Why do interventions work in some places and not others: A breastfeeding support group trial

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Introduction

Public health policy initiatives addressing aspects of parental behaviour are popular with Governments and randomisation to provide more robust evidence is important (Macintyre, 2003). However, often complex intervention trials provide insufficient data on context, development, rationale and implementation processes to be able to explain negative outcomes (Armstrong et al., 2008). Implementation science is a relatively new area of health services research and a more theoretically informed approach is needed (Eccles, Grimshaw, Walker, Johnston, & Pitts, 2005).

An ecological approach to health promotion policy advocates interventions that change the social environment, with the assumption that these will result in individual behavioural change (McLeroy, Bibeau, Steckler, & Glanz, 1988). This is relevant to a complex bi–psycho–social behaviour like breastfeeding which interfaces primary, secondary health and social care and can be considered liminal (Mahon-Daly & Andrews, 2002). The context of space and place, particularly the public–private interface and tensions between a mother’s choice and societal pressures are important (Bailey & Pain, 2001). Hospital cultural and organisational rituals can adversely affect the caring time for breastfeeding (Dykes, 2005), however, how primary care organisation interfaces with breastfeeding has received little attention.

The breastfeeding in groups (BIG) trial (Hoddinott et al., 2009) was not effective at increasing breastfeeding rates and the variation in breastfeeding outcomes could not be explained by the quantity of intervention delivered (Box 1). The trial design (Fig. 1) was guided by a realist approach, the model explained variation in (a) policy implementation (b) the breastfeeding outcomes, whereas the quantity of intervention delivered did not. In the three localities where breastfeeding rates declined, negative aspects of place including deprivation, unsuitable premises and geographical barriers to inter-professional communication; personnel resources including staff shortages, high workload and low morale; and organisational change predominated (the base model tiers). Managers focused on solving these problems rather than delivering the policy and evidence of progress to the higher model tiers was weak. In contrast, where breastfeeding rates increased the base tiers of the model were less problematic, there was more evidence of leadership, focus on the policy, multi-disciplinary partnership working and reflective action cycles (the higher model tiers). We advocate an ethnographic approach to the design and evaluation of complex intervention trials and illustrate how this can assist in developing an explanatory model. More attention should be given to the complex systems within which policies and interventions occur, to identify and understand the favourable conditions necessary for a successful intervention.

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by research questions derived from our preliminary study (http://www.abdn.ac.uk/crh/research/completed/big). Blaikie (2000) describes four research strategies (inductive, deductive, retroductive and abductive) and argues for a pragmatic attitude given the deficiencies of each. From the outset, we hypothesised that:

(a) localities would differ in baseline contexts and in how they implemented the policy (amount, processes and execution)

(b) changes in both context and intervention implementation would occur during the 2 year trial

(c) outcomes in intervention localities would differ.

In this paper, we ask: why did breastfeeding rates decline in 3 of 7 intervention localities? Our evaluation was informed by a realist approach (Pawson, 2006) to understanding how the implementation of the policy influenced outcomes. Realist evaluation proposes

**Fig. 1.** Trial design and strategy: embedded in ethnography.
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