who trained along same lines as we are because you're faytin a losing battle."*
> *(Sophie, Q139)*

O'Neill (2007) identified the same pattern when midwives used battle language, talking about 'fighting for normality' against the dominant medical model. Theresa also acknowledged that mothers don't always listen to health professionals:

> *"Sometimes they don't even they don't always listen to a health professional anyway. I think sometimes that puts 'em off."*
> *(Theresa, Q134)*

The peer counsellors provided an alternative to the health professionals and offered to support mothers if they needed to see their health professional.

5.4.3 *Peer Counsellors and Health Professionals: Bridges and Blocks*

Theresa was also gauging what the mothers wanted and it sometimes was not a health professional:

> *"Oh yeah, but if you go out and see somebody they don't always want them [meaning health professionals] there."*
> *(Theresa, Q136)*

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Sophie indicated the reason why she thought mothers preferred non-professional support:

> *"And I've been confused by health professionals because one said one thing and my doctor said another and my midwife said another and then the health visitor said another thing, so sometimes ... you know, sometimes if you've got somebody who's not a health professional."*
> *(Sophie, Q137)*

There has always been a resistance to the dominant biomedical discourse from women confused by conflicting advice or instructions that contradict their own knowledge (Curtis et al 2001). Certainly, Sophie and Theresa's statements were clear about how personal experience of breastfeeding problems together with an enabling, not advising, approach can be empowering for mothers who are enabled to make their own decision. The health professional training is discussed in more detail later in this chapter.

5.5 *Relationships with Each Other and the Wider Community*

The peer counsellors were aware that they had to be careful in their community so that they did not appear to be 'evangelical'

> *"Because if you ... if we're seen to be wearing these like T-shirts Sonia and Theresa said you get people with the automatic attitude, Oh god, they're going to try and come and throw it down us throats, flippin' hell and it's not. We just want to be here for if they want help. They might come to us I were going to say not like Jehovah's witnesses coming knocking on your door put your foot in the door if like they say no."*
> *(Eliza, Q247)*

It was important for them to strike a balance between supporting and *'pushing it'* on their community and these were some of the responses when I asked about their family and friends' reaction:

> *"You've talked about health professionals, but there's like your family and friends. What have they thought about you doing your training? Have they got any?"*
> *(Interviewer 1, Q228)*

There was a mixed reaction and Sophie said her family had been very supportive:

> *"They love what I'm doing."*
> *(Sophie, Q229)*

Sonia said it depended on who it was to the reaction she had:

> *"Different reactions from different people."*
> *(Sonia, Q230)*

I asked what the reactions were:

> *"Very against it."*
> *(Sonia, Q232)*

> *"Pushing it on people?"*
> *(Theresa, Q233)*

> *"Yeah, and they don't ...shouldn't be, you shouldn't be doing that sort of thing."*
> *(Sonia, Q234)*

Promoting breastfeeding appeared to be a taboo subject in their community, however there was a compromise of how strongly they promoted this to women, explaining the options without putting women off:

"It's not pushing it on people though, is it?" (Eliza and Sonia speak Simultaneously)
(Eliza, Q235)

"It's not done in the area. You just don't ... you don't interfere in other people's business."
(Sonia, Q236)

However there were tensions, especially when people thought they were being pushed into breastfeeding; Sonia and Eliza defended their promotion as not 'pushing it' and were aware of not interfering in other people's business. Theresa gave an example of what happened when she was at the doctors:

"And there's people in general up at the doctors, isn't there? We sit up there doing what ... for people that want us and then there are people there and we forget whom we've seen, don't we and they're really rude. I were like, "Oh god (Laughing)"
(Theresa, Q238)

"It were like, Well ..." She says, Well, we're only doing us ... you know, us job like, and if they're not interested then they move away, but we can only ask. Bit us 'ead off."
(Theresa, Q238)

It was difficult for them and the stories of the reaction to them continued in this manner. The group served as a safe place they could share similar stories of the negative reactions that they received:

"You've got to be strong to go out to start with, I think, to get some hammer, yeah."
(Theresa, Q252)

"They don't want your help or they're rude."
(Sonia, Q255)

Theresa and Sonia appeared to have been treated with contempt by the same individual and talked about how they needed to be together; there was great loyalty between them when it came to situations like this:

> "Everybody listens to us but on us own but on us own it's very hard to do it on us own."
> (Theresa, Q129)

> "I think one thing that is vital is ... between us that's sat here in this room, we need to be able to support each other"
> (Ann, Q763)

There was a positive side though as the community started to respond:

> "You're going to find different people and meet different views wherever you go. It's the same with everything, isn't it? Everyone's got different views. You've got to take the good with the bad, haven't you?"
> (Sam, Q263)

Sam balanced the comments the peer counsellors gave and understood that people could be like that. It appeared to be more varied and complex around how and who decided what the reciprocal arrangements would be. The peer counsellors had a great loyalty to the health professionals who trained them and talked of many battles for being a breastfeeding peer counsellor; however they were balanced about the situation and supported women in a way that was mutually beneficial.

5.6 Peer Counsellors Filling the Gaps

In this section, I will explore what the peer counsellors identified as the support gaps for breastfeeding mothers. The peer counsellors saw themselves as filling the gap by being a bridge between mothers and health professionals. This created tension as the peer counsellors threatened the role boundaries of the health professionals. They were also part of an artificially constructed network created by an organisation filling the 'lost skill gap' of mother's experience of breastfeeding. There was a personal

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cost to them, facing the stigma and negative attitudes from people in the community towards them and other breastfeeding mothers.

Ann gives her definition of what she thinks their informal support network does and it appears that the peers can fill this gap for mothers:

> *"It's just about talking to people."*
> *(Ann, Q102)*

Social networks are very important, especially for the peer counsellors who were intent on reversing the negative culture of bottle-feeding and creating a natural network of breastfeeding mothers. The following identifies the essence of a network:

> This 'network of social relations' is at the hub of society, it is the system through which people relate to each other. Where they construct mutually understood meanings from their actions, where information is sent and received, and where they acquire sources of help and support.
> (Darby 2006 p 320)

The study of social networks is complex and my thesis does not lend itself to debate the construction of this social network. However I have referred to it as an artificial network because of the way it was established and will discuss this assumption later in the chapter. Raine and Woodward (2003) describe that deprived areas of the country are seen as having lost skills in breastfeeding, with little 'tradition' of breastfeeding for new mothers to draw on. Social networks that include breastfeeding are generally lacking, which results in women having little experience of breastfeeding as an everyday activity. (Earle 2002)

Dykes (2006) teases out the essence of this subtle social support as 'caring time': It is important to acknowledge here that the peer counsellors stressed the importance of 'talking' about breast-feeding. It was what had been lost over several generations, the handed-down-knowledge from mother to daughter and these peer counsellors were filling that gap.

Becoming a peer counsellor in contemporary Britain appears to be interwoven with State ownership and involvement. Holdsworth (1988) gathered personal recollections of the momentous changes in women's lives in the 20th century and makes reference to schools of mothers in the early part of the 19th century who were run by 'peers' that ran cookery demonstrations, sewing lessons and provided numerous helpful hints on feeding schedules.

These schools were gradually taken over by the State and there was evidence of conflict between the statutory early health visiting services and the mother's location and beliefs around feeding and caring for their babies. This resonates with how the peer counsellors explained that their experience was supporting mothers alongside health professionals and about the confused information given by health professionals and GPs. This stands in contrast with informal support networks; historically women have provided informal support networks for many centuries. The peer counsellors saw themselves as filling the gap of lost skills surrounding breastfeeding and they discussed why their 'advice' was better than a health professional.

It appears that the alternative support system is required rather than the professional one (Bocar and Shrago 1993). According to Brown (1998) the medicalised approach has not considered the importance of mother to mother support. Sophie gives her thoughts on this too:

> *"I think if you've experienced it yourself as well, experience how painful it is, engorgement, saying about midwives not experiencing for themselves, sometimes, you know."*
> *(Sophie, Q406)*

> *(Comes in and speaks what Sophie is saying) ... might be able to give them better advice than what a midwife can or a health visitor.*
> *(Lots of group agreement)*
> *(Theresa, Q407)*

The peer counsellors saw themselves as offering an alternative approach to the health professionals and the peer counsellors were delicately trying to rebalance and rebuild a lost social network. The group came across many barriers accomplishing this. The peer counsellors were listeners and buffers for mothers facing the 'stigma' of breastfeeding because it conflicted with the community set on artificially feeding their babies.

5.7 Peer Counsellors Facing Stigma and Negative Attitudes

Eliza and Ann identified that their community stigmatised them for promoting breastfeeding and the group sensitively worked through the reasons why their community were set against breastfeeding mothers:

> "There's a stigma attached to it, isn't there?"
> (Eliza, Q244)

> "What in your area?"
> (Interviewer 1, Q246)

> "Breastfeeding in general and for us ... specially in this area."
> (Eliza, Q246)

Ann talked about teenagers and how they faced the negative attitudes of possibly four generations of 'bottle-feeders':

> "Yeah. Because I mean some of these kids, they'll be third and fourth generation bottle-feeders."
> (Ann, Q320)

Sonia had personal experience of being a young mother and thought the medical profession were responsible for some of the stigma:

> "It comes back down to the medical people because I know when I ... when I first had my first I were 20 and I've had three. My first they offered me an abortion."
> (Sonia, Q335)

It was particularly difficult for Sonia, who had experienced the double stigma of being a young mother and breastfeeding. The group was very heated about this topic, why teenagers did not breastfeed. Sonia referred to teenagers as 'children' and it was their mothers that the peer counsellors needed to talk to. There was a well-established natural network of mothers and grandmothers who had years of experience bottle-feeding and that posed a dilemma. They understood that the grandmothers were trying to protect their daughters from the pain of breastfeeding, as this was a picture of their experiences due to the misinformation. Curtis et al. (2001) identified that the peer supporters in her study were isolated and did not know anyone else who had breastfed. There was also a similar discussion on teenagers. The peer counsellors in this study sensitively talked about what caused this and how they could reverse this. There is a difficulty of women succeeding if they rarely see anyone breastfeeding a baby (Dykes and Griffiths 1998) and formula feeding is normal practice.

It was especially difficult for young mothers. Ann had visited a teenage group and this is what they thought of breastfeeding:

> *"I'm not getting me tits out in public, were the main one and nobody else will be able to do it so I'll have to do it all."*
> *(Ann, Q285)*

Four main themes were discussed: social embarrassment, breastfeeding not being covered in schools, family pressure to bottle-feed, and grandmothers and friends protecting mothers from experiencing the same problems they had. This mirrored the statistics that teenage mothers are the least likely group to breastfeed in public; only 27% of them did according to a recent study (Bolling et al. 2007). It appears that a small number of women in the survey felt it was due to negative attitudes, and there seems to be more concern about the presence and suitability of places to breastfeed. It was also noted that it was the first time the survey had addressed this very important area and was a benchmark for future surveys. It was interesting that the peer counsellors said teenagers felt the main reason was that they did not want to breastfeed in public. Eliza led the group into a discussion about schools and conducting a questionnaire; how

they could tackle the problem of teenagers not breastfeeding. It was a very lively debate and illuminated some of the most important local issues:

> "I still think it should be covered more in schools though."
> (Eliza, Q302)

Locally, education around breastfeeding in schools was inconsistent and dependent on the attitude of the school towards the importance of breastfeeding. Young children are vulnerable to influences and reflect the prevailing ethos of their society, and then negativity towards breastfeeding can be reinforced in children through exposure to positive images of bottle-feeding (Swanson et al. 2006) There were disagreements about how the group would be able to change this.

Eliza thought that finding out why teenagers did not breastfeed was a good idea, however Sam thought it was more likely they would bottle-feed because of the teenager's parents bottle-feeding:

> "Would it be worth doing a questionnaire and sending it out to mums in the area?"
> (Eliza, Q308)

> "With the best will in the world, I mean if they fill it ... if they're still 16 and live at home and their mum wants them to bottle-feed".
> (Sam, Q314)

> "No, I know but ... that's fine. I'm not saying that we're trying to get them to breastfeed. I'm just saying that we can look at their answers for things to look at ... areas to look at and approach and try and change attitudes because that's what it's supposed to be about".
> (Sam starts to argue her point with Theresa but Theresa carries firmly on)
> (Eliza, Q315)

> "But like targeting their parents, not targeting the person."
> (Sam, Q316)

Ann recognised there were broader issues, that it was related to cultural issues. Renfrew et al. (2000) suggests that it is important to remain aware that individual women may be personally ambivalent to, or have antipathy towards, breastfeeding. The very act of breastfeeding can be a controversial decision in communities that are staunch bottle-feeders and can be one of the reasons women do not choose to breastfeed (Rodriguez-Garcia 1995).

> *"So, what you're looking at then is not educating kids, it's educating older."*
> *(Ann, Q318)*

> *"Well, the thing is as well, if these stout bottle-feeders, I think the thing ... the thing about them is that they're not sort of ... they're not bad people, but they've probably... Because of how they were told to feed their kids have probably had big problems like engorgement and sore nipples and mastitis because they've tried doing 10 minutes each side and things like ... all these things and all they're doing is they don't want their kids or grandkids to go through the same pain that they went through."*
> *(Ann, Q338)*

Dykes et al. (2003), in a paper on the reasons why adolescents did not choose to breastfeed, found that they were more vulnerable to low confidence (low self-efficacy), related to their inexperience and, in some cases, lack of role models. Ann identified this as a problem for teenagers she had come across, as the pressure from others to bottle-feed their babies:

> *"I mean if you're 16 do health benefits really make a difference to you? If you think back to when you were 16, do you really care?"*
> *(Ann, Q294)*

> *"With the best will in the world, I mean if they're still 16 and live at home and their mum wants them to bottle-feed."*
> *(Sam, Q314)*

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Dykes et al. (2003) identified a thematic network of support needs for teenagers, as the norm was for women to report experiences of over tiredness and nipple pain (Schmied et al. 1999).According to Brown (1998), the medicalised approach has not considered the importance of mother to mother support (Kitzinger 1995); the peer counsellors reflected that their support was vital. Smale (2004) identified in her training pack:

> It is hoped that the presence, actions and words of peer supporters might also 'promote' breastfeeding as a worthwhile and feasible choice by their own confidence in what they have achieved, while not judging those unable to make or sustain such a decision.
> (Smale 2004, p7)

Ann observed that there was little support, that the older generation did not promote it, and there was a gap, with few grandmothers to offer support:

> *"And you'd think it'd be the older generation that'd push it and they dun't, do they?"*
> *(Theresa, Q329)*

There were not enough allies in the community and the peer counsellors were very reliant on each other to provide that support. Dykes et al. (2003) developed a thematic network of identified support needs and included instrumental support, informational support, emotional support, esteem support and network support. The peer counsellors had identified, throughout their discussions that all these types of support were sadly lacking in their community.

5.8 *'Unnatural' Breastfeeding Support Network; More than a Job's Worth*

The peer counsellors were an artificially constructed network, created by the health professionals, target driven to increase the initiation of breastfeeding rates in the community.

The peer counsellors claimed that Sure Start were only interested in numbers:

> "I think a lot of it and I know ... I know you've worked for Sure Start not knocking but I think that because Sure Start want the numbers and they want to know how many numbers blah blah blah through the door."
> (Sonia, Q678)

> "That's what I said pressure with the numbers, yeah."
> (Theresa, Q679)

Even the health professionals, who had been supportive, were under pressure to get the numbers up and went to extraordinary lengths to do this. Theresa talked about how she was treated when she did not turn up for a Christmas party organised by the local Sure Start:

> "I mean I'm not knocking Jackie because I think the world of Jackie, but the first time I missed going on a Monday afternoon I got an ass holing because we didn't turn up."
> (Theresa, Q701)

> "Come to my house bollocking me in me own house because I didn't go to the party. Whether I go to the party or not, that's up to me, nobody else."
> (Theresa, Q710)

Theresa was loyal to the supportive health professional and believed it was the pressure from Sure Start that had caused this behaviour:

> "But it is. Sure Start will be pressuring Jackie, I'm telling you now."
> (Theresa, Q713)

The group began to raise their voices and there was a lot of cross talking and anger vented as they spoke of their roles having gone too far, because they were not just filling a gap. Eliza was a voice for the group:

> *"And that's why to us it has gone beyond being a peer supporter."*
> *(Eliza, Q711)*

> *"I do a group every Monday afternoon. I do Friday morning down at the playgroup. I think I do enough do you know what I mean? And it's still … no matter what I do isn't enough for em. Do you understand what I mean?"*
> *(Eliza, Q819)*

Certainly, they were dedicating many hours and not feeling recompensed for it; it was a bone of contention that they were doing more than the paid health professionals:

> *"Going back to the paying and all, I think that it's a much to expect peer counsellors to take on without some form of incentive or summat theya because for what we've been doing anybody else … if it were … Going back to the health professionals, if it were an health professional doing it, they'd be getting paid an absolute fortune for doing what we're doing with these mams that we're not getting nowt for apart from that feeling that we're helping somebody and that's it."*
> *(Eliza, Q531)*

In the UK peer counsellors may be paid (Haider et al. 2002; Battersby 2002b), however most are not. Those in this study were not paid. The White Paper (Department of Health 2004a) proposed payment to personal trainers:

> "I don't know because then at the same time you I'm sort of getting to the point sometimes where I'm thinking, For all that time I could be spending in that, I could have got a job doing something else and getting paid for it. I think it's a lot of time for voluntary work ..."
> (Eliza, Q536)

Peer counselling had become a job and they had chosen not to work because of wanting to stay with their children:

> "But whatever I do entails our Ryan, so even though I'm doing this I can still have my kids with me whereas if a job I couldn't have my kids with me."
> (Theresa, Q537)

> "I think ... no, I don't think the thing itself is a job. I think it's the things that ... the other pressures that they put onto you. That's the job bit."
> (Sonia, Q541)

> "But the actual sitting with the woman."
> (Eliza, Q545)

Eliza summed up what was missing for mothers, was being listened to, and they all felt that this was not a job. It was not technical but it was highly effective and did not incur great expenses. This was a reason the peer counsellors felt angry towards the health professional: that they were being paid and not giving the correct information and support.

Chapter 6: Group Tensions

There were three main themes emerging from the peer counsellors' discussion around power balance and how they were disempowered by the system:

Being 'chucked in' /organisational commitments
Group safety
Peer Counsellors' relationships with mothers and health professionals; differences with power and commitment

6.1 *Being 'Chucked In':Organisational Commitments*

Eliza said she had been 'chucked in'. The group were generally of the same opinion and it created fear because of their loss of control, and highlighted their vulnerability in their community working with the Sure Start organisation:

> *"It's suddenly become, "Right, in a year or so you're going to get chucked in. You'll have to sort your funding out. You'll have to sort this out. You'll 'ave to sort that out" and it were like, "Whoa, hang on a minute."*
> *(Eliza, Q571)*

Theresa said it was difficult when they had been so enthusiastic in their training and then suggested they were let down, disempowered and victims of their own success:

> *"When we finished that training I did not know what we were going to end up having to do."*
> *(Theresa, Q522)*

The groups' concerns were well founded and they were being treated unfairly. Sonia recognised the need for the group to reflect and understand what was happening:

> "We need to take a step back."
> (Sonia, Q563)

It was difficult for the group to step back; they were deeply committed to supporting other women to breastfeed because they wanted them to succeed. However they were tied up with Sure Start and felt used and it had quite nasty emotional effects on some of them:

> "A lot of people that I've had dealings with are like, "God, you don't do nowt for Sure Start, do you?" and I says, "Yeah, I do quite a lot because I want to." I just ... I do everything with Sure Start. Swimming, playgroup. I do everything that does that and they just kick you in the teeth."
> (Theresa, Q580)

> "But that comes to the politics and the dynamics of Sure Start itself."
> (Eliza, Q581)

> "Yeah. Yeah, in general yeah. It does not matter what you put in to them, they'll rip you to bits."
> (Theresa, Q584)

Ann introduced another group dynamic, regarding a group split in their roles and responsibilities:

> "Well, I ... this'll not go down well. I feel a bit like we're becoming them and us in this group now, here. I feel that coming across. That like that ...that half of the table and it's like, "You don't come to meetings. You don't do this. You don't do that," and I mean I know you've said it ... you've acknowledged it. Just because you don't hear everything that I do for our group doesn't mean ... every meeting I go to, you can vouch."
> (Ann, Q775)

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It was difficult for the peer counsellors and they were torn by the drive to support mothers in a way that they had not been and an underlying resentment that this work was taking them away from their own families. The group used the focus group as a place to explore their feelings about what was happening to them:

> "I don't know because then at the same time you ... I'm sort of getting to the point sometimes where I'm thinking, "For all that time I could be spending in that, I could have got a job doing something else and getting paid for it." I think it's a lot of time for voluntary work."
> (Eliza, Q536)

It was clear this group used the energy from each other to continue their work. The group had connected to a powerful force that challenged their community's belief in artificial feeding and the health professionals' ignorance surrounding breastfeeding. Just as individuals have an identity form and a corresponding energy form, so too do groups (Starhawk 1987). This energy though began to spiral down as the group began to tell stories of how the organisation was abusing them.

Theresa did everything she could to support the Sure Start and felt 'kicked in the teeth'; she seemed to identify with the victim role and felt she was persecuted for what she was doing for Sure Start:

> "I dun't want to go every Thursday morning because I want to start doing stuff with him." [Referring to her son and leaving him to go to the breastfeeding drop in]
> (Theresa, Q821)

> "I feel a bit like it's becoming a job under the Sure Start thing [with] all this, it feels like it's becoming a job because I'm having to collect all this information to relay back to them so that we can sort out for keeping going, you know what I mean?"
> (Eliza, Q587)

"It's the sort of things you'd expect if you were in employment, isn't it?"
(Sonia, Q542)

"The thing is though, there's nowhere else. At the minute there's nowhere else. We can't have X place because of the politics that's going off."
(Eliza, Q657)

It was a political minefield for them. They had become embroiled in the politics and they started to blame themselves, as well as the organisation, for their situation:

"It's our own enthusiasm that's killed it. We've done it ourselves. It's from Ann said, because everybody's tried to do too much, I think and make it such a success that now it's just beyond control."
(Sophie, Q664)

They were losing control. It seemed unfair that their step back had resulted in the group being the target and it appeared more of an organisation issue and training issues around their roles than a group issue.

Not wearing the T-shirts that identified them with Sure Start and health professionals seemed to give them more power back:

"On that dodgy ground though with Sure Start wearing those t-shirts."
(Sonia, Q559)

"People think you're a worker."
(Spoken in unison, Q561)

"You're a worker and you're part of something else and I dun't wear em. I dun't wear anymore because it'. I fully believe this, that we're too health professionally."
(Ann, Q562)

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"Because we've applied for funding and you've got to have it in place and procedures and things like that. But we've totally changed things there because people were ... they were thinking that if they didn't make it more of an institution rather than what we're supposed to be To go to a meeting every week and had to do summat on computer, that they weren't a peer supporter, but then they weren't doing ... they weren't talking to any women about ... and it's not talking ... having to go to clinic every week or having to go theya. It's just talking on bus and at school gates and your mate and things like that. That's what it ... To me that's what it is."
(Ann, Q564)

They were trying to maintain their objectives, but it seemed the organisation they worked for was trying to change them into something they were not. They were struggling with who and what they were and Ann seemed to define their roles clearly.

Ann spoke about how they had become embroiled in funding issues and it seemed that none of the organisations involved had the foresight to address the basic steps of project development. No one had sufficiently thought this through before setting the peer counsellors on a lonely path; just like the mothers they were so keen to give breastfeeding support to.

6.2 *Group Safety*

On the flip side to being 'chucked in', they had an opportunity to make a difference to the mothers who wanted to breastfeed and the peer counsellors were able to say who, why and how they would support local women in their community. The group served as a safe place for them to express their feelings and recognise and understand how they were shaping and creating their own ideas and boundaries:

"Ideas come from us for what we were going to be doing."
(Eliza, Q525)

Women can find this quite difficult to learn, to think about themselves (Eichenbaum et al. 1993). Bloom (2005) discussed this with student midwives exploring sensitive psychosocial feelings that can trigger recollection of painful emotions connected with clinical work. I drew a parallel with the peer counsellors' exploration of psychosocial issues; they were in touch with deep emotions surrounding their own breastfeeding experience and the emotionality of other mother's breastfeeding experiences. Such knowledge and experience is rare in our society.

The group's experience cemented them together. Nevertheless the external influences of the organisation abusing their skills and knowledge had an impact on the group, who found it increasingly difficult to manage their frustrations and vented their anger from the external factors onto the individuals in the focus group. It became quite explosive; they were survivors of the bottle-feeding default culture and utilised defensive behaviour in the group as a shield to protect against being deeply subversive to their kin network (Plotkin 1997; Klein 1988a). Their aim was to build up trust with their community in breastfeeding. Elias (1998) spoke of trust being deeply programmed into us by way of a recorded memory of an interaction, a learned experience. This was difficult when the majority of the community had learned to bottle-feed and there was no trust in breastfeeding and a faith that women could do it. The breastfeeding support group was an option that Sophie discussed. The group had set up a drop-in, because of the gaps they had experienced, and were also comparing themselves to other groups in their area that were now setting up and did not seem to encounter the same problems as them.

However, speaking candidly seemed to split the group, it seemed to focus around the roles and the time the group gave to being a peer counsellor.

Laura identified some of the reasons why there seemed to be tensions for her:

"I think we need to be more in contact with each other because people feel like they've got so much pressure on them. It's like I'm at college now and I'm looking after my mum because she's deteriorating fast, but I have got ... I have got free time and my problem is ... I mean dun't get me post a lot of time either and I don't seem to know what's going off or people say they'll phone me and then I never get a phone call."
(Laura, Q741)

Some group members made comments about being put upon:

"For all these ideas that everybody's had it's been put on us three and that's why we've got this attitude now because it's just felt like everything's been, "Right, you've said this, you want to do that, you want to do that." Other people's ideas for the group, but we're the ones that's having to do it."
(Eliza, Q669)

There was rebellion in the group about the reasons why they could not give everything to this project; some just simply had to work to keep their families afloat:

"We're not lucky enough not to be able ... not to work. I've got to work to keep my house and to keep my kids."
(Theresa, Q672)

The group had some major issues to contend with, both personally and as a peer counsellor, and one was the fear of being sued for the information they were giving. It was far from an easy world for them. Not only were they living in a community that did not understand them, organisations abused their knowledge skill and art of breastfeeding and spoke of performing risk assessments around supporting mothers to breastfeed. The group safety was being undermined and there was a lack of respect for mothers' intuitive breastfeeding knowledge and the group served as a

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microcosm of how structures can support but can also undermine the human instinct of a mother breastfeeding and another mother supporting her.

6.3 *Peer Counsellors' Relationality with Mothers and Health Professionals: Differences with Power and Commitment*

The peer counsellors were developing their boundaries with mothers and health professionals. Ann checked with the group that they would all call the health professionals when they thought a woman had a suspected mastitis. The peer counsellors spoke at length about litigation and taking risks and they gave examples of when they would contact the health professionals. It was still work in progress and it appeared that the peer counsellors saw themselves, in a voluntary capacity, more committed to women than a paid health professional was. They felt that they were crossing several lines to support breastfeeding mothers and the focus group provided them with the time and space to think about where they stood in relation to women and health professionals, as they acted as human conduits between them and their community.

Their approach put mothers in the 'driving seat' although Sonia and Eliza used the word 'advice'; it was predominantly about offering women options. This was as opposed to the term and model of the 'advising' health professionals. Sonia talked about women pushing her into a corner to give advice, and how she skilfully made suggestions. They had excellent interpersonal skills and had developed great diplomacy in their 'struggle' to support the local mothers to breastfeed. It was not easy when they were dealing with the power of health professionals and they were very clear that they were not advising mothers:

> *"There's a fine line though isn't there, between advice and we*
> *covered this in us training, didn't we? You've to try and do it so*
> *you're not advising because then it can come back on you as well."*
> *(Eliza, Q433)*

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"Give them information, you haven't got to dictate to them have you and tell them what to do. You've got to ... (Ann comes in)"
(Theresa, Q435)

"If you just give them information and then they make their own mind up, don't they, about what they do and then that way you've not sort of said, "You should do this. You should do that. You need to do this."
(Ann, Q436)

It came down to the peer counsellors talking about liability and the question of whether they should go down that avenue:

"Its liability, I think at the end of the day."
(Sophie, Q438)

"But then, do you think as a group we ought to? We ought to have public liability."
(Theresa, Q440)

The group was unsure of how to manage their boundaries. Public liability insurance seemed to give them security they needed and reduce the fear of the responsibility that they felt giving support to mothers. Theresa said that no one knew what they were going to do when they finished their training.

It was a delicate situation. The peers were being used to change this culture with no forethought from the organisations that ran or hosted the training.
To understand the complexities of their own personal experiences, and the need to stop other women suffering like they had, they needed to understand they were becoming victims in another sense as they battled to change the culture that they had become victims of initially.

The group identified that there was great strength from a communal approach and that this was an opportunity for the peer counsellors to reverse the culture away from the language and approaches of some of the

health professionals, in the hope of saving other mothers from being victims of the bottle-feeding culture.

The group had lacked a natural network of role models, indeed this lack was the reason for the group's existence, other than the health professionals who were in an advisory capacity. The group suggested the health professionals had passed on the art of breastfeeding like a medical procedure. They had to work against the hard core of bottle-feeders who resisted change and were powerful role models.

The peer counsellors had ultimate faith in women being able to breastfeed their babies and it had been subverted by some of the health professionals and the formula companies were capitalising on this by subtly undermining mothers' ability to breastfeed.

The healthcare professionals and communities had been blighted by generations of under-confidence in a mothers' ability to feed her own baby, and battles with health professionals and healthcare systems that require a 180-degree turnaround to change their organisational philosophy. This group of peer counsellors were admirable considering the barriers they faced and were not respected for their mothering and intuitive knowledge of breastfeeding. Popay et al. (1996) observed that the most effective way of reaching the hardest-to-reach families is not through direct contact but by mediation with their personal networks.

The peer counsellors faced many barriers, and ignorance about breastfeeding was a major barrier for the peer counsellors and were an excellent resource. Having children had equipped them with many mothering skills, beyond breastfeeding:

> *"You've had children yourself sort of thing, so you can like help with other aspects, not just the feeding part."*
> *(Eliza, Q163)*

There was recognition that peer counsellors and health professionals lacked mutual respect for each other's role in the community supporting

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breast-feeding mothers. The peer counsellors supported women in a mother centred way and actively listened to them. In the next chapter there is an exploration of how the peer counsellors interpreted how health professionals breastfeeding support varied depending on the way they had trained and saw this as either a circle of support around the mother or a chain of command 'advising' mothers.

Chapter 7: Discussion: Circle of Support v Chain of Command

The discussion of my research findings is presented in two chapters, reflecting the two central aspects of the focus group discussion. This chapter examines the peer counsellors' knowledge and how they used their knowledge to be enabling, not directive, for mothers. Yet they found their knowledge to be contested relative to expert professional knowledge.

As well as issues concerning knowledge, the peer counsellors raised many issues about being volunteers, especially concerning their involvement in community and organisational activities and their support. These are discussed in the next chapter.

7.1 Peer Counsellors Contested Knowledge

The peer counsellors supported breastfeeding mothers in an embodied way. This can be likened to a circle of support enabling a mother to make her own decisions around breastfeeding. They saw this in contrast to the health professionals who appeared to approach support through a hierarchical system that reflected a chain of command, of instructions to mothers that appeared to lack warmth and empathy.

The peer counsellors questioned the power and rigidity of the medicalised approach. Their observations linked with the analysis of Barnes et al (1999), using a group- analytic perspective:

> When problems arise within organisations and institutions these typically have to do with imbalance with respect to the relationship between task, power, information and responsibility.
> (Barnes et al. 1999 p33)

The health service culture is rapidly changing responding with the impact of World Class Commissioning (see the glossary). The introduction of payment by results and the Local Service Delivery Plan to increase breastfeeding initiation rates by two percentage points per year have all impacted on the delivery of 'care'.

The peer counsellors' embodied experiences acted as a new currency in this evolving system and were very powerful. The group were able to articulate their embodied skill as 'truth' and it appeared to impact on the power position of the health professionals. The way the peer counsellors and health professionals articulated their support was a key factor in recognising the difference in power around the embodied mother and disembodied health professional experience of breastfeeding.

There was a stark contrast in how both groups acquired knowledge and skill in supporting mothers to breastfeed and the extent to which that knowledge was used in conjunction with and acknowledgement of the mothers' own knowledge.

Rather than demonise the health professional I utilised the work of Fairclough (1992) on discourse and social change, recognising this as a system failure in which modern societies have a tendency towards increasing control. Health professionals, who felt their professional actions controlled by targets, including those concerning breastfeeding, could respond to mothers in a controlling manner. Thus the peer counsellors came into contact with health professionals who were influenced by systems that controlled and silenced embodied knowledge. This resulted in either breastfeeding mothers having support that gave freedom to choose their favoured option, if they received peer support, or being directed, depending on the professional support offered and the way the professionals had been trained within their professional chain of command.

I hope to bring insight to how the peer counsellors intelligently processed and integrated their own embodied knowledge with their La Leche League training.

This empowered them to question the dominant professional authoritative knowledge and the group was a medium to express the tensions created.

There is little literature concerning women's embodied experience of breastfeeding. It is consequently difficult to develop a balanced theoretical argument with the biomedical discourse on breastfeeding that has proved disabling for many mothers for over a century. To support this discussion, I drew upon the work of Smale (2004) on women's knowledge of breastfeeding within the context of current thinking on the biomedical principles and practices that imprint on women's experiences of breastfeeding. I interweaved her work with Battersby, which explored the social constructs that underpin midwives' knowledge and experiences of breastfeeding. The study, along with the evaluation of the La Leche League programme, were key pieces of work in enabling me to understand the polarised positions that these peer counsellors supported mothers in. The research work enabled me to have an understanding of how the dominant health professionals knowingly or unknowingly serve to silence women's embodied breastfeeding knowledge.

The peer counsellors suggested joint breastfeeding training with professional in order to balance the competing paradigms. I worked with a midwife group analyst and was able to look at the group tensions and how the peer counsellors articulated the way in which knowledge and power was controlled. I consulted with a sociologist to discuss the group as a network and how their development was artificially constructed in their endeavour to renew and rebirth a natural generation of breastfeeding mothers whose voices we have lost.

7.2 Peer Counsellors as Authors of Embodied Breastfeeding Support and Insight

The mothers came together as a group with the experience and skill of breastfeeding their babies; women's breastfeeding knowledge in this community was scarce and the peer counsellors had authentic experience that women in their community could identify with. However, that knowledge could be seen to compete with the dominant health professional

model. The peer counsellors appeared angry about how their knowledge was sometimes silenced by the dominant biomedical knowledge. Their difficulty in being heard was understandable due to the demise of women's knowledge over many years, partly a consequence of powerful artificial formula marketing and governments ignoring the catastrophic health effects of artificial feeding (Renfrew 2003). Theresa suggested that if the health professionals had not breastfed, in her experience, they were 'clueless' and that the young health professionals, although they were confident in their health professional capacity, did not know about breastfeeding. Ann had unfaltering confidence in breastfeeding and that other women could do it. However, from the beginning of the 20th century, infant feeding knowledge was being constructed by medical scientists and health professionals (Ryan and Grace et al. 2001; Dykes 2006). The peer counsellors spoke about how strong they needed to be. Starhawk (1987) spoke of collective women's power and Kitzinger (2003) of warrior women, and these descriptions fitted these peer counsellors who were fighting against the tidal wave of thought that bottle-feeding was normal.

7.3 *Embodied Knowledge amid the Complexity of the Subject*

The peer counsellors approached their support in an embodied way and this was at odds with the scientific research-based philosophy and body of knowledge that has become so accepted. The peer counsellors did not see this medical knowledge as common sense though and this created great tension. Ann clearly shows the juxtaposition of the cultural conditioning with the biomedical understanding; of how the peer counsellor would explain to a mother how to feed a baby as opposed to the health professional approach. The difficulties of the different dialogue highlight the different sets of belief systems identified in the work of Smale et al. (2006). Eliza spoke about how the health professionals had complicated a natural process and made rules about how a mother breastfeeds. Ann agreed and Theresa recognised that they needed to train alongside each other.

The local health professionals, on the whole, had not been trained in a way that respected and valued mothers' skills and knowledge on mothering and breastfeeding (Davis-Floyd 2001; Dykes 2006). The peer counsellors had

been encouraged to connect embodied knowledge with the theoretical knowledge from their training. Conversely, the health professionals had been socialised in a system that was dominated by masculine authority and authorised methods of knowing, embedded within cultural discourse. Dykes (2006) pointed out, in her study that discussed intuitive knowledge, that there was a general lack of acknowledgement of its relevance or even existence within midwifery. Battersby (2006) identified a similar phenomenon.

Debold et al. (1996) examined authority and split subjectivities in girls' epistemological development. They found that girls coming of age and coming to know the dominant culture typically find themselves torn and, ultimately, split from their own power to authorise their experience as real and as knowledge (Brown and Gilligan 1992; Debold 1996). They offered an alternative approach from that of Women's Ways of Knowing (WWK) Belenky et al. (1986). For the women in the WWK study, the 'subjectivist' position represents a turning away from external, often male, authorities to a new inner source of strength. From the subjectivist perspective, truth is 'personal, private, and subjectively known or intuited'; a perspective that health professionals have seemed to silence rather than integrate when they had a personal breastfeeding experience, and distanced themselves from their own mind-body experience, as demonstrated in the Leeds Training Analysis work (Smale 2006).

Michael Foucault (1980) highlighted two meanings of subject, that of subject of self or subject, becomes divided against itself through an incorporation of knowledge that functions as a form of power. The peer counsellors did not want to be subject to the health professionals' authoritative knowledge, which idealised western society's core values that were strongly orientated towards science, high technology economic profit, and patriarchal governed institutions. Davis-Floyd (1992) and Dykes (2006) discussed the importance of balancing the two paradigms of women's subjective or self -knowledge and scientific methods.

Dykes (2006) wrote:

> Knowledge about breastfeeding generated through scientific methods should not be disregarded simply because it stems from techno-medical disciplines. However, such knowledge should not be considered as more legitimate than women's embodied knowledge simply because it constitutes 'evidence based' enquiry. Insights from this field have a place, but their position must be alongside and not above, the knowledge's generated through the experiences and accounts of women.
>
> (Dykes 2006, p177)

The peer counsellors recognised the need to work alongside the health professionals. However this was not easy for the local health professionals, bound by hierarchical professional accountability that women's knowledge, fortunately, is not affected by.

7.4 *The Dilemmas of Lay Experts*

There were tensions surrounding health professional knowledge and the local mothers' confidence in the skill of the peer counsellors' valuable knowledge. Experts may just as easily emerge from the ranks of the lay populace:

> Through a more or less systematic process whereby experience is checked against life events, circumstances and history, lay people acquire an 'expert' body of knowledge.
>
> (Popay and Williams 1996, p 760)

This body of knowledge is often seen as a challenge to both the 'objectivity' of expert knowledge and to the authority of professionals (Popay and Williams 1996). These peer counsellors shared their stories of what it is like supporting a mother when the health professionals are not skilled and prepared to support mothers. However the mothers still have confidence because of a basic assumption that the health professional is more knowledgeable than the peer counsellor.

By their nature, as non-professionals, peer counsellors can be seen as a threat to the professional authoritative knowledge. As a result of the challenges and critiques to the monopoly of professions since 1970s, there has been a growing argument that professions are losing their power. Haug (1976) evidenced the erosion of the professional monopoly over knowledge, the questioning of professional autonomy and authority, and challenges to professional status. The peer counsellors were touching a very sensitive professional nerve.

Evaluations of breastfeeding peer support projects have demonstrated great diversity in professionals' response to peer counsellors, ranging from welcoming their help and clear, ongoing, two way communication, to ambivalence and even discouragement (Curtis et al. 2001; McInnes and Stone 2001), poor communication, discouragement and 'negative rapport' (Bronner et al. 2001).

Foucault (1976; 1977; 1981) sees power as transmitted through the body, as a text inscribed upon, constructed and constituted by discourse. Dykes (2006), acknowledging the deep inscription of bodies by discourse however, disputes this notion that the body is passive and argues that a person's body is also an agent in its own world construction (Fairclough 1992; Street 1992; Lyon and Barbalet 1994; Shildrick 1997). Dykes (2006) argues that Foucault's (1976) notion be balanced with a theory of embodiment and draws upon the work of Schmied (1998), in relation to breastfeeding women and argues that maternal subjectivity and breastfeeding must be viewed as both an embodied experience and discursive construction. Dykes (2006) continues to theorise a third dimension, stemming from the political economy of health, and raises awareness of the profoundly political and medicalised nature of bodily experiences. The peer counsellors spoke of how the formula companies attended a health event and gave away cuddly fluffy cows to subtly market their product to mothers undermining breastfeeding.

Eliza identified how the government paid lip service to the protection and promotion of breastfeeding and the ensuing battles around this. Starhawk

(1987) spoke of the psychic and social structures that destroy us and saw that the challenge is communal. To face this challenge we must be empowered to create structures that embody values of connection, community, empowerment and balance. There is a long way to go to achieve the ideal, when governments still passively promote, protect and support mothers to bottle-feed. The peer counsellors were confident in disputing the knowledge of the health professionals, the tactics of formula companies undermining breast milk, and the inactivity of the government; in the light of their own experience and the training they received to become peer counsellors.

By their nature, as non-professionals, peer counsellors can be seen as a threat to authoritative knowledge (Davis-Floyd and Sargent 1997). The power of language is evident as Lackoff (2004) noted in her linguistic work the correlation between type of speech and type of person is widely recognised. Smale discussed how dialogue marked the division of biomedical and cultural belief systems. Her enablement model for training peer supporters made them aware of this dialogue whilst valuing embodied knowledge. This is the basis of peer supporters' own later interventions and intends knowledge to be seen as relevant and not theoretical. Smale (2004) saw this model as a deliberate attempt to deprofessionalise breastfeeding and create, in peer supporters, resources of breastfeeding skills and knowledge within their community. Kirkham in her foreword of the enablement model pack (Smale 2004), found this approach deeply subversive to the dominant health professional model. A different model was used to train the peer counsellors in this project, but the underlying values were the same.

Smale felt the difficulties arose from the official silencing of embodied experiences, which happened frequently with health professionals and I feel that, to a certain degree, I can draw a similar conclusion on behalf of the peer counsellors. In personal communication from Smale (2007, p155), she felt that this was relevant: 'That those who managed their own breastfeeding successfully or who enjoyed the experience were likely to be silenced, reflecting a fear of passing on seemingly impossible expectations into the clinical setting.'

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I had discussed this in a joint paper with Mary Smale (Trewick and Smale 2005) on how I had been trained as a midwife and had my own breastfeeding experience silenced because it was not acknowledged as valid in my midwifery training. Thus my embodied and professional knowledge was not integrated and I was able to identify this only after training to be a National Childbirth Trust breastfeeding counsellor, after working with breastfeeding counsellors for 10 years. There was a midwifery cultural norm that breastfeeding was 'cocooned and belonged to the patient/client'. This was apparent in Battersby's (2006) work when she identified a phenomenon of dissonance because of the competing paradigms, conflicts and dichotomies that exist within midwifery knowledge. Curtis also Identified in an evaluation of a peer support group a similar theme of health professionals containing and silencing their own infant feeding experience in a 'clinical setting'

> Health professionals were not asked for, and neither did they divulge, information that concerned their personal experiences of infant feeding. They referred instead to knowledge they had acquired during the course of professional training. But if participants did have personal experience of breastfeeding, this was entirely sidelined or silenced within the discussion.
> (Curtis 2001, p28)

Smale et al. (2006), in a project conducted by the Mother and Infant Research Unit in the University of Leeds between 1999 and 2001, correlated data from 107 in-depth interviews with health and social care professionals, educators, and breastfeeding women. It identified that there was little evidence of informal shared learning among professional groups:

> Data revealed contrasting opinions about health professionals' learning via embodied experience. This was acknowledged as an important source of understanding, but there was considerable concern about passing on this knowledge to others in the health service.
> (Smale 2007 p145)

What was immensely important was the way that the health professionals assimilate their knowledge and attitudes in practice towards breastfeeding mothers. Battersby (2006) identified that the formation of midwives' attitudes to infant feeding was categorised into three types of attitude: Type 1, pro breastfeeding; Type 2, accepts breast-feeding; and Type 3, anti breastfeeding. Battersby (2006) asked that midwives consider where their attitude lies when supporting and protecting mothers to breastfeed. There appeared to be silencing of women's embodied experience within the medical domain. Bradfield (1996) found that as women's knowledge increased through feeding their children so did the conflict with the dominant health professionals that are spoken of by the peer counsellors.

The production of theory is described as a social activity, which is culturally and socially embedded, thus resulting in 'situated knowledge's' (Haraway 1998). Feminist, post-modern, post-structural, hermeneutic, interpretive and critical discourses recognise that knowledge and understanding are contextually and historically grounded, as well as linguistically constituted (Mauthner and Doucet 2003). Dykes (2006) suggested that enlightenment was pivotal in the development of rationalistic science as a supreme source of authoritative knowledge. Authoritative knowledge is described as the legitimisation of one form of 'knowing' over other ways of knowing'; subordinating, devaluing, delegitimizing and, often, dismissing them (Pelling et al. 1995). In Dykes' (2006) work she sees women as active agents, while acknowledging there are many socio-cultural constraints upon them.

The peer counsellors conveyed a message to their community that women can breastfeed and that their embodied knowledge was a powerful catalyst of change and was under a 'cultural gaze'. The next chapter explores the peer counsellors' thoughts on their involvement and support of mothers in their community.

Chapter 8: Discussion: Peer Counsellor Views on their Involvement and Support

The ways in which the peer counsellors reported being supported and managed varied considerably. The "Lay Health Workers on primary and community health care: the systematic review of trials", the only global scale evaluation based on RCT's of the effectiveness of LWH interventions, identified the benefits of breastfeeding peer support. (Lewin et al. 2006). Etzioni (1993) examined the notion of the spirit of community in the context of contemporary discussion on societal improvement and the challenges for educators and policy makers to develop an understanding of citizen's responsibilities in relation to their rights. The peer counsellors studied were concerned about their rights and wanted to do 'good' by supporting other mothers to breastfeed in their community. Nevertheless, their 'sacrifice' of time was costly to their families. Several important themes emerged from their discussion concerning being part of that 'spirit of community'.

8.1 *Unsure of the Boundaries of their Roles and Level of Participation*

The definition of volunteering: 'Volunteers provide a social support infrastructure and help increase community cohesion, social inclusion and social capital. They are instrumental in founding and fuelling social movements and in developing innovative responses to social problems.' (Commission on the Future of Volunteering, 2008 p vii)

The formal organisation for the peer counsellors studied here was problematic. They talked of being used more than a worker; there seemed to be no safety net to support them and they were left to manage themselves.

It would appear that many volunteers do not receive the kind of support often promoted as good practice in volunteer management (Commission on the Future of Volunteering 2008). The peer counsellors appeared to feel that they had been used by the Sure Start and were doing more than they expected, It was difficult for them and they seemed to have no clarity about their responsibility and needed support to explore their levels of

participation. Several spoke of having to limit their time commitment because of their own children.

This was a major concern because the peer counsellors had chosen not to gain paid employment in order to spend time raising their families.

Dinham (2005) discusses, in the paper "Empowered or overpowered?" the notion of participation:

> The notion of participation has growing currency at many levels of social policy in the UK where the Labour government uses it to denote the engagement of "local people" in decision making about the services and structures which affect their daily lives.
> (Dinham 2005, p301)

The local Sure Start was under pressure to mobilise mothers who had breastfed to support other mothers and it was clear that this intervention did improve the uptake of women breastfeeding. The peer counsellors felt they were a tool used to achieve that aim without real regard for them as individuals. Etzioni (1993, p323) "spoke of a populist vision of a nation working together in a manner that reflects societal needs as well as personal goals."

This was true in so far as the peer counsellors' commitment to breastfeeding fitted with the aims of Sure Start. Yet they paid a high personal price for serving their community and their loyalty and citizenship was tested to the limit by a community who mostly did not want to listen. They were very resilient and collaborated with the health professionals involved in the project, developing and improving the process and structures surrounding recruitment and the roles and responsibilities of being a volunteer. The peer counsellors wanted to protect future peer counsellors from taking on too much (see Chapter Six).

Arnstein (1969) likened the levels of citizen participation to a ladder, each rung corresponding to the extent of a citizen's power in determining the plan.

These peer counsellors were fully engaged, climbing 'the rungs of the ladder' as Arnstein (1969) noted, however the rungs seemed to give way as they fought back against a long legacy of bottle feeding and powerful health professionals who the peer counsellors felt were ignorant about breastfeeding.

The Helping Out Study, carried out in 2006-07 (Low et al. 2007) provides a new evidence-base about people's volunteering in England and explored the real and perceived value of volunteering and giving. Of 2,156 respondents interviewed, nearly a third (31%) of regular volunteers felt their volunteering could have been better organised. This figure has decreased significantly from the 71% of respondents who reported in 1997 that their volunteering could have been better organised (Davis Smith 1998). Nonetheless, despite the improvement, it is still an area of concern. The peer counsellors identified that it was a major concern for their group and one they seemed to take responsibility for. The Volunteering Hub funded a study of leadership in grassroots volunteer-led organisations (Ockenden 2008) such organisations and their volunteers, are often not members of support networks or are isolated from the volunteering infrastructure. Although the group was under the umbrella of Sure Start they seemed to be isolated and struggling with issues that they had not imagined they would be involved in. They felt powerless and victims of their own success, though the group made it clear it was not the fault of the project team. The local Sure Start was pushed to deliver on the nationally set target for increasing the initiation of breastfeeding (DH 2007a). Unfortunately these peer counsellors became involved in a complex web of governmental requirements and this was certainly not on their agenda when they initially volunteered. They were the first peer counsellor volunteers in their area and were, therefore, 'guinea pigs' to some extent.

8.2 *Reaching Out in the Community and their Perceived Risks, Accountability and Volunteer Satisfaction*

In relation to participation, the peer counsellors voiced anxiety about the perceived risks of providing support to other breastfeeding mothers'. Over the past 10 years Volunteer England reported that there had also been a dramatic increase in enquiries regarding risk management issues (Brewis 2008).

The issue of liability insurance was raised with real concern in the focus group. The peer counsellors felt some protection from the fact that they did not advise and only offered suggestions, thus supporting women's own decision-making and hopefully escaping the litigation risks of health professionals. The peer counsellors offered great scope for change, developing new ways of working with the community and handing power back to mothers. However it was not easy for organisations or individual professionals to relinquish their power.

Accountability in volunteering has dramatically changed in the past few years with the advent of risk management and the existent blame culture. Community projects such as this one are the new vogue and the project team endeavoured to quickly develop mechanisms to support and protect volunteers. These peer counsellors did admirably, considering the lack of structure after the training programme was completed. The project team had tried to provide a service with limited resources and the mothers and peer counsellors were bearing the brunt of it. The accountability was too much for some of the peer counsellors from the project team when they felt criticised for not attending meetings and drop in sessions. There was discussion of how the organisation exerted pressure, through the health professional project team, onto them.

In a recent report 'Managing for success: volunteers views on their involvement and support' (Gaskin 2008), it was identified that there are many different approaches to managing volunteers and one size does not fit all. Nevertheless there was a responsibility to support the peer counsellors in an appropriate way. The report continued to explore common

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concerns around volunteering. Although risk and liability were identified as a factor putting off volunteers, it was more the bureaucracy that impacted on their satisfaction. The report suggested that organisations and the volunteering sector had some way to go in reducing barriers, overcoming concerns and fears, and promoting volunteer experience. This was true of the peer counsellors; they had great loyalty to the mothers in the community and the project team despite all the barriers they faced.

8.3 *Hearing Women*

The peer counsellors in this study were angry at the system; however, at the end of the focus group, they all said that they felt heard. This was important to them, that they were respected and trusted to support mothers, as this anger can often undermine future communications and relationships (Lipskey 1980;Menzies 1988; Obholzer and Roberts 1994; Perkins 1997).

Kirkham (1993) observed that we need to let women speak in order to know their concerns and to improve our ability to listen to women's words and cues. It was the collective voice of the group that we were hearing and by listening to them it will enable women's silenced voices that are knowledgeable to be accepted as the truth, alongside the evidenced-based professional knowledge, not over it. Battersby (2006), drawing on the work of (Johnson 1999; Browner and Press 1997; Ryan and Grace 2001), acknowledges that it is only recently that embodied knowledge has received any consideration; Dykes (2006) supports this position. Battersby (2006) continues to acknowledge that as more research is undertaken that recounts women's experiences of breastfeeding, the greater our understanding of how to provide individualistic care for breastfeeding women could be developed.

Midwives should be encouraged to think about how their embodied knowledge should be acknowledged as having implications for care. I would like to take this further, even before health professionals apply the right 'care'. Listening connectedly to women who have an embodied experience of breastfeeding will challenge the social and professional structure of our society as we know it in relation to women breastfeeding

their babies. The peer counsellors suffered and battled because of their commitment to providing that challenge.

8.4 Research and Policy Directives that have influenced the development of Peer Counsellors/Supporters

8.4.1 Research Evidence

The development of the peer counsellor role has been heavily influenced by underpinning national guidance and policy directives. There was a policy commitment within the National Health Service Plan (DH 2000) to increase support for breastfeeding by 2004, in order to increase breastfeeding initiation and continuation rates as part of a proposed strategy to improve diet and nutrition, improve health and provide cost savings to the National Health Service (NHS)

The NHS Plan (DH 2000) identified that experienced and/or trained peers have been shown to increase the number of women breastfeeding (DH 2000). However, Sikorski et al. (2004), reviewing the studies over the last decade of lay support which included access to support from breastfeeding counsellors, found that this type of support only increased breastfeeding initiation rates where they were already high.

Mckinnes et al. (2000) conducted a randomised control trial in the UK, and showed that peer support appeared to have a limited impact on the duration of breastfeeding in an area of low uptake.

Protheroe et al. (2003) concluded that, as a standalone intervention, peer support was effective. Two earlier systematic reviews have looked at the evidence around peer support programmes, concentrating on their effect on the initiation of breastfeeding in groups with low breastfeeding rates, (Tedstone 1998; Fairbank et al. 2000) concluding that peer support interventions helped women sustain breastfeeding. Renfrew et al. (2003) identified that peer support appears to increase exclusive breastfeeding but not necessarily overall duration.

D'Souza et al. (2003) reached conclusions that peer support is beneficial in mediating between low income mothers and healthcare professionals.

There was an increase in peer support programmes after the work conducted by Dykes (2004) finding that peer supporters brought 'practical realism' to breastfeeding. She concluded that, with the appropriate infrastructure, the capacity of the peer support programmes to empower should not be underestimated. This was evident in projects evaluated by Curtis et al. (2000) and Battersby (2002).

A Cochrane review comparing extra support for breastfeeding mothers with usual maternity care (Britton et al. 2007) suggested that additional peer support for women could be effective in increasing breastfeeding rates. Battersby and Bennett et al. (2007) were able to prove, through the limited data available, that their peer support scheme could actuate a cost saving to the NHS. Battersby and Bennett et al. (2007) were able to demonstrate, through taking a societal perspective, that breastfeeding peer support schemes can offer value-added benefits to a community as well as assisting in achieving the five key outcomes laid down in the Every Child Matters initiative (Department for Education and Skills 2004).

8.4.2 Policy Underpinning the Development of Peer Support

Since the study began there has been major policy change and Primary Care Trusts were tasked to produce an action plan which demonstrated how they were working towards improving breastfeeding initiation and duration rates in collaboration with their Local Authority and Partners Health organisations.

There has been a whole raft of policy directives that strengthened the support for breastfeeding mothers, policy drivers which included Every Child Matters (DfES 2004) Children, Young People And Maternity Services NSF Standards 1 and 11 (DH 2004b), Choosing Health (DH 2004a). WHO recommended implementation of breastfeeding peer support projects (WHO 2003). The implementation of sustainable peer support programmes has become a priority issue (Dyson et al. 2006) the National Institute for

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Health and Clinical Excellence recommended breastfeeding peer support programmes are part of a multidisciplinary team approach to supporting mothers to breastfeed and The Maternal and Child Nutrition: Guidance (2008) recommended providing local, easily accessible breastfeeding peer support programmes and ensuring peer supporters are part of a multidisciplinary team (NICE 2008).

It is pleasing that there is a commissioning guide that provides support for the local implementation of NICE public health guidance through commissioning, and is a resource to help health professionals in England to commission an effective peer-support programme for women who breastfeed (2008). It is with relief that policy direction is favourable to reverse the catastrophic results of babies not having breast milk. More research is required around the relationship of peer supporters and health professionals and how the peer counsellors/peer supporters skills and knowledge can be respected.

Chapter 9: Conclusion

9.1 *Key Issues*

The study explored the peer counsellors' challenge to be respected for their skill in supporting women to breastfeed and to bridge the gap between health professionals and their community. The barriers were societal, governmental, and personal and the impact of the peer programme being 'parachuted' into the community had major implications on the group members' experience of being peer counsellors. The peer counsellors were also resistant to being used by Sure Start to support mothers as part of the organisation reaching government targets. The group had no clear understanding of what their role entailed and this weakened them. However the peer counsellors were resilient community change agents.

The study enabled me to have a deeper understanding of the actual experiences of women who trained to be peer counsellors and the cultural and professional barriers they faced. I was privileged to listen to women who had trained to be peer counsellors and I understood how my health professional knowledge had structured and limited my own understanding of a natural process of feeding babies.

9.2 *Circle of Support*

Although the project was well set up within its own system of Sure Start, there was no infrastructure to support the peer counsellors once they had completed their training. Throughout the focus group there was a feeling of sadness for mothers being failed by the system that undermined breastfeeding because of the lack of support for women and the undermining by health professionals who lacked knowledge around breastfeeding.

The peer counsellors' embodied knowledge of breastfeeding in relation to trained professional knowledge had enabled the mothers to speak out with courage and confidence in their belief that breastfeeding a baby is possible.

This was subversive in several ways as they questioned the powerful medicalised knowledge and approach. Their aim was to have a 'circle of support' for a mother as opposed to the 'chain of command' imposed by the health professional model.

The data provides a bittersweet insight into the highs and eventual lows of a group under pressure from so many attacks from some of their community and health professionals. The peer counsellors were in danger of becoming enmeshed in a matrix of power that was very destructive. This study identifies the difficulties of voluntary and statutory organisations interfacing with each other.

9.3 Limitations of the study

This is a small piece of research which consisted of a one off focus group in one area of the UK. The study design was also limited because it concerned the first group in that community to train as peer counsellors. Inevitably their experience was that of 'guinea pigs', an experience which they changed for future volunteers by being part of their training and support. The project to which they were the first recruits met many teething problems, which impacted on their experience as volunteers. However that must not undermine the powerful voices and views of the peer counsellors who gave their time and spoke with honesty about their experience of being a peer counsellor. The findings of this study are congruent with other research studies on this immensely important area of support. (Dykes 2003, 2005a; Sikorski et al. 2004; WHO 2003)

Further research is required on the professional peer interface and this would hopefully enable peer counsellors' valuable knowledge to be heard and valued by health professionals. Further exploration of the effect of government targets on communities would be beneficial, together with research on how government agencies collaborate and participate with communities.

9.4 *Recommendations*

The following recommendations are vital in strengthening widespread implementation of peer support projects that are part of multifaceted interventions to improve the uptake of breastfeeding:

1. The health professionals involved with breastfeeding peer counsellor/support programmes need awareness training on how to support and enable peer counsellors to support mothers in an informal network.

2. The La Leche League Peer Counsellor programme is an excellent standalone programme, however, a recommendation would be for peer counsellors to have an understanding of the reality of interrelating with health professionals who are unsure of volunteers and their accountability in 'allowing them' to support other mothers.

3. There needs to be a cultural shift in midwifery and health visiting thinking and the way health professional's interface with breastfeeding peer counsellors. Together they need to provide a platform for listening to each other, acknowledging the differences and how the peer counsellors can complement and enhance a woman's breastfeeding experience.

4. Health professionals should recognise and respect peer counsellors' intuitive and social knowledge on breastfeeding. A suggestion would be to build into health visitor and midwifery university courses specific modules about volunteers and discussions on the complex inter relationships between the statutory and voluntary sectors. Catch-up training for health professionals is needed to transform their awareness of their responsibility in building trust between peer supporters/counsellors/women and health professionals.

5. There is a need for further exploration of the language health professionals use with regard to breastfeeding and the importance of language in relationships between peer counsellors and health professionals supporting mothers in order for women to feel supported in their choices.

6. Structural mechanisms would be beneficial to embed volunteers into the health care systems in a way that respects their skills and knowledge, such as a compact agreement or service level agreement between the Sure Start, Hospital and Peer Counsellor Training and specific training and awareness sessions (see Appendix 3 re compact agreement).

7. Closer work with national organisations, such as Volunteer England, and local voluntary and community organisation that have an understanding of interfacing with the third sector and statutory organisations would reduce the likelihood of smaller voluntary organisations becoming isolated.

8. Further examination is needed of the accountability of government agencies when parachuting activities and projects into communities, and the top down approach which can produce effects which are artificial and not owned by or embedded into the community.

9. Opportunities for cross fertilisation of health professionals and community development workers' experiences would enable health professionals to have an understanding of socially based approaches health and wellbeing. The main focus of this would be awareness that the peer counsellors were the substitute grandmothers, and avoidance of them becoming an artificial health professional substitute is vital.

References and Bibliography

Acheson, D. (Chair) (1998). *Independent Inquiry into Inequalities in Health.* London: Stationery Office.

Agar, M and MacDonald, J. (1995). Focus groups and Ethnography. *Human Organization,* **54** (1), 78-86.

Anderson, T and Grant, M. (2001). The Art of Community-based Breastfeeding Support. The Blandford Breastfeeding Support Group, incorporating the 'Blanford Bosom Buddies'. *MIDIRS Midwifery Digest,* **11** (Supp. 1), 20-23.

Altheide, D and Johnson, J. (1994). Criteria for Assessing Interpretive Validity. In: Denzin and Y.S. Lincoln, eds. *Handbook of Qualitative Research.* London: Sage.

Aniansson, J. Alm, B. and Anderson, B. (1994). A prospective cohort study on breastfeeding and otitis media in Swedish infants. *Pediatric Infectious Disease Journal,* **13** (8), 183-188

Apple, R. (1987). *Mothers and Medicine: A Social History of Infant Feeding 1890-1950.* London: The University of Wisconsin Press.

Arnstein S (1969) *'A Ladder of Public Participation',* Journal of the American Institute of Planners. **35** (4), 216-224.

Atkinson, P. (1990). *The Ethnographic Imagination:Textual construction of Reality.* London, Routlege.

Atkinson, P. (1992). *Understanding Ethnographic Texts.* Newbury Park, CA:Sage.

Baker, R and Hinton, R. (1999). Focus groups facilitate meaningful participation in social research? In: Barbour, R. S and Kitzinger, J. (eds). *Developing Focus Group Research: Politics Theory and Practice.* London, Sage. 9-98.

Barnes, B. Ernst, S and Hyde, K. (1999*). Introduction to Groupwork a Group-Analytic Perspective* London, Palgrave Macmillan Press Ltd.

Ball, T.M. and Wright, A.L. (1999). Health Care Costs of Formula-Feeding in the First Year of Life. *Pediatrics*, (103) 870-876.

Barbour, R and Kitzinger, J. (1999). *Developing Focus Group Research*. London: Sage Publications.

Bartlett, A. (2000) Thinking through Breasts. Writing Maternity, *Feminist Theory*. Vol **1** (2) 173-188.

Battersby, S. (1999). Midwives Experiences of Breastfeeding: Can the Attitudes Developed Affect how Midwives Support and Promote Breastfeeding? Paper presented at the *Proceedings of the International Confederation of Midwives 25th Triennial Congress Midwifery and Safe Motherhood: Beyond the Year 2000*. Manila, May 22-27. unpublished.

Battersby, S. (2002b). *The Breastfeeding is the Best Supporters Project: An evaluation of the merged Breastfeeding Peer Support Programmes, a Research and Evaluation Report for the Foxhill and Parsons Cross Sure Start*. University of Sheffield: Sheffield.

Battersby, S. (2006). *Dissonance and Competing Paradigms in Midwives' Experiences of Breastfeeding*. University of Sheffield: School of Nursing and Midwifery.

Battersby, S. (2007). *An Evaluation of La Leche League, Great Britain*. Breastfeeding Peer Counselor Programme.

Battersby, S. Bennett, K. (2007). Exploring the cost-effectiveness of a breastfeeding peer support programme. In: Richens, Y. (eds). Challenges for Midwives Vol **2** Quay Books 85-94.

Belenky, M.F. Clinchy, B.M. Goldberger, N.R and Tarule, J.M. (1986). *Women's Ways of Knowing: The Development of Self Voice, and Mind.* New York: Basic Books, A Subsidiary of Perseus Books, L.L.C.

Beral, V. (2002). Breast Cancer and Breastfeeding: Collaborative Reanalysis of Individual Data. 47 Epidemiological Studies in 30 Countries, including 50302 Women with Breast Cancer and 96973 Women Without the Disease. *Lancet,* 360, .87-195.

Berger, P and Luckman, T. (1966). *The Social Construction of Reality.* London: Allen Lane.

Bhatt, A. (1975). *Caste, Class and Politics.* Delhi.

Bloom, J.A. (2005). Group Analytical Perspective on Midwifery Education. *British Journal of Midwifery.* **13** (8). 486-489.

Bocar, D and Shrago, L. (1993). Breastfeeding Education In Riorden, J and Auerback, K. (eds). *Breastfeeding and Human Lactation.* London: Jones and Bartlett. 181-210.

Bolling, K. Grant C. Hamlyn, B. Thornton, A. (2007). Infant Feeding Survey 2005. London: NHS.

Bradfield, O. (1995). Knowledge, power and control as women learn to breastfeed. *New Zealand College of Midwives Journal* 15:25-28.

Brewis,G. Volunteering Hub Final Report 2005-2008 (2008). Volunteering England Last accessed 1st January 2010 at http://www.volunteering.org.uk/NR/rdonlyres/7C2D1070-CB02-4E6E-A9BA-88370C84A88E/0/Hub_final_report.pdf.

Britton, J. Hoddinott, P and McInnes, R. (2006). Breastfeeding Peer Support: Health Service Programmes in Scotland. *British Journal of Midwifery,* **14** (1), 12-14, 16-19.

Britton, C. McCormick F.M. Renfrew, M.J. Wade, A. King, S.E. (2007). *Support for breastfeeding mothers* (Review) *The Cochrane Collaboration*. London: Wiley & Sons Ltd.

Bromberg, Bar-Yam. N. (2003). Breastfeeding and Human Rights: Is there a Right to Breastfeed? Is there a Right to be Breastfed? *Journal of Human Lactation,* **19** 357-361.

Bronner, Y.L. Barber, T. Davis, S. (2001). Breastfeeding Peer Counselling: Policy Implications. *Journal of Human Lactation* **17** (2). 105-109.

Brown, L.M and Gilligan, C. (1992). *Meeting At The Crossroads: Women's Psychology and Girls' Development.* Feminism and Psychology, **3** (1), 11-35.

Brown, S. (1998). Peer Support for Breastfeeding. *The Practicing Midwife,* **1** (7/8), 18-20.

Browner, C. H and Press, N. (1997). The Production of Authorative Knowledge in American Prenatal care. In: Davis-Floyd, R and Sargent, C. (eds). *Childbirth and Authorative Knowledge.* Berkeley: University of California Press.

Bruner, J. (1983). *Child's Talk: Learning to use Language*. New York: Norton.

Burman, E. (2001). Beyond the baby and the bathwater: Post Dualistic Psychologies. *European Early Childhood Education Research Journal 1752-1807,* **9** (1) .5–22.

Burr, M. L. Miskelly, F. G and Butland, B. K. (1989). Environmental Factors and Symptoms in Infants at High Risk of Allergy. *Journal of Epidemiology and Community Health,* **43**, 125-32.

Burt, S. (1999). The Social Capital of Opinion Leaders. *The Annals of the American Academy of Political and Social Science,* **566** (1), 37-54.

Cesar, J. A. Victora, C. G. Barros, F. C. Santos, I. S. and Flores, J. A. (1999). Impact of Breast feeding on Admission for Pneumonia during Post-natal Period in Brazil: Nested Case-Control Study. *British Medical Journal* **318**: 1316-22.

Charmaz, C. (2000). Grounded Theory: Objectivist and Constructivist Methods. In: Denzin, N. and Lincoln, Y. eds. 2000. *Handbook of Qualitative Research.* 2nd ed. London, Sage.

Chesney, M. (2001). Dilemmas of Self in The Method. *Qualitative Health Research,* **11**(1), 127-135.

Chesney, M. (2004). *Birth For Some Women in Pakistan: Defining and Defiling.* Ph.D. University of Sheffield.

Commission on the Future of Volunteering, (2008). *Manifesto for Change: Report of the Commission on the Future of Volunteering.* London: Volunteering England.

Commission on the Future of Volunteering, (2008). *Understanding How to Engage People in Volunteering.* London: Volunteering England.

Curtis, P., Stapleton, H. Kirkham, M and Smale, M. (2001). Evaluation of the Doncaster Breastfriends 2000 Initiative. *Report to the Department of Health. WICH Research Group*: University of Sheffield.

Curtis, P. Woodhill, R. Stapleton, H. (2007). The Peer-Professional Interface in a Community-Based, Breast Feeding Peer. *Midwifery,* **23** (2), 146-156.

Dalal, Farhad. (1998). *Taking the Group Seriously: Towards a Post-Foulkesian Group Analytic Theory.* United Kingdom, Jessica Kingsley Publishers Ltd.

Darby, F.C. (2006). *Managing Child Health: The Network Dynamics of Social Exchange.* PhD Thesis. University of York.

Davis-Floyd, R E. (1992) *Birth as an American Rite of Passage.* Berkley: University of California Press.

Davis-Floyd, R. and Sargent, F. eds. (1997). *Childbirth and Authorative Knowledge: Cross-Cultural Perspectives.* London: University of California Press.

Davis-Floyd, R. (2001). The Technocratic, Humanistic and Holistic Paradigms of Childbirth. *International Journal of Gynaecology and Obstetrics,* **75** (supp 1), 5-23.

Davis Smith, J. (1998). *The 1997 National Survey of Volunteering* The National Centre for Volunteering: London.

Debold, E., Tolman, D. and Brown, L. M. (1996). Embodying Knowledge, Knowing Desire: Authority and Split Subjectivities in Girls' Epistemological Development. In: Goldberger, N. Tarule, J. Blythe, C. and Belenky (eds). *Knowledge, Difference, and Power: Essays Inspired by Women's Ways of Knowing.* New York: Basic Books, 85-125.

Deery, R. (2003). *Engaging with Clinical Supervision in a Community Midwifery setting: An Action Research Study.* PhD Thesis, University of Sheffield.

Deery, R. and Kirkham, M. (2007). *Drained and Dumped On: The Generation and Accumulation of Emotional Toxic Waste in Community Midwifery.* In: Exploring the Dirty Side of Women's Health. (Eds). Kirkham. M, London and New York. Routledge. 72-83.

Dennis, C.L. (2002). Breastfeeding Peer Support: Maternal and Volunteer Perceptions from a Randomized Controlled Trial. *Birth* 2002; **29** (3),169-76.

GREAT BRITAIN, Department for Communities and Local Government (2007). *The New Performance Framework for Local Authorities and Local Authority Partnerships: Single Set of National Indicators.* London: DCLG.

GREAT BRITAIN, Department of Health (1998). *Independent Inquiry Into Inequalities in Health.* London: HMSO.

GREAT BRITAIN, Department of Health. (1999). *Saving Lives: Our Healthier Nation*. London: HMSO.

GREAT BRITAIN, Department of Health. (2000). *The NHS Plan: a Plan for Investment a Plan for Reform* London: DH.

GREAT BRITAIN, Department of Health, (2001a). *Research Governance Framework for Health and SocialCare*.[online] accessed 4th November 2004.Available :http://www.dh.gov.uk/PublicationsAndStatistics/Publications/Pu blicationsPolicyAnd Guidance/PublicationsPolicyAndArticle/fs/en?CONTENT-id=4008777&CHK=DmrD/5.

GREAT BRITAIN, Department of Health. (2001b). *Governance Arrangements for NHS Research Ethics Committees*.[online]Last accessed 4th November Available at: http://www.suht.nhs.uk/media/pdf/b/1/Governanace-Arrangements-for-NHS-Research-Ethics-Committees.PDF.

GREAT BRITAIN, Department of Health. (2002). Improvement, Expansion and Reform: *The Next Three Years Priorities and Planning Framework 2003-2006.London: DH Inequalities: A Programme For Action*. London. DH.

Department of Health, (2003a), *Priorities and Planning Framework 2003-2006*. London: HMSO.

GREAT BRITAIN, Department of Health. (2003b). *Infant Feeding Recommendation*. London: HMSO.

GREAT BRITAIN, Department for Education and Skills. (2004). *Every Child Matters: Change for Children*. London: HMSO.

GREAT BRITAIN, Department of Health, (2004a). *Choosing Health: Making Healthier Choices Easier*. London: HMSO.

GREAT BRITAIN, Department of Health. (2004b). *National Service Framework for Young People and Maternity Services*. London: HMSO.

GREAT BRITAIN, Department of Health, (2005). *Clarification of Breastfeeding Initiation Data Collection* last accessed 1st July 2009 [online]. Available at: www.dh.gov.uk/assetRoot/04/07/16/96/04071696.pdf.

GREAT BRITAIN, Department of Health. (2006), *Standards of Better Health* London: DH.

GREAT BRITAIN, Department of Health, (2007). *Delivering health services through Sure Start Children's Centres* [online]. Available at: last accessed 1st July 2009 at: http://www.dh.gov.uk/en/Publication sandstatistics/Publications/PublicationsPolicyAndGuidance/DH_076333

GREAT BRITAIN, Department of Health. (2007a). *Review of Health Inequalities Infant Mortality PSA Target.* London: DH.

GREAT BRITAIN, Department of Health. (2009). *Healthy Child Programme – Pregnancy and the First Five Years.* London: DH.

D'Souza, L. Garcia, J. (2003). Limiting the Impact of Poverty and Disadvantage on the Health and Wellbeing of Low- Income Pregnant Women, New Mothers and their Babies: Results of a Mapping Exercise. (draft March 2003) *National Perinatal Epidemilogy Unit and the Maternity Alliance* http://www.npeu.ox.ac.uk/images/mapping%20exercise.pdf.

Dewey, K. G. Heinig, M. J. Nommsen, L. Peerson, J. M. and Lonnerdal, B. (1992). Growth of Breast-Fed and Formula-Fed Infants From 0 to 18 Months: the DARLING study. *Pediatrics* **89**: 1035-41.

Dewey, K. G. Heinig, M. J. and Nommsen, L. (1993). Maternal Weight Loss Patterns during Prolonged Lactation. *American Journal of Clinical Nutrition,* **58**, .162-6.

Dinham, A. (2005). Empowered or Over-powered? The Real Experiences of Local Participation in the UK's New Deal for Communities. *Community Development Journal,* **40** (3), 301-312.

Duncan, B., Ey, J., and Holberg, C. J. (1993) Exclusive Breastfeeding for at Least Four Months Protects Against Otitis Media. *Pediatrics,* **91** 867-872.

Dykes, F and Griffiths, H. (1998). Societal Influences Upon Initiation and Continuation of Breastfeeding. *British Journal of Midwifery,* **6** (2), 76-80.

Dykes, F., Burt, S. Edwards, J. (2003). Adolescent Mothers and Breastfeeding: Experiences and Support Needs - An Exploratory Study. *Journal of Human Lactation,* **19** (4), 391-401.

Dykes, F. (2003). *Infant Feeding Initiative: A Report Evaluating the Breastfeeding Practice Projects 1999-2002.* London: DH.

Dykes, F. (2005a). A Critical Ethnographic Study of Encounters Between Midwives and Breastfeeding Women on Postnatal Wards. *Midwifery,* **21**, 241-252.

Dykes, F. (2005b). Supply and Demand: Breastfeeding as Labour. *Social Science & Medicine* **60**, 2283-2293.

Dykes, F. (2006). *Breastfeeding in Hospital: Mothers, Midwives and the Production.* London & New York: Routledge.

Dyson, S and Brown, B. (2006). *Social Theory and Applied Health Research.* Maidenhead: Open University Press.

Dyson, L. McCormick, F and Renfrew, M. J. (2005). Interventions for Promoting the Initiation of Breastfeeding (Review). *Cochrane Database Syst Rev. CD001688(2).*

Dyson, L. Renfrew, M. McFadden, A. McCormick, F. Herbert, G. Thomas, J. (2006). Effective action briefing on the initiation and duration of breastfeeding. London: National Institute for Clinical Excellence.

Earle, S. (2002). Factors Affecting the Initiation of Breastfeeding: Implications for Breastfeeding Promotion. *Health Promotion International,* **17** (3), .205-214.

Eaves, Y. D. (2001). A Synthesis Technique for Grounded Theory Data Analysis. *Journal of Advanced Nursing, 35*, 654-663.

Eichenbaum, I and Orbach, S. (1983). *What Do Women Want? Exploding the Myth of Dependency.* London: Michael Joseph, 1983, New York: Coward McCann, 1983.

Elias, N. (1991). *The Symbol Theory.* London: Sage.

Enkin, Murray, Keirse, M. J. Neilson, J. Crowther, C. Duley, L. Hodnett, E and Hofmeyr, Justus. (2000). *A Guide to Effective Care in Pregnancy & Childbirth* (3rd ed.). Oxford New York.

Edwards, R and Ribbens, Jane. (1998). *Living on the Edges: Public Knowledge and Private Lives, Personal experiences.* In: J. Ribbens and R. Edwards, (eds.) *Feminist Dilemmas in Qualitative Research.* London: Thousand Oaks New California Publications.

Edwards, N. (2005). *Birthing Autonomy.* London and New York: Routledge.

Etzioni, A. (1993). *The Spirit of Community: The Reinvention of American Society.* New York: Touchstone.

Fairbank, L. O'Meara, S. Renfrew, M. J. Woolridge, M. Sowden, A. J and Lister-Sharp, D. (2000). A Systematic Review to Evaluate the Effectiveness of Interventions to Promote the Initiation of Breastfeeding. *Health Technology Assessment Programme* **4** (25).

Fairbank, L. Lister-Sharpe, D, Renfrew, M.J.Wolridge, M.W.Sowden, A.J.S and O'Meara, S. (2002) Interventions for Promoting the Initiation of Breastfeeding (Cochrane Review) In: *The Cochrane Library, Volume 1.* Oxford: Update Software.

Fairclough, N. (1992). *Discourse and Social Change.* Cambridge: Polity Press.

Fern, Edward, F. (2001). *Advanced Focus Group Research*. Thousand Oaks: Sage.

Fewtrell, M.S. (2004). The Long Term Benefits of Having Been Breastfeed. *Current paediatrics* **14**, 97-103.

Finlay, L. (2002). "Outing" the Researcher: The Provenance, Process, and Practice of Reflexivity. *Qualitative Health Research*, **12** (4), 531-545. Open University, UK.

Finlay, L. (2003). *The Reflexive Journey: Mapping Multiple Routes*. In: Finlay, L. and Gough, B. Eds. *Reflexivity: A Practical Guide for Researchers in Health and Social Science*. Oxford: Blackwell Publishing.

Finlay, L. (2008). A Dance Between the Reduction and Reflexivity: Explicating the "Phenomenological Psychological Attitude", *Journal of Phenomenological Psychology*, **39** (1), 1-32.

Foucault, M. (1976) *The Birth of the Clinic: Archaeology of Medical Perception*. London: Tavistock.

Foucault, M. (1977). *Discipline and Punish: The Birth of Prison*. Harmondsworth: Penguin.

Foucault, M. (1980). Power/Knowledge: Selected Interviews and other Writings 1972-1977, ed. Colin Gordon. Brighton: Harvester Press.

Foucault, M. (1981) *The History of Sexuality: An Introduction*. London: Tavistock.

Foulkes, S.H. (1948). *Introduction to Group Analytic Psychotherapy*. London: William Heinemann Medical Books.

Gaskin, K. (2006a). *On the Safe Side: Risk, Risk Management and Volunteering.* London: Volunteering England and the Institute for Volunteering Research.

Gaskin, K. (2006b). *Risk Toolkit: How to take care of risk in Volunteering.* London: Volunteering England and the Institute for Volunteering Research.

Gaskin, K. Hutchinson, R. Hutin, M. and Zimmeck, M. (2008). *The Commission on the Future of Volunteering: Results of the Public Consultation.* London: Volunteering England.

Gilbertson, J. Green, G and Grimsley, J. M. (2005). *The Dynamic of Social Capital, Health and Economy: The Impact of Regeneration in South Yorkshire Coalfield Communities, report produced by the centre for Regional Economic and Social Research, Sheffield Hallam University.*

Gilligan, C. (1982). *In a Different Voice: Psychological Theory and Women's Development.* Cambridge, MA: Harvard University Press.

Giorgi, A. (1994). A Phenomenological Perspective on Certain Qualitative Research Methods. *Journal of Phenomenological Psychology,* **25**,190-220.

Glaser, B. (1992). *Basics of Grounded Theory Analysis: Emergence vs. Forcing.* Mill Valley, CA: Sociology Press.

Glaser, B.G. (1999). The Future of Grounded Theory. *Qualitative Health Research,* **9** (6), 836-845.

Goffman, E. (1990). *The Presentation of Self in Everyday Life,* Penguin, Harmondsworth. First published in 1959.

Greer, F. R. and Apple, R. D. (1991). Physicians, Formula Companies, and Advertising: A Historical Perspective. *American Journal of Disease Child.* **145** (3), 282-286.

Haider, R. Ashworth A. Kabir, I. Huttly, S. (2000). Effect of Community-Based Peer Counsellors on Exclusive Breastfeeding Practices in Dhaka, Bangladesh: A Randomised Controlled Trial. *The Lancet,* **356** (9242. 1643-1647).

130

Haider, R. Kabir, I. Huttly, S. Ashworth, A. (2002). Training peer supporters to promote and support exclusive breastfeeding in Bangladesh. *Journal of Human Lactation* **18** (1), 7-12.

Hall Moran, V. Dykes, F. (2006). (eds). *Maternal and Infant Nutrition & Nurture: Controversies and Challenges.* London: Quay Books ISBN: 1 85642 285 2.

Hamlyn, B. Brooker, S. Oleinikova, K. Wands, S (2002). *Infant Feeding 2000* The Stationery Office, London.

Hannula,Kaunonen, M and Tarkka, Marja-Terttu, (2008) A Systematic Review of Professional Support Interventions for Breastfeeding. *Journal of Clinical Nursing,* **17** (9), 1132-1143.

Haraway, D. (1988). Situated Knowledges: The Science Question in Feminism and the Privilege of Partial Perspective. *Feminist Studies.* **14** (3), 575-599.

Haug, M. (1975). The Deprofessionalization of Everyone? *Sociological Focus,* **8** (3), 197-213.

Haug. M.R. (1976) The Erosion of Professional Authority: A Cross Cultural Inquiry in the Case of the Physician. The Millbank Memorial Fund Quarterly.

Health and Society. Vol 54, **1** (Winter), 83-106 Last accessed 20.01.10 http://www.jstor.org/stable/3349670.

Howie, P. W. Forsyth, J. S. Ogston, S. A. Clarke, A. and Florey, C. D. (1990). Protective effect of breastfeeding against infection. *British Medical Journal* 300: 11-6.

Healthcare Commission, (2008). *The Annual Health Check: 2007/08 A National Overview of the Performance of NHS trusts in England.* London: HMSO.

Hoddinott, P. and Pill, R. (2000). A Qualitative Study of Women's Views about How Health Professionals Communicate About Infant Feeding *Health Expectations, 224-233(10).*

Hoddinott, P. Tappin, D. and Wright, C. (2008). Breast Feeding. *British Medical Journal,* **336**, 881-887.

Hoey, C. and Ware J. (1997). Economic Advantages of Breastfeeding (sic) in an HMO setting: A pilot study. *America Journal Man. Care,* **3**.361-365.

Hogan, D. P. Eggebeen, D. J. and Clogg, C. (1993). The Structure of Intergenerational Exchanges in American Families. *American Journal of Sociology,* **98** *1428-1458.*

Holdsworth, A. (1988). *Out of the Dolls House: The Story of Women in the 20th Century.* BBC Books.

Hollway, W. and Jefferson, T. (2002). *Doing Qualitative Research Differently: Free Association, Narrative and the Interview Method.* London: Sage Publications.

Howie, P. W. Forsyth, J. S. Ogston, S. A. Clarke, A, and Florey, C. D. (1990). Protective Effect of Breastfeeding Against Infection. *British Medical Journal* **300** 1-6.

Humphreys, A. S. Thompson, N. J and Miner, K. (1998). Intention to Breastfeed in Low-Income Pregnant Women: The Role of Social Support and Previous Experience. *Birth,* **25** (3), 169–174.

Hunter, B. (2004). Conflicting Ideologies as a Source of Emotion Work in Midwifery. *Midwifery,* **20** 261-272.

Hunter, B. (2004). The Importance of Emotional Intelligence in Midwifery. *Editorial, British Journal of Midwifery,* **12** (10), 1-2.

Hunter, B and Deery, R. (2005). Building our Knowledge about Emotion Work in Midwifery: Combining and Comparing Findings from Two Different Research Studies, *Evidence Based Midwifery,* **3**(1), 10-15.

132

Hunter, B and Deery, R. eds. (2009). *Emotions in Midwifery and Reproduction.* London: Palgrave Macmillan.

Johnson, M.L. (1999). Embodied Reason. In: G. Weiss and H.F. Haber. *Perspectives on Embodiment: Intersections of Nature and Culture.* New York and London: Routledge.

Kaler, A. (2001). 'Its Some Kind of Women's Empowerment': The Ambiguity Of The Female Condom as a Marker of Female Empowerment. *Social Science and Medicine* **52**, 783-796.

Khan, M and Manderson, L. (1992). *Focus Groups in Tropical Diseases. Research Health Policy and Planning,* **7**(1),56-66.[online] Available at: http://heapol.oxfordjournals.org/misc/terms.shtml.

Kirkham, M. J and Perkins, E. R. (eds) (1993) *Reflections on Midwifery.* Balliere and Tindall.

Kirkham, M. (1997). Reflection in Midwifery: Professional Narcism or Seeing with Women? *British Journal of Midwifery,* **5** (5) .259-262.

Kirkham, M (1999) The Culture of Midwifery in the NHS in England. Journal of Advanced Nursing **30**, (3), 732-39.

Kirkham, M and Stapelton, H. (2000). *Informed Choice in Maternity Care: An Evaluation of Evidence Based Leaflets.* The University of Sheffield & The University of Glamorgan.

Kirkham, M. (2005). Unpublished. *An Exploration of Relationships within and Around Breastfeeding Peer Support Programmes in Sheffield – Preliminary to a National Study.* The University of Sheffield

Kirkham, M. Sherridan, A. Thornton, D. Smale, M. (2006). Chapter 8 250-273 'Breastfriends' Doncaster: The Story of our Peer Support Project. In: *Maternal and Infant Nutrition and Nurture Controversies and Challenges London: Quay Books.*

Kirkham, M. (2009). Chapter 13:227 In: B. Hunter and R. Deery, (eds.) (2009). *Emotions in Midwifery and Reproduction.* London: Palgrave Macmillan.

Kistin, N. Abramson, R. and Dublin, P. (1994). Effect of Peer Counsellors on Breastfeeding Initiation, Exclusivity and Duration Among Low-Income Women. *Journal of Human Lactation,* **10** (1), 11-15.

Kitzinger, J. (1995) 'Introducing focus groups', *British Medical Journal* **311**, 299-302.

Kitzinger, S. (2003). Sheila Kitzinger's letter from Europe: The Clock, The Bed, The Chair, The Pool. *Birth,* **30** (1), .54-56.

Klein, M. (1988a). *Envy and Gratitude and Other Works 1946-1963.* London:Virago Press.

Kramer, M. Chalmers, B. Hodnett, H. Sevovskaya, Z. Dzikovich, I. Shapiro, S. Collett, J. P. Vanilovich, I. Mezen, I. Ducruet, T. Shishko, G. Zubovich, V. Mkuik,D. Gluchanina, E. Dombrovsky, V. Ustinovitch, A. Kot, T. Bogdonavich, N. Ovchinikova, L. and Helsing, E. (2001). Promotion of Breastfeeding Intervention Trial (PROBIT).*Journal of the American Medical Association* **285**: 413-20.

Kreuger, R. A. (1994*). Focus Groups: A Practical Guide for Applied Research,* 2nd ed. London: Sage.

Krueger, Richard, A and Casey, MA. (2000). *Focus Groups: A Practical Guide for Applied Research.* 3rd ed. Thousand Oaks, California, Sage.

La Leche League, (2003b). *La Leche League's Purpose.* [online] 1st July 2009 Available at: http://www.lalecheleague.org/purpose.html.

La Leche League, (2003d). *About La Leche League Peer Counselor Program.*Last accessed 1st July 2009 [online] Available at: http://www.lalecheleague.org/PeerAbout.html.

Lakoff, T.R. and Bucholtz, M. (2004). *Language and Woman's Place*. 2nd ed. Oxford: Oxford University Press.

Lande B, Andersen LF, Baerug A . (2003). Infant Feeding Practices and Associated Factors in The First Six Months of Life: The Norwegian Infant Nutrition Survey. *Acta Paediatrica* **92**: 152–161.

Lewin, SA. Babigumira, SM. Bosch-Capblanch, X. Aja, G. Van Wyk, B. Glenton, C. Scheel, I. Zwarenstein, M. Daniels, K. (2006). Lay Health Workers in Primary and Community Health Care: *A systematic Review of Trials WHO.*

Lipskey, M. (1980). *Street Level Bureaucracy: Dilemmas of the Individual in Public Services.* New York: Russel Sage Foundation.

Love, M. Gardner, K and Legion, V. (1997). Community Health Workers: Who They Are and What They Do. *Health, Education and Behaviour,* **24** (4),510-522. Last accessed 27th January 2010 at:http://heb.sagepub.com/cgi/content/abstract/24/4/510

Low, N. Butt, S. Ellis Paine, A and Davis Smith, J. (2007). *Helping Out: A National Survey of Volunteering and Charitable Giving,* Cabinet Office: London.

Lucas, A. Brooke, O. G. Morley, R. Cole, T. J and Bamford, M. F. (1990). Early Diet of Preterm Infants and The Development of Allergic or Atopic Disease: Randomised Prospective Study. *British Medical Journal* **300** 837-40.

Lyon, M.L and Barbalet, J. M. (1994). Society's Body: Emotion and the "Somatization" Of Society and Theory. In: T. Csordas (ed) *Embodiment and Experience: The Existential Ground of Culture and Self.* Cambridge: Cambridge University Press. 48-68.

Magalhaes, R. (2003). Mother to Mother: Support for Breastfeeding. *World Alliance for Breastfeeding Action.*

Marild, S. Jodal, U and Hanson, L. A. (1990). Breastfeeding and Urinary Tract Infection. *Lancet,* 336, .942.

Martin, R. M. et al. (2004). Does Breast-Feeding in Infancy Lower Blood Pressure in Childhood? *Circulation*, **109**, 1259-1266.

Mason, J, (1996). *Qualitative Researching*. London: Sage.

Mauthner, N and Doucet, A. (1998). *Reflections on a Voice-Centred Relational Method: Analysing Maternal and Domestic Voices*. In: Ribbens, J and Edwards, R. (eds). *Feminist Dilemmas in Qualitative Research*. London: Thousand Oaks New Delhi: Sage Publications. 119-146.

Mauthner, N and Doucet, A. (2003). Reflexive Accounts and Accounts of Reflexivity in Qualitative Data Analysis. *Sociology,* Vol **37,** (3) 413-431.

Mayer,E. J. Hamman, R. F and Gay, E. C. (1988). Reduced Risk of IDDM Among Breastfed Children: The Colorado IDDM registry. *Diabetes* **37**: 1625-32.

McDonald, M (1999) Chapter 4. In Walter, *M. (2006) Social Research* Methods: An *Australian Perspective. Australia:OUP Australia & New Zealand.*

McInnes, R. J. Love, J. G and Stone, D.H. (2000). Evaluation Of A Community Based Intervention To Increase Breastfeeding Prevalence. *Journal of Public Health Medicine,* Vol **22** (2), 138-145.

McInnes, R. J and Stone, D. H. (2001). The Process of Implementing a Community-based Breastfeeding Support Programme. *Midwifery, (17*), 65-73.

Meier, E.R. Olson, B.H. Benton, P. Eghtedary, K. Song Won, O. (2007). A Qualitative Evaluation Of a Breastfeeding Peer Counselor Program. *Journal of Hum Lac;* Vol **23** (3), 262-8.

Menzies, L. I. (1988). *Containing Anxiety in Institution*s. London: Free Association Books.

Merton, R, K and Kendall, Patricia. L. (1946). The Focused Interview. *American Journal of Sociology*, **51**, 541-557.

Merton, R.K. Fiske, M and Kendall, P.L. (1990). *The Focused Interview*. 2nd Ed. New York: The Free Press.

Miles, M. B and Huberman, A. M. (1994). *Qualitative Data Analysis* 2nd ed. Thousand Oaks, CA: Sage.

Milligan, R. Pugh, L. Bronner, Y. Spatz, D. Brown, L. (2000). Breastfeeding Duration Among Low Income Women *Journal of Midwifery and Women's Health,* Vol 45, **3,** 246-252.

Mishler, E. (1991). *Research Interviewing: Context and Narrative.* Cambridge: Harvard.

Mojab, C. (2002). Helping Mothers Create Breastfeeding Allies.*Leaven,* Dec/Jan, 123-127.

Morgan, D. L. (1997). *Focus Groups As Qualitative Research*. Newbury Park, CA:Sage

Morgan, D. L and Krueger, R. A. (1998). *The Focus Group Kit (vols. 1-6).* Thousand Oaks, CA: Sage.

Morrow, A.L. Guerrero, M.L. Shults, J. Calva, J.J. Lutter, S. Bravo, J.,Ruiz-Palacios, G. Morrow, R.C. Butterfoss, F.D. (1999). Efficacy Of Home-Based Peer Counseling to Promote Exclusive Breastfeeding: A Randomized Controlled Trial. *The Lancet,* **353**, 1226-1231.

Murphy- Lawless, J. (1998a). *Reading Birth and Death: A History of Obstetric Thinking.* Cork University Press.

Newcombe, P. A. Storer, B. E and Longnecker, M. P. (1994). Lactation and A Reduced Risk Of Premenopausal Breast Cancer. *New England Journal of Medicine,* **330**, .81-87.

National Institute for Health and Clinical Excellence. (2007b). *Maternal and Child Nutrition Consultation: Economic Review – Cost Effectiveness of Breastfeeding Support.*

National Institute for Health and Clinical Excellence. (2008). PH11 *Maternal and Child Nutrition:Guidance.* London.

Nitsun, M. (1996). *The Anti-Group.* London and New York: Routledge.

Oakley, A. (1992). *Social Support and Motherhood.* Oxford: Blackwell.

Obholzer, A. S and Roberts V. Z. eds. (1994). *The Unconscious at Work: Individual Organisational Stress in the Human Services.* London: Routledge.

Ockenden, N and Hutin, M. (2008). *Volunteering to Lead: A Study of Leadership within Small Volunteering Groups.* London: Volunteering England and Institute for Volunteering Research.

Olson, K and Shopes, L. (1981). *Crossing Boundaries, Building Bridges: Doing Oral History Among Working Class Women and Men*, in Sherna Berger Gluck and Daphne Patai (eds). *Women's Words: The Feminist Practice of oral history.* London: Routledge.

O'Neill, R. (2007). *Competing Ideologies in Maternity Care: A Discourse Analysis.* Masters' thesis. University of Sheffield: Occupational Psychology.

Opie, A. (1992). Qualitative Research, Appropriation of the 'Other', and Empowerment. *Feminist Review,* **40**, .52-69.

Orbach, S and Eichenbaum, L. (1987). *Between Women: Love, Envy & Competition in Women's Friendships.* London: Arrow Books.

Pelling, M. Harrison, M and Weindling, P. (1995). The Industrial Revolution 1750 to 1848 In: C. Webster. ed. *Caring and Health History and Diversity.* Milton Keynes: Open University Press. 36-62.

Perkins, E. R. (1997). *Midwives Coping: Thinking about Change*. In: Kirkham, M. J and Perkins, E. R. (eds). *Reflections on Midwifery*. London: Balliere.

Pisacane, A. Graziano, L. Mazzarella, G. Scarpellino, B and Zona, G. (1992). Breastfeeding and Urinary Tract Infection. *The Journal of Pediatrics* **120**: 87-9.

Plotkin, H. (1997). Evolution In Mind. London: Allen Lane, Penguin Press.

Polit, D. F and Hungler, B.P. (1993). *Essentials of Nursing Research: Methods, Appraisal, and Utilization*. Philadelphia, USA: J.B. Lippincott Company.

Popay, J and Williams, G. (1996). Public Health Research and Lay Knowledge. *Social Science and Medicine*. **42** (5), 759-768.

Protheroe, L. Dyson, L. Renfrew, M.J. Bull, J. Mulvihill, C. (2003). *The Effectiveness of Public Health Interventions to Promote the Initiation of Breastfeeding*. Evidence Briefing NHS Health Development Agency. Last accessed 28th January 2010 https://www.nice.org.uk/nicemedia/documents/breastfeeding_evidencebriefing.pdf.

Putcha, C and Potter, J. (2004). *Focus Group Practice*. London: Sage Publications.

Raine, P and Woodward, P. (2003). Promoting Breastfeeding: A Peer Support Initiative *Community Practioner*. **76** (6), 211-214.

Raphael-Leff, J. (1991). *Psychological Processes of Childbearing*. London: Chapman and Hall.

Raymond, M. L. (2008). Bogardus and The New Social Research. *Current Sociology*, 56 (2), 307-321.

Renfrew, M. J. Woolridge, M. W and Ross McGill, H. (2000). *Enabling Women to Breastfeed. A Critical Review of the Literature with Evidence-Based Guidance For Practice*. London: HMSO.

Renfrew, M. J. Ansell, P and Macleod, K. L. (2003). Formula Feed Preparation: Helping Reduce the Risks; A Systematic Review. *Arch Dis Child*; **88** (10), 855-858.

Renfrew, M.J. Dyson, L. Wallace, L.M. D'Souza, L. McCormick, F and Spiby, H. (2005). *The Effectiveness of Public Health Interventions To Promote The Duration of Breastfeeding*. National Institute for Health and Clinical Excellence: London.

Renfrew, M.J.Dyson, L. Wallace, L.M. D'Douza, L. McCormick, F. Spiby, H. (2005). Breastfeeding For Longer What Works? *The Journal of The Royal Society for promotion of Health*; **90** (12), 1211-1215.

Renfrew, M.J. Spiby, H. D'Souza, L. Wallace, L.M. Dyson, L. McCormick, F. (2007). Rethinking research in breast-feeding: a critique of the evidence base identified in a systematic review of interventions to promote and support breast-feeding Public Health Nutrition **10** 726-732 Cambridge University Press.

Riordan, J and Aurbeck, K. (1999). *Breastfeeding and Human Lactation*, 2nd ed. Sudbury, M.A: Jones and Bartlett.

Roberts, K and Taylor, B. (1998). *Nursing Research Processes: An Australian Perspective*, South Melbourne: Nelson ITP.

Rodriguez-Frazier, R and Frazier, L. (1995). Cultural Paradoxes Relating to Sexuality and Breastfeeding. *Journal of Human Lactation,* **11** (2), 111-115.

Rogers, E. M. (1995). *Diffusion of Innovations.* 4th ed. New York: The Free Press.

Rosenblatt, K. A. Thomas, D. B. (1993). Lactation and the Risk of Epithelial Ovarian Cancer. *International Journal of Epidemiology,* **22**, 192-197.

Rothstein, B and Uslaner, E. (2005). All for Equality, Corruption and Social Trust. *World Politics,* **58**, 41-72.

Ruddick, S. (1989). *Maternal Thinking:Towards a Politics of Peace*. Boston. MA: Beacon.

Ryan, K and Grace, V. (2001). Medicalisation and Women's Knowledge: The Construction of Understandings of Infant Feeding Experiences In Post WWII New Zealand. *Health Care for Women International,* **22**, 483-500.

Saarinen, U. M and Kajosaari, M. (1995). Breastfeeding as Prophylaxis against Atopic Disease: Prospective Follow up Study until 17 years old. *Lancet,* **346**, 1065-1069.

Sachs, M. (2005). "Following the line". An Ethnographic Study of The Influence of Routine Baby Weighing on Breastfeeding Women In The North West of England". University of Central Lancashire.

Sachs, M. Dykes, F. Carter, B. (2006). Feeding by Numbers: An Ethnographic Study of How Breastfeeding Women Understand Their Babies' Weight Charts. *International Breastfeeding Journal*, 1, 29,1-11.Last accessed 28th January 2010. http://www.internationalbreastfeedingjournal.com/content/1/1/29.

Schafer, E. Vogel, MK. Viegas, S. et al. (1998). Volunteer Peer Counsellors Increase Breastfeeding Duration Among Rural Low-Income Women. *Birth*, 25 (2), 101-106.

Schmied, V. (1999). Connection and Pleasure, Disruption and Distress: Women's Experience of Breastfeeding. *Journal of Human Lactation.* **15** (4), 325-334.

Scott, S and Scott, S. (2000). *Our Mothers Daughters*. In: T. Cosslett, C. Lury and Summerfield, P. *Feminisms and Autobiography Texts, Theories, Methods*. London: Routledge.

Sherridan, A. (2006) Extract from Research Field Notes. Hallam University Unpublished.

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Shih, F. (1998). "Triangulation In Nursing Research: Issues of Conceptual Clarity and Purpose." *Journal of Advanced Nursing 28 (3), 631-64.*

Shildrick, M. (1997). *Leaky Bodies and Boundaries: Feminism, Postmodernism and (Bio) ethics.* London: Routledge.

Silva, P and Buckfield, G. F. (1978). *Some Maternal and Child Developmental Characteristics Associated with Breast Feeding:* A Report from the Dunedin.

Sikorski, J. Renfrew, M.J. Pindoria, S. Wade, A. (2004). Support for Breastfeeding Mothers (Cochrane Review). In: The Cochrane Library, Issue **2**, 2004. Chichester, UK: John Wiley & Sons, Ltd.

Smale, M. (1996). Women's Breastfeeding: an Analysis of Women's Contacts with a National Breastfeeding Counsellor in England 1979-1989. PhD thesis. University of Bradford.

Smale, M. (2004). *Training Breastfeeding Peer Supporters: An Enabling Approach Informed Childbearing and Health.* WICH Research Group ISBN: 1-902411-37-4.

Smale, M. Renfrew, M. Marshall, J.L. Spiby, H. (2006). Turning Policy into Practice: More difficult than it seems. In: *The Case of Breastfeeding Education. Maternal and Child Nutrition 2,* Blackwell Publishing Ltd. 103-113. Last accessed 28.01.10 http://www3.interscience.wiley.com.lcproxy.shu.ac.uk/cgi-bin/fulltext/118592551/PDFSTART.

Smale. M. (2007). *The Pollution Of Practice By Tales From The Outside Evidence For The Denial Of Embodied Understandings Of Feeding Babies In The Initial and Ongoing Learning Of Health Professionals.* In: Exploring The Dirty Side of Women's Health (eds) Kirkham, M. London and New York. Routledge.

Smith –Davis, J. Making a difference: Can governments influence volunteering?*first issue of Voluntary Action Winter 1998 Vol 1 Number 1.*

Starhawk, M.S. (1990). *Truth or Dare: Encounters with Power, Authority, and Mystery*. San Francisco, CA: Harper Collins.

Street, A. F. (1992). I*nside Nursing: A Critical Ethnography of Clinical Nursing Practice*. Albany: State University of New York Press.

Stern, P. N. (1994). *Eroding Grounded Theory*. In J. Morse, (ed.) 1994. *Critical Issues in Qualitative Research Methods*. Thousand Oaks, CA: Sage Publishing. 212-223.

Stewart, D. W and Shamdasani, P.N. (1990). *Focus Groups: Theory and Practice.* London: Sage.

Strauss, A. (1987). *Qualitative Analysis for Social Scientists*. New York, Cambridge University Press.

Strauss, A and Corbin, J. (1990). *Basics of Qualitative Research: Grounded Theory Procedures and Techniques*. CA: Sage.

Swanson, V. Power, K. Binder, K. Carter, H and Shepherd, K. (2006). The Impact Of Knowledge And Social Influences On Adolescents' Breast-Feeding Beliefs and Intentions, *Public Health Nutrition*, 297-305, Last accessed 28.01.10 http://journals.cambridge.org.lcproxy.shu.ac.uk/action/displayFulltext?type=1&fi d=633056&jid=PHN&volumeId=9&issueId=03&aid=585800.

Tedstone, A. Dunce, N. Aviles, M. Shetty, P. Daniels, L. (1998). Effectiveness of Interventions To Promote Healthy Eating In Infants Under One Year Of Age: A review. Health Education Authority, London.

Trewick, A. (2003). Inside Out – Outside In. In: Families: Myths, Dreams and Realities:*The National Association of Childbirth Educators (NACE) Book of Abstracts* NACE Conference (Sydney, 2003).Unpublished.

Trewick, A and Smale, M. (2005). *Making Explicit Previous Cultural and Personal Learning About Infant Feeding During The Training Of Those Supporting Breastfeeding Mothers: 'Like Breaking Down A Jigsaw And Putting it Back Together Again.'* Sydney U.T.S. Research Tour.

Tronto, J.C. (1995). Care as a Basis for Radical Political Judgements. *Hypatia (Symposium on Care and Justice).* **10** (2), 141-149. Last accessed http://www.jstor.org.lcproxy.shu.ac.uk/pss/3810286.

Umaña-Taylor, A. J and Bámaca, M. Y. (2004). Conducting Focus Groups with Latino Families: Lessons from the Field. *Family Relations,* **53** (3), 261-272.

Uslaner, E. (2002). The Moral Foundations of Trust. Cambridge: Cambridge University Press.

Vygotsky, L. (1978). Interaction between Learning and Development. In: *Mind in Society.* Translated by M. Cole. Cambridge, MA: Harvard University Press 79-91.

Virtanen, S. M. Fasanen, L and Aro, A. (1991). Infant feeding in Finnish Children Less Than 7yr Of Age With Newly Diagnosed IDDM. *Diabetes Care,* **14,** 415-417.

Volunteer England. (2007). *Volunteers and the Law.* [online] Last accessed 1st January 2010 Available at: www.Volunteering.org.uk/publications.

Volunteer England. (2008). *The Helping Out Study 2006-07.* Volunteer England.

Von Kries, R. Koletzo, B. Sauerveld, T. Von Mutius, E. Barnert, D. Grunert, V. Von Voss, H. (1999). Breastfeeding and Obesity: Cross Sectional Study. *British Medical Journal* **319**:147-50.

Wilkinson, S. (1999). Focus Groups a Feminist Method. *Psychology of Women Quarterly* **23** (2), .221-244.

Wilkinson, R and Pickett, K. (2009). *The Spirit Level: Why More Equal Societies Almost Always Do Better.* Allen Lane.

Wilson, A.C. Forsyth, J.S. Greene, S.A. Irvine, L. Hau, C and Howie, P.W. (1998). Relation Of Infant Diet to Childhood Health: Seven Year Follow-up of Cohort of Children in Dundee Infant Feeding Study. BMJ, 316:21-5.

Willlams, H.A. (1995). There Are No Free Gifts! Social Support and the Need for Reciprocity. Vol **54**, Number 4 / Winter 1995   401 – 409.

World Health Organization, (1989). *Protecting, Promoting and Supporting Breastfeeding: The Special Role of the Maternity Services.* Geneva: WHO.

WHO, UNICEF. (2003).*Global Strategy for Infant Feeding and Young Child Feeding.* Geneva: WHO.

World Health Organization. (2008), *Ten facts on breastfeeding.* [online] Last accessed 1st January 2010 Available at: http://www.who.int/features/factfiles/breastfeeding/en/ Geneva: WHO.

Appendices

Appendix 1 Interview Schedule

Appendix 2 Spreadsheet and Legend

Appendix 3 Compact agreement

SAMPLE

A study exploring Breastfeeding Peer Counsellors' Reflections on their role in a Northern Town

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INTERVIEW SCHEDULE - Breastfeeding peer counsellors

- Go through Information sheet
- Negotiate written informed consent

1. General introductions and ask how are things going? Explain confidentiality

2. Ask about their experience of support?

3. How were you recruited to the project?

4. What information were you given about the programme?

5. What drove you to become a peer counsellor?

6. How do you feel about your training programme?

7. How were you supported during the programme?

8. How was your experience after your training?

9. Have you noticed a difference in your community?

10. Payments for peer supporters: thoughts on this?

11. What information would you give to other breastfeeding peer counsellors and any other thoughts?

Appendix 2 Legend and Spreadsheet

The spreadsheet enabled me to reflect on how I was listening to the peer counsellors and approached the data analysis through my own voice in different roles.

Peer Counsellors

Theresa
Ann
Sam
Sonia
Sophie
Eliza
Laura

Health Professionals

Catrina, Jackie and Andrea

Interviewer 1= Int 1
Interviewer 2 =Int 2

Roles

I have analysed the data through my own voices in different roles.

M- Mother
R- Researcher
GF-Group Facilitator
MW- Midwife
ME
MR – Marathon Runner
BFC- Breastfeeding Counsellor
DBFIFC- Doncaster Breastfriends Infant feeing Co-ordinator

Layers of Readings

Reading 1 - The Plot and my Responses -

Three readings of the first reading A1,A2,A3.

This enabled me to listen to the peer counsellors voices, my story is parallel with their story.

Reading 2 - Reading for the voice of the 'I' read once B1.

Reading 3 - Reading for Relationships read once C1.

Reading 4- Placing people within cultural contexts and social structures

This was threaded through out the data

Appendix 2

	Name	Transcript	Readi	The Plot & My Responses	Role
38	Int 1:	Right. You know, when you first ... going back, how did you get to find out about being a peer counsellor?		38-54 finding a breastfeeding mother	
39	Eliza:	MW named [xxxx].			
40	Int 1:	Did she			
41	Laura :	She just phoned me up out of the blue. I didn't even know her.			
42	Int 1:	What did she do? Did she just knock on your door?	C1	thinking about my NCT counselling skills and recognising closed questions.	MW
43	Laura:	No, she phoned ... she got my phone number off Sure Start computer system and phoned me up.			
44	Int 1:	right			
	Eliza:	My sister she did. She went on the street ... she was driving down the street trying to find someone who had breastfed. "That lady that lives there breastfed," so she went to my sister's and asked her if she's be interested.	C1	Parallels with my first project in Doncaster and how I had ran around to find mothers who had breastfed going on leads and I think how crazy it is	MW,CBC,M,Mother
45	Int 1:	yeah			
46	Eliza:	She said, "No, but my sister might," so I didn't even know MW x until I went to my sister's and she were there trying to sell it all to me.	C1	The pressure and linking it to sell rather than an opportunity	
47	Int 1:	yeah			
48					
49	Ann:	And I didn't know MW x either.			
50	Int 1:	yeah			
51	Ann.	I saw it in the Sure Start newsletter.			
52	Int 1:	yeah			
53	Ann:	but I'd already heard about it peer support before so when I saw that but I wana do that.			
54	Sam:	A friend of mine works for Sure Start and told me what MWx were doing and asked me if I'd be interested and I got in touch with MWx.	C1	various tactics to recruit volunteers to the programme, not all the group responded and as a GF questioned my skill in bringing all the group and the silent voices what they were thinking	R,GF
55				55 onwards what is a peer supporter	
56	Int 1:	How did it feel though when she were ringing? you were saying you knew about Peer support Ann.	C1	recognition of how I tend to think of peer support and the group are peer counsellors	R,M,Sub concious
57	Sonia:	Sonia speaks of her experience	A1	Expressed voluntary work key to the plot and it wasn't clear about their role.	R,CBC,GF

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	Name	Transcript	Readi	The Plot & My Responses	Role	
251	Int 1	So, it sounds like it has made a difference to you personally, don't it, as well? If you're going out into the community.			Me,R,GF,MW,CBC,	
252	Theresa	You've got to be strong to go out to start with, I think to get some hammer, yeah.	A1,C1	strength to carry on		
253		[xxxx] knock back [xxxx].				
254	Theresa	You've got to be pretty strong to take it and questions ...				
255	Sonia	[xxxx] they don't want your help or they're rude or whatever. You're not [xxxx].				
256	Theresa	They were very rude ... very rude.				
257	Theresa	I were gobsmacked, me. I just looked at her and I were like ...				
258	Int 1	Yeah, because it's interesting talking about that because I know they're looking at paying peer supporters as well.				
259	Theresa	Yeah, they should. (Raucous laughter) We should get some at God, we put some reight hours in, us.				
	Sam	But everyone's different because I've approached some people at a health ... a different antenatal class and when I've gone up they've been really ... they couldn't be more appreciative and they really want your help.		260-263 Emerging Findings of their perception of how the community is responding		
260	Theresa	Some are. Some are, aren't they?				
261	Theresa	They [just] wait for you to come over and see them. They don't want to come and talk to you, but they wait ... they're waiting for you to go and approach them and then they really want to listen and they're wanting to know everything that you've got to say.				
262	Sam	You're going to find different people [and meet] different views wherever you go. It's the same with everything, isn't it? Everyone's got different views. You've got to take the good with the bad, haven't you.	A1,C1	A balanced viewpoint and a voice that hasn't been heard a lot before	R,GF	
263		Well, that's it, yeah.				
264	Theresa	But I will be honest, there is more now that's more open about it, that will talk about it now, isn't it? Or they're like ... you see them up at the doctors and they are feeding and you think, "Oh great, yeah. Have I helped to do that or ..."	A1,C1	The community is starting to respond to them in a positive way	R,GF	
265	Int 1	Have you noticed a difference then while you've been ... since you've				

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	Name	Transcript	Readi	The Plot & My Responses	Role	
341	Int 1	I mean you've told me a few stories about people you know, like your wet nursing and things like that so ... and you've said about it coming from somewhere else like this move to bottle feeding. Do you ...? Who do you think ...?	C1	Feel that I moved this on too quickly as a GF and needed to let the group develop their ideas rather than try to reflect on this part	GF	
342	Eliza	[xxxx] coming from the health professionals with the sound of this, in	C1	Blame. Scapegoat. HP		
343	Sophie	I fully believe it came from the health professionals, so it's been like [xxxx].				
344	Ann	Well, mothers didn't invent formula, did they and come up with this thing. Somebody else gave them that option. And really they've had [xxxx ...]				
345						
346	Ann	Yeah, their right to breastfeed their kids taken away from em.	C1	Human rights taken away from them, I wept at this point in my data analysis because I had pictures in my mind of the stories women have told me in the past and present about how they have been treated by not only HP but by their communities. A formula rep came to me and wept in my office as she had been victimized for being in her role and it was the flip side to my role and how was often held to account in the most unsavoury ways for my role promoting breastfeeding. The women themselves in the data felt victims and in battles and the battle needs to end, it is human emotional catastrophy to carry on without addressing what is happening here.	R,GF,MW,CBC,MR,	Me,
347	Int 1	I mean that for you, it must be a difficult thing because you're in a position where you're a mother [whose doing this xxxx] so how does that feel if you've got that in your head as well [xxxx].				
348	Eliza	Frustrating.				
	Ann	I find it very difficult to think about because I think ... well, you know all ... you know, I do because I describe me sen as a bra burner on this [lots of laughingxxxx]. I just find it so annoying that ... you know, we can talk to women about informed choice and it's not an informed	C1	348 Informed choiceThis relates to the work Mavis and Penny Curtis did on informed choice and basically it is not an informed choice and it is the way we dress it up and women feeding their	Me,R,,MW,CBC	

Key / Reading 1 / Reading 2 / Reading 3 / Reading 4 / Summary Reading 1

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Sample of a Compact Agreement for peer supporters (Information and support provided by the Compact)

The Compact is an agreement between Government and the voluntary and community sector in England. It recognises shared values, principles and commitments and sets out guidelines for how both parties should work together.

Although the Compact is not legally binding and is built on trust and mutual goodwill, its authority is derived from its endorsement by government and by the voluntary and community sector itself through its consultation process.

National Council for Voluntary Organisations
http://www.thecompact.org.uk/homepage/100016/home/;commisson
for compacts accessed 2009

BACKGROUND

The breastfeeding compact was developed after breastfeeding peer supporters/counsellors found that the Organisations hosting peer supporters in antenatal clinics and baby clinics needed to set a standard that would respect the social benefits of mother to mother support and would provide a benchmark for all the organisations signing up to the compact to commit to being consistent with public law principles and exemplify the important values of mutual respect and understanding of the diversity of volunteer support; and ultimately the recognition of the valuable contribution peer supporter volunteers make to mothers and babies in our community.

CODE OF CONDUCT BETWEEN PRIMARY CARE TRUST AND PROVIDER ORGANISATIONS FOR BREASTFEEDING PEER SUPPORT

This Code of Conduct is an agreement between the Primary Care Trust (PCT) and organisations providing Breastfeeding Peer Support. Its aims are to enable Breastfeeding Peer Supporters to support women within Primary Care Trust premises, and to enable the PCT to refer women who are their patients to Breastfeeding Peer Support organisations.

DUTIES OF THE PROVIDER

1. Carry out a recruitment process which ensures as far as possible that the Breastfeeding Peer Supporters have the appropriate experience and capability for the role
2. Carry out either the La Leche League Peer Counsellor programme or the Mary Smale's enablement model as part of the training programme.
3. Have a confidentiality policy and include this policy in the training programme for Breastfeeding Peer Supporters.
4. Train the Breastfeeding Peer Supporters in appropriate record keeping
5. Ensure the provision of regular support and supervision including updates on best practice and other relevant issues for the Breast Feeding Peer Supporters and review of the Breastfeeding Peer Supporters' experiences
6. Provide an induction process which has been approved by the PCT – including an induction check-list for the inductor
7. Ensure that the Breastfeeding Peer Supporters are covered by the Public Liability and Employers Liability Insurance of the provider organisation
8. Ensure that when Breastfeeding Peer Supporters use their own cars on Peer Support work their insurance covers them for voluntary work
9. Have in place a standard policy for payment of Breastfeeding Peer Supporters expenses agreed by all provider organisations
10. Have in operation a Volunteer Policy, a Volunteer agreement signed by each Breastfeeding Peer Supporter which covers the role and issues such as confidentiality, and a Volunteer handbook given to each Breastfeeding Peer Supporter before starting their work that are acceptable to the PCT
11. Have in place an Equal Opportunities Policy, and a Health and Safety Policy (and a Lone Worker Policy if this is not covered within the Health and Safety Policy) that are acceptable to the PCT
12. Ensure up to date enhanced CRB checks have been undertaken for all Breastfeeding Peer Supporters.
13. Have in place a procedure enabling Breastfeeding Peer Supporters to raise concerns about the welfare of the mothers and babies, child protection issues, or about their own roles
14. Update the PCT Peer Support database
15. Ensure that any premises outside the PCT which are being used for Peer Support work comply with all relevant health and safety and fire regulations, and are accessible and appropriate for Breastfeeding Peer Support work