Title

Women's perceptions and experiences of breastfeeding support: A metasynthesis.

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Background: Both peer and professional support have been identified as important to the success of breastfeeding. The aim of this metasynthesis was to examine women's perceptions and experiences of breastfeeding support, either professional or peer, in order to illuminate the components of support that they deem 'supportive'.

Methods: The metasynthesis included studies of both formal or 'created' peer and professional support for breastfeeding women but excluded studies of family or informal support. Qualitative studies were included as well as large scale surveys if they reported the analysis of qualitative data gathered through open ended responses. Primiparous and multiparous women who initiated breastfeeding were included. Only studies published in English, in peer reviewed journals and undertaken between 1990 and December 2007 were included. After assessment for relevance and quality, 31 studies were included in the metasynthesis. Meta-ethnographic methods were used to identify categories and themes.

Results: The metasynthesis resulted in four categories comprising a total of 20 themes. The synthesis indicates that support for breastfeeding occurs along a continuum from **authentic presence** at one end, perceived as effective support, to **disconnected encounters** at the other, perceived as ineffective or even discouraging and counterproductive**.** Second, the synthesis identified a **facilitative approach**, versus a **reductionist approach** as contrasting styles of support women experienced as helpful or unhelpful.

Conclusions: The findings of this metasynthesis emphasise the importance of person-centred communication skills and of relationships in supporting a woman to breastfeed.
Organisational systems and services that facilitate continuity of care/r, for example continuity of midwifery care or peer support models, are more likely to facilitate an authentic presence.

Keywords 4 to 5 key words

Metasynthesis, breastfeeding, support, peer support, professional support

Background

Breastfeeding is universally acknowledged as providing health benefits to both mothers and infants, reducing infant mortality and morbidity, particularly in developing countries, but also in more affluent societies (1). The World Health Organisation (WHO), together with the United Nations International Children's Fund (UNICEF), have implemented a number of initiatives to protect and promote breastfeeding globally (2). Despite these global policies, breastfeeding rates especially exclusive breastfeeding, remain lower than recommended, and are highly variable across different settings (3).

Infant feeding support can come from various sources including professional, peer support (paid or volunteer) and informal social networks. Both peer and professional support have been identified as important to the success of breastfeeding (4). At the same time there is research suggesting that poor support may contribute to early cessation of breastfeeding (5-7). A number of studies have identified women expect they will seek and/or receive professional support for breastfeeding in the early postpartum period (7, 8) viewing this period as a time of learning (9, 10). Consistent with this, health professionals, particularly midwives, also view breastfeeding 'education' as a significant component of their role (11).

Despite the apparent shared understanding between midwives (and lactation consultants) and mothers about the need for support, midwives, lactation consultants and other health professionals are often unable to provide the support women need (5, 12-14). Women describe breastfeeding support from professionals variously in terms of positive or negative support (5-7, 15). Peer supporters have been identified as positive role models for women with regard to breastfeeding (16, 17). Two systematic reviews of support for breastfeeding indicate all forms of extra support demonstrate an increase in initiation (18) and duration of

any (partial and exclusive) breastfeeding (4). Lay and professional support together extended duration of any breastfeeding significantly before 2 months (4). The Cochrane review further identified that 'the relative effectiveness of the intervention components' and women's views should be considered in further trials, suggesting these are two areas that are under explored (4)

For this study we used the term Professional Suppor*t* as defined by the Cochrane Review of Breastfeeding Support, as that "provided by a variety of medical, nursing and allied professionals (for example nutritionists)"(4). Peer Support was defined in the Cochrane review as either voluntary or remunerated. For the purposes of this study however, we chose Dennis's (19) more descriptive definition of peer support: 'The provision of emotional, appraisal, and informational assistance by a created social network member who possesses experiential knowledge of a specific behaviour or stressor or similar characteristics as the target population'. (p. 329). The term 'created social network' indicates that peer supporters are not part of the woman's own informal social network, but are linked with her for the specific purpose of providing support. In the studies reviewed, this is by means of a peer support project or scheme, whether the supporter is paid or not.

Review Aims

The aim of this metasynthesis was to examine women's perceptions and experiences of breastfeeding support (as defined above) in order to illuminate the components they deem 'supportive'. A secondary aim was to describe any differences between components of Peer and Professional support.

METHOD

A metasynthesis is a rigorous and analytical process of synthesising the findings of qualitative research on a particular phenomenon (20). This metasynthesis included studies of both formal or 'created' peer and professional support for both primiparous and multiparous breastfeeding women. It excluded studies of family or other informal forms of support for breastfeeding. Studies selected for review were qualitative, or qualitative components of larger studies. Large scale surveys were also included if they reported in sufficient detail the analysis of qualitative data gathered through open ended responses or included a smaller number of in depth interviews.

Studies were limited to those published or available in English, in peer reviewed journals, and undertaken between 1990 and December 2007. The year 1990 was chosen as a cut off date because 1990 was the year the Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding was first produced and adopted (21). Following on from the Innocenti declaration in 1990 the Baby Friendly Hospital Initiative (BFHI) was launched in 1991. The BFHI is the most significant internationally structured program to be developed and implemented jointly by WHO and UNICEF as part of the global commitment to protecting and promoting breastfeeding and is based on the Ten Steps to Successful breastfeeding (2).

The literature search for this review was conducted in October to December 2007 using the following data bases: Medline, Cinahl, The Cochrane Library, PubMed, Meditext, Nursing Consult, Midirs, PsychINFO, Current Contents, WHO Library database, Scopus, Science Citation Index, Embase, BMC. Search terms used were: breastfeeding, qualitative research, breast feeding support, peer support, professional support, postnatal support, post-natal

support, volunteer support, lay support, social support, breastfeeding counsellors, lactation consultants, health education, breastfeeding education and lactation. Figure 1 outlines the review process; 254 studies were initially identified and following review of abstracts for relevance, 46 remained. These papers were read in full and a further eight were excluded because they were not original research, or focused on health professionals' experience.

Thirty-eight articles were assessed using the Joanna Briggs Institute for Evidence Based Nursing Qualitative Assessment and Review Instrument (JBI-QARI) (22). Seven studies were excluded because they included very little qualitative data directly relevant to the review focus. The studies reviewed were of reasonable quality in terms of clarity, appropriate methodology, credibility and evidence cited to support the conclusions. Most however, included relatively limited discussion of theoretical or conceptual perspectives, discussion of relevant literature and reflection on the roles of the researchers.

A total of 31 articles were included in the metasynthesis, outlined in Table 1. The number of women who participated in the included studies ranged from 8 to 654 women. Three studies using structured surveys with open ended responses had sample sizes of over 150 women but not all participants provided open ended responses. Two studies did not report the number of participants. Of the remaining 26 studies using only qualitative methods, the median number of women participants was 21, with a range of 8 to 130.

The meta-ethnographic methods of Noblit & Hare (23), particularly reciprocal translation, were used to identify "key metaphors, phrases, ideas, and/or concepts" which are similar across the studies (23) and to then derive concepts that encompass at least two but typically

more of the studies being synthesised (24). Further details of the methods of review and synthesis can be obtained from the authors.

Results

The categories and themes that have emerged from the synthesis of studies are summarised in Figure 2. Examples of quotes drawn form the original studies to illustrate each theme are presented in Table 2. The categories and themes identified and discussed in the review were found consistently in most of the articles.

The synthesis suggested that support for breastfeeding occurs along a continuum from **authentic presence** at one end, perceived as effective support, to **disconnected encounters** at the other, perceived as ineffective or even discouraging and counterproductive**.** Second, the synthesis identified a **facilitative approach**, versus a **reductionist approach** as contrasting styles of support women experienced as helpful or unhelpful.

Authentic Presence

The category '**an authentic presence**' describes care provided by professionals or peers which women found 'supportive'. An authentic presence was comprised of seven themes (outlined in Figure 2). Authentic presence reflects a trusting relationship or connectedness and rapport between the woman and her carer/supporter. Providing an authentic presence helps ensure that support given is appropriate to the woman's needs, and enhances its perceived effectiveness.

'Being there for me**'** is an important component of an authentic presence, conveying to the woman that the health professional or supporter is available for her when needed either in the

hospital setting or at home. Studies that report 'being there for me' note that this can occur even when the midwives and postnatal wards are busy. Not surprisingly, an ***'e***mpathetic approach***'*** was also integral to an authentic presence. Showing empathy is important to whether women feel any help offered is supportive, rather than undermining. An empathetic approach is enhanced when the health professional or supporter listens and has a warm and positive approach.

'Taking time, Touching base' was about giving sufficient time to the women. This was important to women, not only to feel relaxed and comfortable and to avoid feeling pressurised by rushed professionals, but also for practical reasons. Taking time to sit and observe a feed, offering practical help (see facilitative style below) and tips and getting to know the woman and her needs was supportive. Even brief encounters described by Dykes (13) as 'touching base' were valued by women. An advantage of peer supporters from the women's accounts was that they were able to spend sufficient time with the woman to make a difference, to provide feedback and tips or information which was centred on the woman's and her baby's personal needs. 'Taking time' also made it easier to ask questions of the supporter or professional (13).

'Providing affirmation'***:*** Many women, across the studies, lacked confidence and found the uncertainty and transition of early parenthood very challenging, so affirmation, reassurance and encouragement were very important. Affirmation wasn't just about affirming that what the women were doing was okay it was also about acknowledging what the woman was experiencing. Listening and responding to women was highly valued. ***'***Being responsive***'*** is very different from offering support that 'presumes and tells'. In keeping with an authentic

presence and a facilitative style (see below), being responsive means that professionals or supporters offer the type of support or help that suits the woman's needs, and in a timely way.

'Sharing the experience'***:*** Authentic presence also means the carer / supporter is prepared to share the experience with the new mother and demonstrates an interest in the woman's perspective. Women found it particularly valuable when peer supporters were able to share their personal experiences although it was identified in one study this needs care and sensitivity, as experiences are individual.

'Having a relationship***':*** Authentic presence was more likely to be achieved where the woman had the opportunity to build or to have a relationship with the carer / supporter, someone she could relate to and share the experience with: **'..***It was like I knew her before*' *(25 p. 257).* Authentic presence is associated with the second category of having a *facilitative style* which enables learning and results in 'feeling confident' and able to make one's own decisions.

<u>Facilitative style</u>

Adopting a **facilitative style** is an approach to health promotion, or helping, that is about enabling people to draw on a range of information and experience and learn for themselves. This emerged consistently across the studies as a positive form of support and was strongly associated with an *authentic presence.* The style and manner in which information, help and support were offered, was central to women's perceptions of support. **A facilitative style** is similar to what is often described in partnership models (26) and as adult-learning or learner-centred approach to learning, and to the concept of critical pedagogy described by Freire (27). Five themes comprised the category (see Figure 2).

'Realistic information'**:** Women wanted to hear more about the personal and practical aspects of breastfeeding in a positive but realistic way, including challenges and difficulties they might encounter, as well as the positive benefits. When information was not realistic, however positively intended, this was not supportive particularly when women encountered difficulties: '*You are told over and over that there is only pain if the baby is not attached properly. Well I am sorry, but I beg to differ*' *(28 p. 8).* Women also want 'accurate and sufficiently detailed information**'** and in a number of studies women commented that positive detailed information about breastfeeding and practical tips on how to manage was really appreciated and encouraging*: '(She) made sure that I knew what I needed to know' (29 p. 5).*

Participants in studies appeared aware that '*breast is best*' and knew about benefits, but not necessarily all, and many wanted more detailed information to gain a really good understanding of the range of benefits, and also the mechanisms of breastfeeding, what can help and why. Standardised packages of information, as illustrated in Table 2 did not provide this, according to the women. Although aware that giving 'full details' may deter women from breastfeeding, women wanted to be the one in control of that decision.

Adopting a facilitative approach involved providing **'**encouragement for breastfeeding' but in a sensitive and effective way, rather than creating pressure. Adolescent mothers in general felt that professionals did not really encourage or expect them to breastfeed, and some wanted active and supportive encouragement.

> *If they had encouraged me a bit more when I was thinking about putting him on the bottle ... like said why don't you give it another day I would have carried on ... but they were just well ... it's up to you (30 p. 396).*

A key feature of a facilitative teaching or support style is that information is not all one-way but is discursive and interactive, enabling the ’learner’ to raise topics, ask questions and discuss issues or concerns. It involves ‘creating a dialogue*’* between the ‘learner’ and the ‘teacher’ or facilitator. Women wanted to be able to give their own views, and in group learning situations such as antenatal education, women liked to discuss and share them with others.

*‘*Practical help’ is valued and is captured in the comment ‘*show me, don’t tell me’ (31 p. 405).* It involves instrumental (practical) and informational support, which is broader than a narrow concept of feeding support, because it is responsive to the woman’s needs. This includes observing feeding, demonstrating techniques and approaches that may help, offering practical help (and tips) that facilitate or enable learning of what is an embodied experience and skill. Women also appreciate professionals who are proactive. ‘Being proactive’ involves anticipating what the woman may need to know and what type of support or help will suit her and giving it in a timely way.

> *She really watched the baby and was real intuitive about what was going on. She watched how she fed, and tried to feed, and she could see what was going on, where the others just brought the baby in to me and said, ‘Here, it's not working. We'll come back and try again later’ (32 p. 42).*

Offering ‘practical help’ using a **facilitative style** was very different from imposing, or creating pressure, as discussed below (see disconnected encounters). It is not about making assumptions about the woman’s needs and simply acting on these without finding out about what will work for her.

Reductionist approach

Contrary to a facilitative style is a **reductionist approach** or style. Reductionism can be described as the analysis of something into simpler parts or organized systems, especially with a view to explaining or understanding it: the oversimplifying of something complex, or the misguided belief that everything can be explained in simple terms (33). A **reductionist approach** means that information and advice is given in a dogmatic and or didactic style. This may be related to a personal style and lack of effective training in how to provide 'education' or support, but more likely can be attributed to an environment that does not facilitate opportunities for professionals and supporters to work in facilitative ways. Consequently, a reductionist style tended to be found alongside 'disconnected encounters' see below. Figure 2 lists the themes synthesised into this category.

In a **reductionist approach, *i***nformation and advice provided by different professionals is more likely to appear conflicting and can cause confusion, distress, and undermine confidence. In most studies, participants described 'conflicting information and advice' given in busy clinical situations where care was fragmented with little opportunity for forming relationships. Women described the confusing or stressful nature of 'conflicting information and advice' given on issues such as positioning and latching, supplementation, length and timing of feedings, and milk supply.

Many women also described being given 'standardised information' that was not appropriate to their situation (such as telling them what they already knew or missing information that they did not know and needed). In addition, this was connected to the way in which information was packaged and offered: '*they tell you in health talk*', '*they use medical jargon*', and '*Her explanations were real technical. I guess I felt a bit rushed' (34 p. 123).*

Standard advice and information is often combined with a 'didactic approach'. The reductionist style of interacting with women, means the midwife/nurse is not listening and asking but presuming and telling: '*No-one asked me what I wanted' (35).* Consequences of a 'didactic approach' appeared to be that many women were not getting the information in an effective way and were often confused or felt undermined rather than supported by it.

Disconnected Encounters

At the other end of the continuum to authentic presence are **disconnected encounters** characterised by limited or no relationship and a lack of rapport (see Figure 2). This category was also associated with a **reductionist approach**, and seemed to inhibit learning, leading to women lacking confidence and being less likely to sustain breastfeeding. As a result some women then feel guilty and disempowered. In disconnected encounters there is no sense of having or building relationships**:** *'they just do what they need to do and go. There's no relationship or anything*' *(15 p. 41).*

'Undermining and blaming' was identified in a number of studies. Women believed that health professionals could undermine their efforts to breastfeed. For some, this was perceived to be the result of well intentioned interventions by professionals that did not address the woman's needs, and the help offered was inappropriate.

Certain behaviours or styles of interaction could also have a more detrimental effect, when comments or giving advice undermined the woman's confidence, rather than encouraging her. In such instances, this could extend to the woman feeling a sense of guilt and blame**.** While a health professional may not intend to provoke guilt, a critical manner or use of words

can be perceived this way, especially when women are feeling vulnerable, uncertain and physically and emotionally tired. Some of the studies identified women's experience of 'feeling pressured' about feeding. This pressure was experienced both by women who were breastfeeding as well as those who were formula feeding.

In many of the studies, it was common for women to report that staff were simply too busy with other women and tasks to be able to spend the time women needed. Typically, this was not perceived as being a fault of health professionals but more a limitation of their work environment. Dykes labelled this 'communicating temporal pressure' (13). However, women talked less about feeling rushed when they received care from peer supporters or home based postnatal care. When women are aware of the pressures on midwives, they tended to struggle on quietly, recognising that asking for support or information was to request scarce midwifery time; less assertive women tended to be those from lower socio-economic occupational groups (14).

'They don't give you time' Along with conveying temporal pressure, the theme 'they don't give you time' describes how when health professionals did not give attention to individual women, and they did not receive help this was often perceived as rushed and the nature of interactions were often experienced as unhelpful:

> *From day one, I thought I would breast-feed, but when I went into the hospital, and I wasn't getting much help, I just thought stuff it....I didn't even know how to start myself, and the nurse showed me once, but after that I still couldn't do it....and I started getting myself depressed and anxious, and I thought' No. I won't be able to cope (35)* .

While women strongly valued a ‘hands-on’ proactive approach, attempts by professionals to help in a hands-on, practical way were often experienced as intrusive and rough. This ‘Insensitive and invasive touch’ meant some women felt as though they were being treated in a disembodied way – as though the breast was just a feeding implement ‘In contrast, practical help – such as with latching on the baby – was appreciated if done sensitively and within the context of a relationship with rapport and empathy.

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Discussion

The aim of this metasynthesis was to examine women’s perceptions and experiences of breastfeeding support, whether peer or professional, in order to illuminate the components of support that they deem ‘supportive’. We argue that support that is perceived positively by women will contribute to wider public health goals (36). Although we included all relevant articles published in English, only one of the articles retrieved was based in a resource-poor country. The study by Omer-Salim et al (37), based on Tanzanian women, identified themes that were consistent with those of other studies, despite the difference in healthcare and social context. The majority of articles came from the United Kingdom or the United States, and so it cannot be assumed that the findings of this synthesis will apply to other countries where the cultural and healthcare context differs.

Findings of this metasynthesis particularly the explication of the components of support are complemented by and build on the work of McInnes and Chambers (38) to explain what it means from a woman’s perspective to be encouraging or reassuring. Both meta-syntheses indicate health service support is currently inadequate often due to time pressures and inadequate staffing however, it is also clear that many health professional practices are unhelpful.

The variation in the nature of the support received suggests that the wider culture, conditions of the profession and organisation and culture of care may all affect the support provided. Authentic presence is facilitated by having a trusting relationship. Organisational systems and services that offer models of continuity of care(er), for example continuity of midwifery care or peer support models are more likely to facilitate authentic presence because these models foster relationship building. Peer supporters were more likely than professionals to be described as 'being there' for women, having a relationship, sharing the experience.

The category, '**disconnected encounters**' and the lack of rapport which characterised it, appeared to be influenced by organisational structure as it was described by women receiving care in busy fragmented services where professionals lacked opportunity and motivation to establish a relationship. Added to the challenge for health professionals, however, is staff shortage, duplication or multiplication of tasks, which mitigate against giving time and being with women, and professionals may learn to cope by *conveying temporal pressure* to women (13. 14). This was not automatic as in such contexts individual staff did sometimes succeed in conveying an authentic presence, even with more limited time or lack of continuity, because the professional was able to demonstrate 'empathy', 'encouragement' and 'affirmation'.

The nature of the support offered, whether connected or disconnected, facilitative or reductionist, appeared to influence women's personal confidence in breastfeeding. For women who were feeling less confident or more vulnerable, conflicting and contradictory advice tended to compound difficulty with a further loss of confidence. Women reported feeling confused but also feeling pressured, feeling undermined, blamed and guilty as a result. These feelings resonated with those of Larsen et a (39) in a metasynthesis that focused

specifically upon breastfeeding mothers' confidence and the ways in which a lack of confidence resulted in early cessation of breastfeeding.

The potential for peer supporters to act as role-models was also important particularly, but not exclusively, for adolescent mothers and socially disadvantaged women. The ability of peer supporters to share the experience related both to being able to give time and practical support and being perceived as having more shared experience (16, 17, 40). Support, which can offer time, continuity and the encouragement of a 'peer' may be helpful for many women (15, 17, 40) and not just for women who are identified as demographically less likely to breastfeed.

The findings of our metasynthesis resonate with those of Fenwick et al. (41), who conducted ethnographic research on facilitative and inhibitive nursing actions in an Australian neonatal unit. They found that verbal exchanges between a nurse and mother influenced a woman's confidence, sense of control and her feelings of connection with her infant. They identified two types of nursing behaviour with the first described as 'facilitative nursing action', which women felt helped them to feel connected with their babies. The second type of behaviour described as 'inhibitive nursing action' reflected a more authoritarian style of approach (41). This research showed that while the development of a trusting relationship is highly desirable a single encounter in itself can be positive or highly negative to the way a woman feels supported/cared for.

This metasynthesis shows that it is important for supporters to achieve a balance in their approaches: positive but realistic, not over idealistic; encouraging, proactive and focused on the benefits, but not creating pressure on women to breastfeed and making them feel

inadequate or that they are failing if they don't. If women felt they were listened to with empathy and given detailed, realistic information that was centred on their needs, given encouragement and affirmation, they felt supported. The converse of this, which many women experienced, left them feeling lacking in confidence, guilty and incapable of breastfeeding. Women seemed to experience not only conflicting advice but conflicting deep seated messages about breastfeeding. At times, professional supporters in the women's accounts seemed overly zealous, while they often also seemed to lack fundamental confidence in breastfeeding, thus leaving women feeling confused and undermined, rather than helped or empowered to breastfeed. While it is not possible from this review to specifically link perception of support with success in initiation and/or maintenance of breastfeeding, it appears that effective support from a woman's perspective will lead to increased confidence and other research have demonstrated that confidence and self-efficacy is linked to an increase in breastfeeding (7, 42, 43). A key methodological problem with some research on effectiveness of support interventions (generally) is that many studies do not assess properly whether intended support is perceived as supportive by recipients themselves. There is some evidence from the general literature on social support that support that is not perceived as such is less likely to be effective or may even be counter-productive (36; 44).

This study has important implications for practice. The findings suggest that the current 'institutionalisation' of postnatal care limits opportunities for midwives and lactation consultants to offer an authentic presence and a facilitative style. However, as stated, there are some ways that these qualities may be maximised even within institutionalised settings. Secondly, the findings add support for the calls for implementation of breastfeeding peer support for women, not only those from lower socio-economic backgrounds but encompassing the whole spectrum of socio-economic occupational groupings.

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Figure 1. Breastfeeding support papers selected

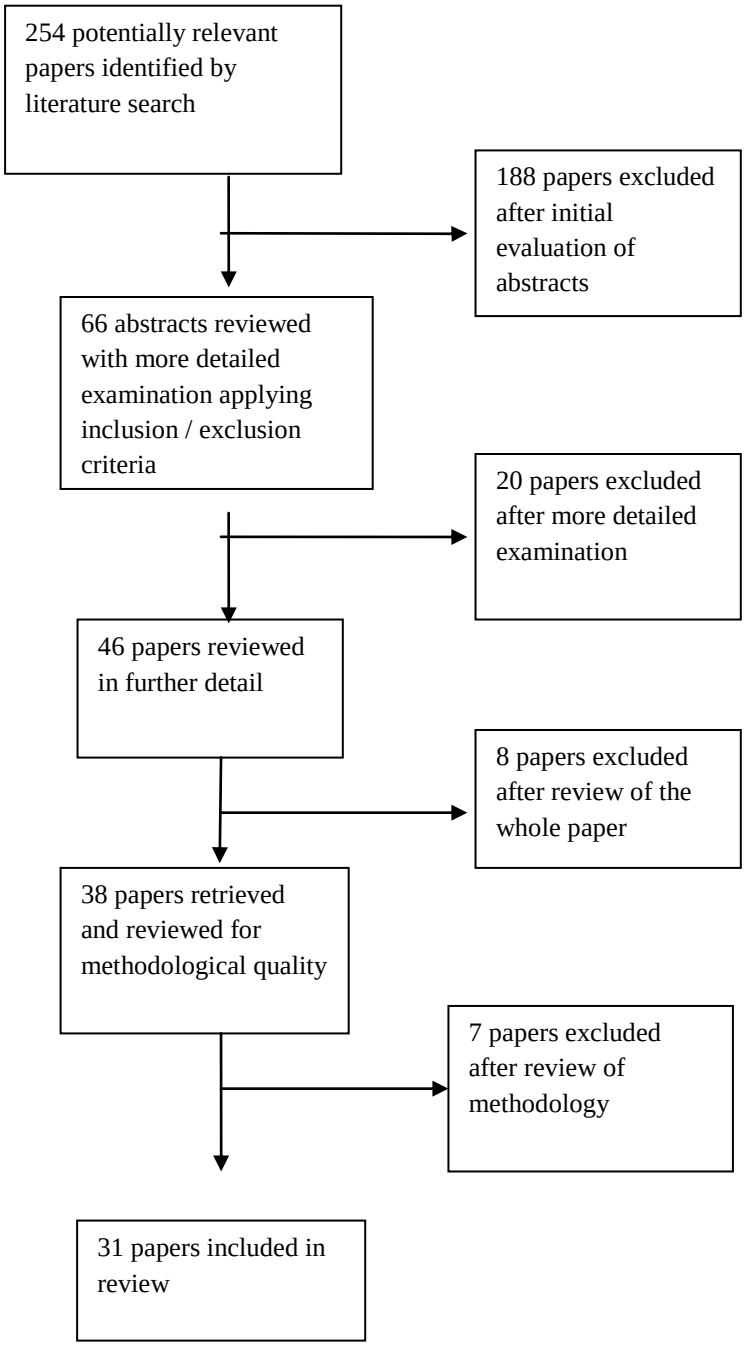

Figure 2: Summary of analysis and synthesis.

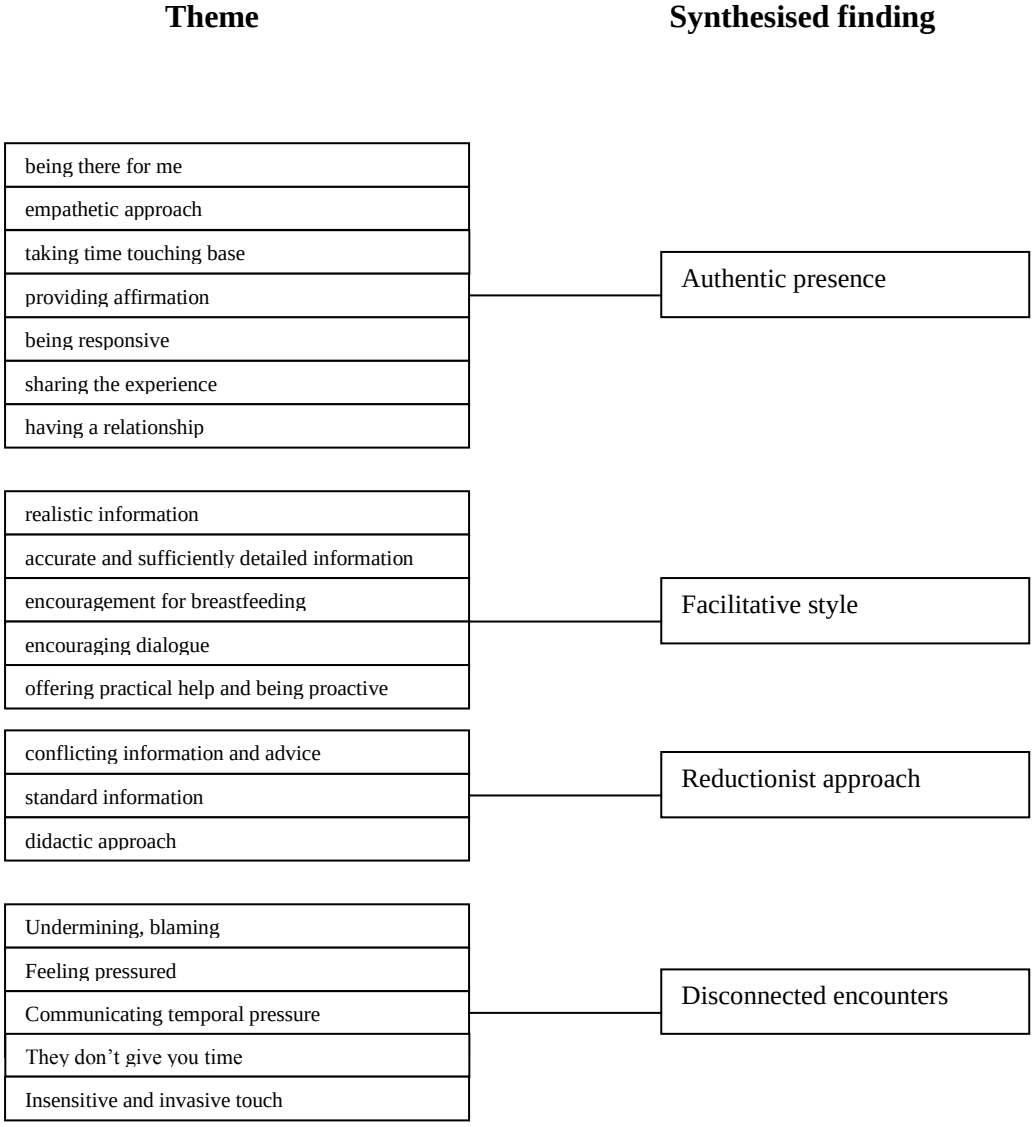

Table 1: Included studies

Study	Methods	Participants
Bailey et al. 2004(45) (United Kingdom)	Semi-structured interviews 1: late pregnancy 2: 3 to 9 weeks after birth	16 Primiparas in low income areas
Baker et al. 2005(46) (United Kingdom)	In-depth interviews	24 mothers
Beake et al. 2005(15) (United Kingdom)	Interviews with women and professionals; Midwife focus group; Pre and post impleme(35)ntation questionnaires; Care logs and feeding rates	9 postpartum women; 5 professionals; focus group (14); 33 pre and 11 post implementation questionnaires
Bowes & Domokos 1998(35) United Kingdom	In-depth interviews	62 Pakistani women, 68 white women, 50 health visitors, 25 general practitioners
Coreil et al. 1995 (12) (United States)	Focus groups with women; Focus groups and interviews with professionals	Not specified
Cricco-Lizza 2005 (47) (United States)	Participant observation; in-depth interviews	130 black and Hispanic women, 116 children, 20 grandparents, 17 fathers, 11 friends, 25 other relatives.
Dillaway & Douma 2004 (48) (United States)	Focus groups	16 mothers; healthcare professionals
Dykes 2005a (13) United Kingdom	Participant observation; In-depth interviews	61 women; 39 midwives
Dykes et al. 2003 (30) (United Kingdom)	Focus groups; Interviews	20 teenage mothers
Gill 2001 (31) (United States)	Interviews; Observations	8 breastfeeding mothers; 7 nurses
Graffy & Taylor 2005 (49) (United Kingdom)	Open questionnaire	654 women who began breastfeeding
Hailes & Wellard 2000 (9) (Australia)	Focus group interviews	Women 1 month postpartum
Hall & Hauck 2007 (28) (Australia)	Open ended question on a questionnaire	203 women at 2 days postpartum; 252 women 2 weeks postpartum
Hauck et al 2002 (50) (Australia)	In depth interviews	10 women
Hoddinott & Pill 2000 (5) (United Kingdom)	Semi-structured interviews	21 primiparas
Hong et al. 2003 (29)	Interviews	20 married primiparas within the 1st postpartum

(United States)		month; 15 Caucasian, 4 Hispanic and 1 Pacific Islander
Ingram et al. 2005 (51) (United Kingdom)	Focus groups with peer supporters; Questionnaires with women; Breastfeeding rates	22 mothers who attended the group; 6 peer supporters
Kelleher 2006 (52) (Canada & USA)	Semi-structured, in-depth interviews, 1 month postpartum	52 women –diverse socio-economic and ethnic backgrounds
Manhire et al. 2007 (53) (New Zealand)	Semi-structured survey including some open ended questions	153 breastfeeding women between 4 months and 3 years postnatally
Marshall et al. 2007 (54) (United Kingdom)	Observation of interactions with professionals around feeding; In-depth interviews with mothers	158 interactions between women & midwives or health visitors; 22 women interviewed
McFadden & Toole 2006 (55) (United Kingdom)	Focus groups with women	7 focus groups, 35 women living in the sure start area.
Meier et al. 2007 (56) (United States)	Focus groups with women and peer counsellors	3 women's groups of between 5-9 women (n=20), low income women diverse in ethnicity and age
Memmott & Bonuck 2006 (57) (United States)	Qualitative telephone interviews	21 low-income women (sub-sample of trial of 382 participants)
Moore & Coty 2006 (32) (United States)	Focus groups with women	8 primigravida women in antenatal and postnatal focus groups, plus 1 woman interviewed alone.
Mozingo et al. 2000 (34) (United States)	Interviews	9 women, including 7 primiparas. Initiated breastfeeding but stopped within 2 weeks
Omer-Salim et al. 2007 (37) (Tanzania)	Interviews	8 mothers, 0-6 months postpartum, mixed in ethnicity, educational level and employment
Raine P & Woodward,P. 2003 (58) (United Kingdom)	Observation of peer support groups; Interviews with women; peer supporter diaries; feeding rates	6 breastfeeding mothers
Raisler J. 2000 (25) (United States)	Focus groups with women	7 focus groups 42 women, diverse in age, ethnicity, location parity and feeding method
Scott et al. 2003 (59) (United Kingdom)	Focus groups with women	19 mothers in 4 focus groups
Shakespeare et al. 2004 (8) (United Kingdom)	In-depth interviews	39 postnatal women
Spear 2006 (60) (United States)	Telephone survey	53 young mothers (13-19 years) with uncomplicated birth and breastfeeding on hospital discharge

Table 2: Examples of quotes from articles (Note 'sect' refers to a citation from a web based article)

Categories and Themes	
Authentic Presence	**Example of Quotes**
Being there for me	• I know she's there for me whenever I want her... I don't know her (peer supporter) but I seem to feel I can rely on her all the time (58 p. 213)
Empathetic approach	• Well, I think the, just the... they were so warm… you just felt total trust in the fact they knew what they were talking about, and they knew what I was going through (8 p. 256).
Taking time, Touching base	• It seemed important to her...she took time to talk to me, asked me questions, and gave me suggestions (29 p. 5).
Providing affirmation	• She would just say: You're doing fine, you're doing fine" when I was thinking that I was doing something wrong (25 p. 258)
Being responsive	• I got help when I needed it, and not just about breastfeeding (51 p.115).
Sharing the experience	• even just sitting there, having a cup of tea while I was trying to feed, was the most help I could want. So I wasn't on my own (8 p. 256). • You think nobody understands. It's so nice to have somebody to talk to, because it does encourage you, because they have done it and they will come out and help you (59 p. 274)
Having a relationship	• but her coming round is also relationship-based, She's not coming round just to do her duty, she comes to build a relationship and that actually makes you feel comfortable around her, to actually talk to her and open up to her (15 p. 41)
Facilitative style	**Example of Quotes**
Realistic information	• A balanced discussion of the advantages and disadvantages of different feeding options would be most useful…A presentation of both sides- breast versus bottle.(12 p. 257). • '..focusing to a greater extent on how to overcome common difficulties, albeit in an 'it does get better' framework (45 p. 244)
Accurate and sufficiently detailed information	• answer(ing) all my questions for me' (25 p. 257). • It would have been more helpful if I had information of possible baby behaviours and many different stories on breastfeeding patterns so I would not have been so uncertain for the first days (28 p. 792)

Encouragement for breastfeeding	• I am surprised to find that I hardly know any people who breastfed their babies, so it was difficult to have a role model. I feel that more should be done to encourage mothers to breastfeed at parentcraft classes (49 p. 182)
Encouraging dialogue	• They give you a whole bunch of papers then they say "here read this." That's your education. I think it would be best if they went over it with you. Just not like you're illiterate, but go over it with you instead of just expecting you to go home and read it. (12 p. 267). • They give you a whole bunch of papers then they say "here read this." That's your education. I think it would be best if they went over it with you. Just not like you're illiterate, but go over it with you instead of just expecting you to go home and read it. (12 p. 267).
Offering practical help and being proactive	• It was the first time. We just couldn't seem to get it right. I felt like all thumbs. Then a nurse came in and told me to put his stomach next to mine. She moved him around so he could get my breast. What a difference that made. Such a little thing (31 p. 405)
Reductionist Approach	**Example of Quotes**
Conflicting information and advice	• Every single midwife that came in had an entirely different opinion on what to do and it was just, it was far too confusing (54 p. 2152)
Standard information	• they tell you in health talk, 'they use medical jargon, and 'Her explanations were real technical. I guess I felt a bit rushed (34 p. 123) • There are a lot of things I asked them [nurses] not to do. I know they have rules, but it means a lot to me to do it my way . . . to feed him when he's hungry, not when they say it's time (31 p. 406).
Didactic approach	• 'No-one asked me what I wanted' (35 sect. 4.1) • Some aren't interested in what others have told you '(13 p. 247) • I wasn't ready for her telling me how to express. I wasn't at the stage where I wanted to know about that. I felt that things were going well… she was determined to tell me (13 p. 247).
Disconnected Encounters	**Example of Quotes**
Disconnected encounters	• I don't know if there was a box that she had to tick, to say that she had covered everything. To me she seemed to be only interested in checking my pulse, filling all her forms out and ticking the boxes (13 p. 246)
Undermining and blaming	• I had great difficulty getting him to latch on or suck, and I very much felt the midwives blamed me for this. When I said to one, "It isn't easy", she replied, "Of course it's easy all the other mothers can do it!" (49 p. 183)

Feeling pressured	• It's really drummed into people, you know, breastfeeding is best, you shouldn't bottle feed and I just when I changed her over to the bottle I just felt guilty because everyone there's so much hype about breastfeeding and she is just as happy, if not more, on the bottle. You know, I don't think they should drum it into you as much. You know ``you should breastfeed." It's your decision, it's up to every individual (5 p. 228). • She [health-visitor] said "Well, that's two weeks, and she hasn't made up her birth-weight. It just means we'll have to take the child to care if you're going to persist with this breast-feeding." I thought that was a terrible thing to say (35 sect. 6.10).
Communicating temporal pressure	• They are so busy, they don't have the time to sit and help you to do it. They really don't. They are rushed off their feet, and are quite harassed, and I was quite willing to give up (35 sect. 4.9).
They don't give you time	• From day one, I thought I would breast-feed, but when I went into the hospital, and I wasn't getting much help, I just thought stuff it....I didn't even know how to start myself, and the nurse showed me once, but after that I still couldn't do it....and I started getting myself depressed and anxious, and I thought' No. I won't be able to cope (35 sect. 4.12).
Insensitive and invasive touch	• They're trying to grab, grab onto your breast. And trying to get it into his mouth (5 p. 123).