Equity-focused peer support and community interventions for breastfeeding in high-income countries: Systematic review and intervention components analysis

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Table of Contents

Scientific Abstract

Background: Breastfeeding and the provision of human milk offers an accessible and cost-effective practice that is health promoting for both the mother and the child. However, in the UK rates of breastfeeding and chest-feeding remain low. There are a range of interventions that aim to promote feeding, which include peer support by trained individuals who share key social characteristics with those they are supporting. Peer support may be delivered in clinical and community settings. Other community provision includes professional and non-professional services delivered through local, regional and community networks. Despite an emerging evidence base for peer-led and community intervention, current knowledge is limited by a lack of understanding as to whether the experiences of intervention generate, maintain, exacerbate, or mitigate health inequities between participating groups. As a complement to our ongoing review on the health equity aspects of women's experiences of peer support and community breastfeeding interventions in the UK, we will update a major Cochrane review to address the following questions: 1) *What* are the equity-focused components that peer support and community breastfeeding interventions evaluated in underserved populations use?; and 2) *How* do these equity-focused components relate to breastfeeding outcomes?

Methods: We will update the searches of a Cochrane review from 2022 in CENTRAL, with a time-limited search in PubMed to address any very recently published trials. We will undertake supplementary literature searching as required. Eligible studies must report results of a randomised trial of a peer support or community breastfeeding intervention in a high-income country evaluated in an underserved population. Both trials from the prior review and from update searches will be screened independently and in duplicate. New trials will be appraised using the original Cochrane risk of bias tool for randomised trials. Intervention descriptions for key trials will be extracted and equity-focused components will be identified using intervention components analysis. Interventions will be charted as to the presence or absence of intervention components and impacts on breastfeeding outcomes. We will continue ongoing engagement with

breastfeeding women and peer supporters to interpret the emerging synthesis and develop funder recommendations.

Dissemination: The review is an output from the NIHR PHR Reviews Team. It will support the funder in setting research and funding priorities.

Summary

Breastfeeding is reported to have positive health benefits for both the mother and child. In the UK rates of breastfeeding are lower than in other countries. But there are differences in rates of breastfeeding between different groups in the UK, with some of the lowest rates among women from more socio-economically deprived areas. Many programmes and services have tried to encourage people to breastfeed. This includes community groups, such as those in family centres. Peer support is also popular, where trained people with experience of breastfeeding give advice and support to mothers. We have previously looked at the experiences of women from different backgrounds to understand what might make these programmes more useful for some people over others. In this work, we will focus instead on what programmes and services have actually done to be more relevant and useful for different groups, and check to see how the things these programmes and services have done to be more relevant and useful makes them more likely to be helpful. We will undertake a systematic review, which means that we will draw together previous research on programmes and services. We will look closely at what this research says about how programmes and services were tailored to specific groups of women. We are doing this work because of what we heard from breastfeeding people and peer supporters in our previous project, and we will continue to discuss with breastfeeding people and peer supporters to understand our findings and to understand how we can make use of the findings to help shape future research and practice.

1. Background

Breastfeeding and the provision of human milk offer an accessible and cost-effective practice that is health promoting for both the mother and the child. The World Health Organisation (WHO) recommends exclusive breastfeeding for the first six months of life[1]. This is to be followed by continued breastfeeding up to two years and beyond, in combination with nutritionally complementary foods.

Definitions related to individuals who breastfeed are complex and continually evolving[2]. The present review is focused on people who give birth, including women, and will use the term ‘women and other birthing people’ to define the population of interest. Breastfeeding and chest-feeding are relevant outcomes within the scope of the review. We define, and include, chest-feeding as the same physiological process as breastfeeding. Chest-feeding is out of scope where it refers to a different physiological process (e.g. feeding an infant with formula or donor milk with a tube taped to the chest) as this may require different specialist support. The term 'breastfeeding' will be used throughout the protocol but should be understood to be inclusive of the term 'chest-feeding' within the parameters above, except where otherwise stated or when quoting data from specific sources.

Despite recommendation, rates of breastfeeding remain a significant public health issue in the UK. While available data from the four nations vary by collection time-point and measurement, they generally present a similar trend in terms of declining rates from initiation. Prevalence in England is reported at six to eight weeks, with quarterly data for 2023 to 2024 standing at 52%[3]. In Northern Ireland, 2020 data indicates that 49.9% of women breastfed at discharge, with rates of 20.8% at six months[4]. For 2022-23 in Scotland, 57% of babies were breastfed at 10-14 days, reducing to 47% at 6-8 weeks and 21% at 13-15 months[5]. Data for 2022 in Wales reports that 63.3% of women breastfed at birth, falling to 26.2% at six months[6]. There are socio-demographic variations in prevalence rates, with individuals from rural and socio-economically deprived communities being less likely to use this form of feeding. For example, in some communities in the UK that score higher on multiple indexes of deprivation, breastfeeding can be as low as 11% at six months[4]. Causes of breastfeeding cessation

are multifarious, including pain and discomfort, perceived low milk quantity, maternal or infant illness, or a return to work [7-9]. Lack of support is often cited as a central factor, both within the immediate family context, and wider community network[10].

A range of interventions have been developed and evaluated to increase breastfeeding initiation and reduce early cessation. Peer and professional education, advice and support interventions remain a significant approach [11], serving as the focus of a recent National Institute for Health and Care Excellence review that underpinned subsequent guideline recommendations[12]. Peer support has been conceived as support offered by trained women or other birthing people who have themselves breastfed, or have the same socio-economic background, ethnicity, or locality as the individuals they are supporting[13]. This type of approach is commonly described by its principles as much as its components, with emphasis on strengths-based or asset-based models. Peer support can be delivered through a variety of mechanisms and settings, including in the community and hospital. Additional community support provision can include delivery by non-hospital-based healthcare professionals (e.g. community health visitors) and non-healthcare professionals[12]. Evidence syntheses indicate mixed effectiveness for peer and community-based support in the UK[12], partly due to low intensity[13]. Meanwhile, international evidence reports issues around lack of awareness and access [14].

Our ongoing systematic review of qualitative research has focused on women in the UK and how their experiences of peer support and community interventions for breastfeeding relate to equity inreach and recruitment, retention, interaction and sustainment across a range of characteristics. Stakeholder consultation has highlighted the need to complement a rich understanding of how equity is generated (or not generated) in interventions with a practical focus on both what interventions have done to address inequities, and the effectiveness of these strategies. To address this, we will identify relevant, equity-focused randomised trials of breastfeeding peer support and community interventions, analyse equity-relevant intervention components, and relate these to intervention effectiveness on breastfeeding outcomes.

2. Review Aim

We will systematically review evidence from completed and reported randomised controlled trials of peer support and community breastfeeding interventions delivered to underserved groups in high-income countries to address the following questions:

1) What are the equity-focused components that peer support and community breastfeeding interventions evaluated in underserved populations use?; and
2) How do these equity-focused components relate to breastfeeding outcomes?

The overarching scope and focus of the review are informed by the associated co-produced logic model, shared with the companion review of qualitative research (Figure 1). The review will a priori classify social characteristics according to the PROGRESS-Plus heuristic[15], which are described in Table 1. Further characteristics, and the potential interaction of characteristics, will be identified through stakeholder engagement and inductive coding of study reports.

3. Methods

3.1. Synthesis Methods

This systematic review will proceed as an update and re-analysis of Gavine et al (2022)[16] hereafter described as the 'parent review', focusing on trials from this review undertaken with underserved populations and identifying any relevant trials published since then. The parent review last undertook searches in 2021, suggesting several years' worth of additional evidence that could inform our synthesis, drawing on most recent developments in the field. Broadly, we will use intervention components analysis[17] within relevant trials to identify components linked to the ways interventions have been tailored for underserved populations, and then we will relate these components to intervention effectiveness on key breastfeeding outcomes.

3.2. Patient and Public Involvement (PPI)

We will continue our programme of PPI engagement with relevant stakeholder groups into this companion review. To date, two phases of engagement have taken place with women who have experienced breastfeeding (n=7) and peer supporters (n=6). Participants were recruited through the ABA Feed and MuM PreDiCT studies.

The first phase (April 2024) centred on protocol refinement and pertinent social characteristics. The second (June 2024) provided feedback on synthesis findings. This engagement clarified the key concepts of community and peer support; provided additional social characteristics beyond those specified by PROGRESS-Plus, including body type and neurodiversity; and clarified the need for practical guidance relating to intervention components. A third session will focus on the development of funder recommendations and refinement of the dissemination strategy. For this companion review, additional engagement will seek feedback on the synthesis as well as the recommendations and dissemination specific to this review (see Table 2).

3.3. Approach to Searching and Data Sources

This search will primarily be structured as a top-up search of the parent review. However, this review used as the key search source the Cochrane Pregnancy and Childbirth Trials Register, which was closed as part of Cochrane's restructure. This means we cannot do a straightforward update of the previous review's search. Therefore, our search strategy will include several steps. First, we will undertake targeted searches of the Cochrane Central Register of Clinical Controlled Trials, or CENTRAL, as well as PubMed in the three months prior to the search date to retrieve any most recent trials. Second, we will follow up all studies identified as ongoing in the parent review. Third, we will forward citation search on both the parent review, as well as on the new trials identified in the database search; we will also explore other citation searching methods following recommendations from the TARCiS statement[18].

3.4. Search Strategy

The search strategy for CENTRAL includes terms relevant to breastfeeding, and is informed by the search strategies used for the Cochrane Pregnancy and Childbirth Trials Register[19]. Because of the date of the parent review's search was 11 May 2021, we will apply a date restriction to search terms to capture records published in 2021 onwards. The search strategy is presented in Supplement A. We will summarise search results using a search summary table[20].

3.5. Inclusion Criteria

This review's eligibility criteria adopts the eligibility criteria of the parent review with additional modifications (see Box 1).

3.6. Study Screening Methods

Full texts identified from the parent review will first be screened independently and in duplicate by two members of the review team. Subsequently, each of the titles and abstracts of study reports retrieved in the top-up search will be screened independently and in duplicate by two members of the review team. Study reports with a conflict in eligibility assessments will progress to full-text screening. Full texts of study reports will also be independently screened by two reviewers.

Conflicts in assessments will be resolved through discussion and recourse to a third member of the review team.

Box 1. Eligibility criteria

Types of studies. Randomised trials, including cluster-randomised or stepped wedge-randomised trials.

Types of participants and contexts. Healthy women and other birthing people who are pregnant and "…considering or intending to breastfeed or […] who were breastfeeding healthy babies" delivered at term[16]. **For this review,** participants must also be resident in high-income countries during the intervention.

Types of interventions. As described in the parent review: "Contact with an individual or individuals (either professional or volunteer) offering support which is supplementary to the standard care offered in that setting. Interventions could be delivered as either standalone breastfeeding support interventions (breastfeeding only), or breastfeeding support could be delivered as part of a wider maternal and newborn health intervention (breastfeeding plus) where additional services are also provided (e.g. vaccination, intrapartum care, well baby clinics). Contact with an individual or individuals (either professional or volunteer) offering support which is supplementary to the standard care offered in that setting" but excluding antenatal-only and educational-only interventions[16]. **For this review,** interventions must also have been:

- delivered either a) by volunteer or peer supporters in hospital or community contexts, or b) by health professionals in community contexts, or c) by a combination of the above, and possibly including digital technologies; and
- delivered specifically and by trialists' intention to underserved groups or in areas described as underserved (e.g. 'disadvantaged' areas), with reference to the PROGRESS-Plus heuristic[15].
- Interventions including more than limited health professional involvement in inpatient contexts (e.g. beyond enrolment and induction) will be excluded.

Types of comparators. The parent review included interventions compared to standard of care or an alternative non-breastfeeding intervention.
Types of outcome measures. The parent review included a range of outcome measures, which will be used here: stopping any breastfeeding at four-six weeks, two months, three-four months, six months, nine months, and 12 months postpartum; stopping exclusive breastfeeding at four-six weeks, two months, three-four months, six months postpartum; maternal satisfaction with care; maternal satisfaction with feeding method; all-cause infant or neonatal morbidity; and maternal mental health.
Types of publication. Trials with effectiveness results reported as full text, or in abstract form where sufficient information exists for analysis.

3.7. Software

Retrieved study reports from the data sources will be exported to Endnote 20, where they will be combined and de-duplicated. They will then be uploaded to Covidence review management electronic platform for screening and extraction of characteristics. Data extraction and appraisal will be conducted using Covidence. Intervention components analysis will be undertaken using Microsoft Excel.

3.8. Quality Appraisal

Appraisals will use the original Cochrane Risk of Bias Tool[21] for consistency with the parent review. Appraisal of newly identified trials will be conducted independently by two reviewers. We will calibrate our judgments to any specific nuances in appraisal identified in the parent review.

3.9. Data Extraction and Coding

All extraction will be undertaken by one reviewer and checked by a second. We will extract data items for newly identified trials for: basic study details (first author, year; study location, timing and duration; individual and organizational participant characteristics); study design and methods (design, sampling and sample size, allocation, blinding, accounting for data clustering, data collection, attrition, analysis, standard of care in control arm); and outcome measures (timing, reliability of measures, intra-class correlation coefficients, effect sizes).

For all trials, we will label the focal equity characteristics to which interventions have been tailored, structuring our description using PROGRESS-Plus[15]. Because inequities do not occur ‘one at a time’, we will also label trials with respect to equity characteristics

of interest present in over half of the trial population. For example, if a trial is described as testing an intervention tailored to minoritised women but more than half of the trial population is described as living in poverty, we will label the trial as ‘focally’ about minoritised women but ‘of interest’ for poverty as well.

Finally, we will extract intervention descriptions both in summary and as free text across all included trials.

3.10. Synthesis

To address the first research question, we will use intervention components analysis[17]. Intervention components analysis is an inductive approach to comprehensively describing and categorising intervention components in a target body of evidence. This is an appropriate method to describe intervention components when these components do not fit into pre-existing taxonomies of behaviour change, which is especially the case in this review given our focus on equity-relevant components. Analysis will focus on intervention descriptions in reports of trials. Two reviewers will use open coding to generate a comprehensive list of possible intervention descriptors from five different intervention descriptions relating to a range of underserved groups, focusing on aspects of interventions described by trialists as developed to meet the specific needs of underserved groups. The two lists will be compared and combined. Using principles of axial coding, the two reviewers will proceed through the remaining intervention descriptions, collapsing codes and adding new ones as required and meeting periodically to compare codes, determine if new axial codes are required and organise axial codes into categories. The final result is a comprehensive list of descriptors to characterise the equity-relevant components of included interventions. We will link these components to different equity characteristics to understand which components are especially salient for different groups.

To address the second research question, we will link the presence or absence of equity-relevant components to intervention outcomes categorised according to the parent review, in order to narratively synthesise how intervention components relate to effectiveness. We do not anticipate undertaking a meta-analysis given the diversity of underserved groups to be included in this review.

3.11. Synthesis Output

We will present a summary table of equity-relevant components alongside a) estimates of their frequency both overall and by different equity characteristics, b) exemplar descriptions, and c) conclusions relating to the impact of components on effectiveness where possible. Where appropriate, we will develop an infographic to present the results of the syntheses, map these to existing guidance where appropriate, and collaborate with practice stakeholders to provide an evidence briefing of 'top tips' to increase the likelihood that interventions will be equity-generating. Finally, to support future intervention research and practice in this field, we will develop with our stakeholder groups recommendations for funders and commissioners.

4. Ethics

Ethical approval for the review will not be required. PPI consultation with stakeholder groups will be conducted in accordance with any ethical requirements stipulated by the organisations and research studies that recruit participating members.

5. Discussion

This review will provide one of the first syntheses examining *how* breastfeeding peer and community support interventions can be explicitly tailored to underserved groups[22]. At the same time, there are some limitations that will be present in our analysis. First, equity-relevant characteristics are likely to relate primarily to race and ethnicity[23], and to socio-economic status[24]. Because equity-focused trials tend to focus on one characteristic at a time, we are unlikely to be able to test how identified components address the intersection of different social characteristics in the generation of health inequities. Second, we are limited by the inclusion criteria of the prior review, which means we are unlikely to address specific equity-relevant characteristics related to disability (parental or child) or mental health identified in consultation for the companion review, nor indeed will we be able to analyse interventions for groups requiring specialist support arising from maternal and child health inequalities. However, similar to the companion review, this synthesis will inform future intervention practice in this field by providing useful direction for how interventions can meet the needs of diverse women[25,26].

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Figure 1. Review Logic Model

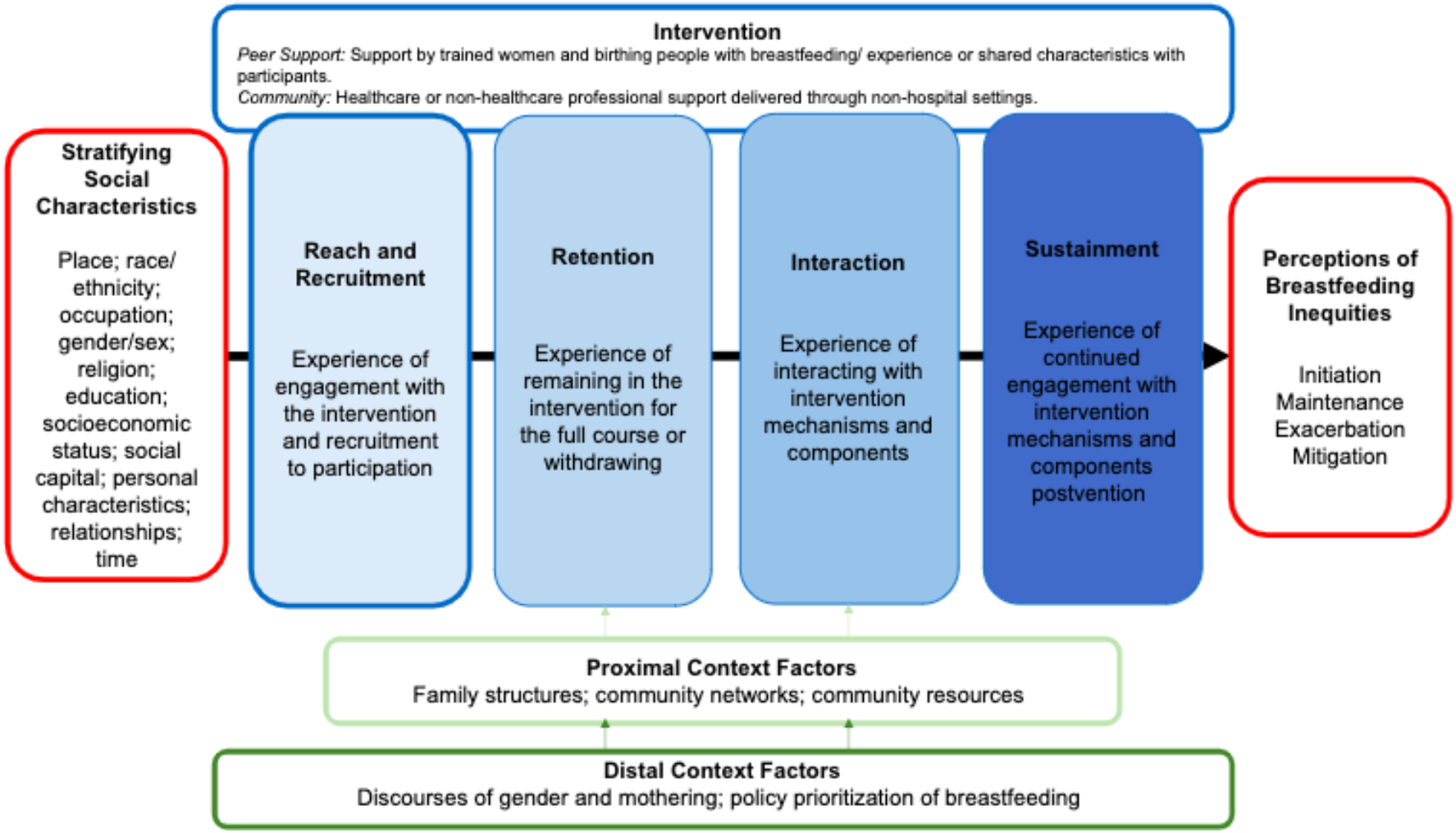

Table 1. PROGRESS-Plus Characteristics that Stratify Health Opportunities and Outcomes

PROGRESS-Plus Stratifying Characteristics	
P	Place of residence
R	Race/ethnicity/culture/language
O	Occupation
G	Gender/sex
R	Religion
E	Education
S	Socioeconomic status
S	Social capital
Plus	1. Personal characteristics associated with discrimination (e.g. age, disability) 2. Features of relationships (e.g. smoking parents, excluded from school) 3. Time-dependent relationships (e.g. leaving the hospital, respite care, other instances where a person may be temporarily at a disadvantage)

Table 2. Stakeholder Engagement in Review Process

Review Stage	Stakeholder Groups	Identification of Stakeholders	Aims of Engagement
Refinement and confirmation of preliminary and final findings	Two stakeholder groups: • One with women who may experience pregnancy • One with breastfeeding peer supporters	Assets-based feeding help Before and After birth (ABA) feasibility trial: • PPI Group • Facebook Group • Peer Supporters MuM-PreDiCT Study • PPI Group • Participants	Provide feedback on preliminary findings. Refine and confirm final findings.
Development and confirmation of recommendations and dissemination strategy	Two stakeholder groups: • One with women who may experience pregnancy • One with breastfeeding peer supporters, and with commissioners and policymakers	Assets-based feeding help Before and After birth (ABA) feasibility trial: • PPI Group • Facebook Group • Peer Supporters MuM-PreDiCT Study • PPI Group • Participants Policy networks specific to the review team	Refine and confirm dissemination strategy. Ensuring findings are accessible to intended audience. Develop recommendations for commissioners and funders.

Supplement A: Example Search Strategy (CENTRAL)

Search Name: Breastfeeding
Date Run: 25/07/2024 16:46:46

#1 MeSH descriptor: [Breast Feeding] explode all trees 2923
#2 ((breastfeed* or breast feed* or breastfed* or breast fed or breastmilk or breast milk or expressed milk* or chestfeed* or chest feed* or bodyfeed* body feed* or chest fed or body fed)):ti,ab,kw 17985
#3 ((feed* NEAR/1 (infant* or baby or babies or newborn*))):ti,ab,kw 1662
#4 (nursing NEAR/2 (baby or infant* or newborn* or mother* or parent* or birthing people or birthing person*)):ti,ab,kw 963
#5 lactation NEAR/2 (consultant* or counsel*):ti,ab,kw 190
#6 #1 or #2 or #3 or #4 or #5 19451
#7 ((breastfeed* or breast feed* or breastfed* or breast fed)):ti 3171
#8 MeSH descriptor: [Peer Group] explode all trees 2017
#9 MeSH descriptor: [Self-Help Groups] this term only 864
#10 Meshdescriptor: [Social Support] explode all trees 4371
#11 MeSH descriptor: [Counselors] this term only 67
#12 ((peer* or mentor* or communit*) NEAR/3 (support* or intervention* or program* or visitor* or support* or mentor* or counsel* or worker*)):ti,ab,kw 18141
#13 (peer* or mentor* or counsel*):ti 9859
#14 #8 or #9 or #10 or #11 or #12 or #13 29849
#15 #6 AND #14 972
#16 #7 or #15 from Jan 2021 to present 919

Supplement B: Timeframes for Review Delivery

All timeframes are for end of month:

- August 2024: agree protocol
- September 2024: complete search and screening
- October 2024: complete intervention components analysis draft
- November 2024: complete initial draft of review
- December (possibly very early January 2024): submit policy and practice output and manuscript
- January 2024: complete dissemination presentations
- **Engagement throughout October-December 2024**