Peer support and community interventions targeting breastfeeding in the UK: Systematic review and equity synthesis of qualitative evidence

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1. 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. 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 women and people who give birth and will use the term women and 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 among women remains a significant public health issue in the UK. While available data from the four nations varies 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 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 implementation issues around lack of awareness and access [14].

A central limitation with the current evidence-base is a paucity of understanding as to whether the experience of various breastfeeding interventions generate, maintain, exacerbate, or mitigate health inequities between participating groups. This is important given the social patterning in outcomes across groups in the UK[4-6]. Some systematic reviews of qualitative research have offered rich explorations of participant experiences, but these variously tend to not have an equity lens, be linked explicitly to peer support or community intervention, or have a UK focus[15-18]. However, there is a strengthening body of primary qualitative research with a strong equity focus from the UK, that could support such a synthesis. For example, data from the NIHR PHR funded Assets-based feeding help Before and After birth (ABA) feasibility trial has informed a taxonomy on how breastfeeding experiences can be determined by a constellation of socio-demographic and service-level differences [19].

While not looking at inequities between groups, there has been significant progress in understanding the experiences of interventions explicitly tailored to minority groups[20]. However, while insightful, the evidence often tends to be explored in relation to two central clusters of social characteristics. In the USA, intervention work has often focused on underserved African American women[21], while in the UK, there is a stronger consideration of socio-economic status[22]. There is less consideration of other social characteristics, and perhaps more importantly a lack of emphasis on their intersection in the generation of health inequities. Moreover, while this research offers significant learning for the development of tailored intervention, there needs to be more systematic attention paid to how experiences of diverse underserved groups differ between targeted and more universal approaches.

Given an emerging and deepening qualitative evidence-base regarding health inequities in breastfeeding intervention, which has not been reflected in evidence syntheses to date, there is an evident need to for a systematic review. We will conduct an evidence synthesis of qualitative research, which may be integrated into a mixed-method process evaluation, of experiences and/or views of peer support and community breastfeeding interventions. This will help to understand how experiences may be impacted by multiple and intersecting social characteristics, and how this may initiate, maintain, exacerbate, or mitigate health inequities. To ensure relevance to the NIHR PHR context, a UK focused review will be of most use.

2. Review Aim

The present review will systematically synthesise evidence from qualitative studies and process evaluations of peer support and community breastfeeding interventions in the UK to address the following questions:

1. *What* social characteristics are identified as relevant to participants' experiences and/or views of peer support and community breastfeeding interventions?
2. *How* are participants' experiences and/or views of peer support and community breastfeeding interventions influenced by different social characteristics?

The overarching scope and focus of the review are presented in the associated logic model (Figure 1). The review will a priori classify social characteristics according to the Cochrane PROGRESS-Plus acronym[23], 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.

In accordance with guidance, frameworks and models for process evaluation and implementation science, we recognise that participants may experience multiple phases of intervention, all of which usually fall within the remit of process evaluation [24, 25]. Construction of discrete but inter-related phases is useful as participants may have complex and contrasting experiences at different time-points. We have a priori classified four key intervention phases to support the structuring of the synthesis (Table 2): 1) Reach and recruitment; 2) Retention; 3) Interaction; and 4) Sustainment.

We note that intervention experiences within process evaluations are commonly described as ‘acceptability’. However, process evaluation guidance critiques the static nature of the concept, suggesting that *interaction* better reflects the dynamic relationship of participants with an intervention, and how this can change through expressions of agency[24]. As such, we have indicated the phase of participating in intervention components as one of interaction.

The logic model also includes reference to proximal and distal context factors, to ensure the review foregrounds the community (proximal) and societal (distal) structures that may shape immediate intervention experiences and/or views [26-28]. For example, dense social capital among community networks may accelerate the diffusion of negative messaging about an intervention, which may inhibit future recruitment.

3. Methodology

3.1. Synthesis Methodology

The systematic review will be conducted in accordance with best practice in qualitative evidence syntheses [29]. We will draw upon Framework Synthesis to support the review. Framework Synthesis entails the generation of an initial framework which is used to structure the categorisation of study reports and the development of themes. As specified, we have developed an a priori conceptual framework based on key methodological guidance in process evaluation: reach and recruitment; retention; interaction; and sustainment. As noted, adoption of an equity lens will be facilitated through use of PROGRESS-Plus to initially identify and map social characteristics [23]. Certainty of evidence will be assessed through GRADE-CERQual[30, 31]. The review protocol is reported with reference to Cochrane qualitative evidence syntheses guidelines[32] and PRISMA-P [33], while recognising future review reporting in accordance with ENTREQ[34] .

3.2. Patient and Public Involvement (PPI)

We will undertake a programme of PPI engagement with relevant stakeholder groups. There will be three phases of engagement (Table 3). First will be engagement in protocol refinement and confirmation, with a primary focus on specifying the inclusion criteria and clarifying social characteristics that might impact on experiences, particularly beyond those specified by PROGRESS-Plus [23]. Second will be engagement to provide feedback on preliminary and final synthesis findings. Third will be engagement on the development of funder recommendations and refinement of the dissemination strategy.

3.3. Approach to Searching and Data Sources

The review's search methods are informed by the Cochrane Handbook guidelines for systematic reviews [35]. We will adapt and update the searches carried out in an existing review conducted by Bengough, Dawson, Cheng, McFadden, Gavine, Rees*et al.* [36]. The review was a comprehensive exploration of qualitative evidence reporting women's engagement with breastfeeding strategies, but the synthesis did not have an equity lens. As such, while the current review will have a different focus, the original search strategy has direct relevance. Searches in the Bengough, Dawson [36] review were undertaken in November 2017. We will update searches from December 2017.

Searches will be undertaken in: Medline (Ovid); Embase (Ovid); PsycINFO (Ovid); CINAHL (EBSCO); BNI (ProQuest); Scopus; ASSIA (ProQuest); Social Policy and Practice (Ovid) and Epistemonikos.

Existing systematic reviews prior to November 2017 will be screened, including the Bengough, Dawson [36] review. Additional supplementary literature searching will be conducted as determined by the needs of the review following the assessment of the key identified reports. This may include checking reference lists, citation tracking, contacting authors and web searching for unpublished material and policy documents.

3.4. Search Strategy

The search strategy includes terms for the review's population and intervention, along with database-appropriate subject terms, keywords and combinations. Terms for qualitative research are drawn from hedges developed by the McMaster Health Knowledge Refinery [37], focusing on the optimum balance of sensitivity and specificity. Terms for the United Kingdom are drawn from Ayiku, Levay, Hudson, Craven, Barrett, Finnegan*et al.* [38] for MEDLINE and Embase and adapted for PsycINFO from MEDLINE.

The search strategy was developed in Medline (Ovid) and is presented in Supplement A. The strategy will be adapted to the functionality of each bibliographic database.

3.5. Inclusion Criteria

The review's eligibility criteria tool was developed in accordance with SPIDER and is presented in Table 4. It will be refined with stakeholders during the first phase of PPI consultation. A subsample of 100 title and abstract retrievals from bibliographic databases will be screened independently and in duplicate by the five members of the review team involved with screening to calibrate the tool.

3.6. Study Screening Methods

Each of the titles and abstracts of retrieved study reports 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.

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 coding and synthesis will be conducted in NVivo 14 qualitative data analysis software.

3.8. Quality Appraisal

The rationale for quality appraisal of study reports is to assess clarity and transparency of reporting; methodological rigour in the research process; robustness in the findings, including robustness in any claims to generalisability; and compliance with ethical standards.

We will use a qualitative method quality appraisal tool developed by Wallace *et al.*[39] and adapted for use in a subsequent public health qualitative evidence synthesis[40]. Assessed items will be research question; theoretical perspective; study design; context; sampling; data collection; data analysis; reflexivity; generalisability; and ethics. As the review has an explicit focus on equity, we will add an additional item: Were social characteristics clearly described? Each item will be assessed as yes, no or cannot tell. Appraisal will be conducted independently by two reviewers. Both appraisals will be presented.

3.9. Number of Reviewers

One member of the review team will lead information specialist activities related to study report retrieval (SR). Five members of the review team will undertake screening, extraction, and appraisal (JK; CD; RE; GMT; SL). The remainder of the review team will serve as arbiters of decision conflicts in study screening, support the synthesis of findings and develop the final funder recommendations.

3.10. Data Extraction and Coding

Data extraction will be guided by the a priori framework. We will extract data items for: method of study identification; first author; publication year; title; aim; country; setting; data collection year; intervention characteristics (mechanisms; components; implementation strategy; targeted outcomes); stage of intervention (reach and recruitment; retention; interaction; sustainment); proximal and/or distal context domains; PROGRESS-Plus or other relevant equity characteristics; participants generating data;

data collection method; and first/second-order construct data. For the first and second order constructs that relate to participants' and experiences and/or views we will conduct inductive line-by-line coding.

As part of the extraction and coding process, we will classify study reports as having: 1) High equity relevance: Reports that direct engage with target participants. They may present within study comparisons of the experiences of participants with different social characteristics or explore the experiences of underserved groups only ; 2) Medium equity relevance: Reports focus on the experiences and/or views of underserved populations, but generate data with stakeholders that are not the target participants; and 3) Low equity relevance: Reports do not explicitly consider differences in experiences between population groups individual or focus on particular underserved population groups. Socio-demographic characteristics of the sample are reported (e.g. in the methodology), which may enable some between population comparisons. This classification will be supported by the quality appraisal item of 'Were social characteristics clearly described?'. One reviewer will code the data, and this will be verified by a second.

3.11. Synthesis

To address the first research question, we will chart which social characteristics are assessed in each study report and how they are defined. For the second, research question, we will initially group study reports according to the phases of intervention addressed or the proximal and distal context domains considered. Drawing on the inductively coded data from each study report we will generate themes within each of the four phases or two context domains, while recognising themes may run across phases and domains. We will commence the generation of themes from study reports that are most equity relevant, and which engage directly with intervention participants. We will them proceed to those that indicate medium relevance. For those that have low equity relevance, we will integrate them into the synthesis in more of a confirmatory manner, permitting us to understand how the equity relevant studies compare to the wider research literature. The social characteristics that give rise to inequities will be described and integrated within each theme. Relevant data that do not fit will be considered separately, with the view of refining our initial framework. The placement of codes within each intervention experience category will be conducted by one member of the review team and checked by another. The generation of themes will be developed and agreed by the wider review team, as will any refinements to the initial framework.

3.12. Synthesis Output

The charting of characteristics addressed in study reports will be presented in a summary table with characteristic definitions and tabulation of frequency. The synthesis of experiences and/or views will be reported as a narrative summary of the themes linked to the prespecified four domains of intervention experience. We will accompany this with summary tables describing the themes and the social characteristics commonly associated with them (e.g. Table 5). The synthesis will include quotations from primary data, along with extracts from author interpretations where appropriate. We will aim for quotations to represent diverse participants, and to illustrate negative cases where available to illustrate discrepancies in perspectives. Where appropriate, we will develop an infographic to present the relationship between intervention phases, themes, and social characteristics. Finally, to support future intervention research and practice in this field, we will develop recommendations for the NIHR PHR to support funding priorities moving forward.

3.13. Certainty of Evidence

We will use the GRADE-CERQual tool to assess the certainty of evidence[30, 31]. We will first construct review findings summaries from the textual narrative. Each review finding will be assessed according to four domains: methodological limitations; coherence; adequacy; and relevance. Each evidence statement will be rated as high in the first instance and rated down where there is concern about each domain. From here an overall assessment of confidence in the evidence will be made, which will be rated as high, moderate, low, or very low. Evidence summaries will we generated by one member of the review team and then discussed and confirmed with the remainder. An Evidence Profile and Summary of Qualitative Findings (SoQF) table will display a summary of each review finding, the CERQual assessment of confidence in that finding and the explanation for that assessment.

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

The present review will provide one of the first syntheses describing how the experiences of peer and community support breastfeeding interventions can be impacted by individuals of different characteristics, thus potentially instigating, maintaining, exacerbating, or mitigating health inequities. The review will inform the needs of future intervention practice in this field, by providing useful direction for the development of contextually relevant approaches or the adaptation of existing practice to meet the needs of underserved population groups[41, 42].

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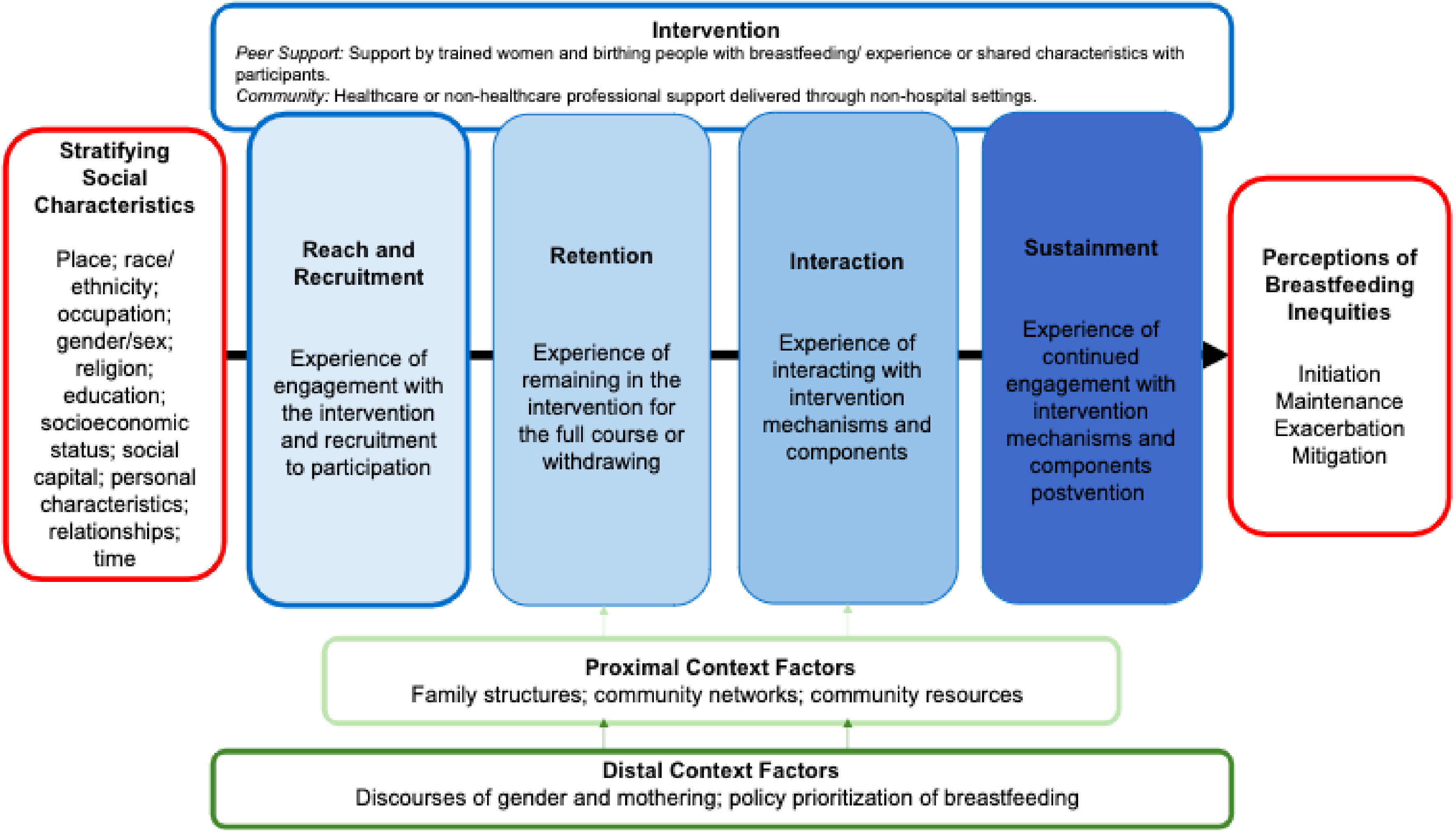
Figure 1. Review Logic Model



Intervention

Peer Support: Support by trained women and birthing people with breastfeeding/ experience or shared characteristics with participants.

Community: Healthcare or non-healthcare professional support delivered through non-hospital settings.

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. Phases of Intervention Experience: Reach and Recruitment; Retention; Interaction; Sustainment

Phases of Intervention Experience	Description
Reach and recruitment	Experience of initial engagement with the intervention and recruitment to participation. For individuals who have not participated, this may include experience of not being adequately or appropriated reached or recruited.
Retention	Experiences that motivate continued engagement or encourage mid-course withdrawal. Withdrawal may be initiated by the individual participant, delivery agents or wider contextual circumstances.
Interaction	Experience of interacting with intervention mechanisms and components.
Sustainment	Experience of continued engagement with intervention mechanisms and resources (e.g. online platforms or handbooks) post intervention delivery. These continued mechanisms and resources may be intended to sustain outcomes. For some evaluation studies, this may denote the period between post-test and longer-term follow-up.

Table 3. Stakeholder Engagement in Review Process

Review Stage	Stakeholder Groups	Identification of Stakeholders	Aims of Engagement
Development and confirmation of protocol	Three stakeholder groups: • Two 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 Multimorbidity and Pregnancy: Determinants, Clusters, Consequences and Trajectories (MuM-PreDiCT) Study • PPI Group • Participants TBC	Refine inclusion criteria through definition of key concepts (e.g. peer support). Generate and confirm relevant equity characteristics. Identify relevant proximal and distal context factors to prioritise in synthesis.
Refinement and confirmation of preliminary and final findings	Three stakeholder groups: • Two with women who may experience pregnancy • One with breastfeeding	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.

	peer supporters TBC	TBC	
Development and confirmation of recommendations and dissemination strategy	Three stakeholder groups: • Two with women who may experience pregnancy • One with breastfeeding peer supporters TBC	Assets-based feeding help Before and After birth (ABA) feasibility trial: • PPI Group • Facebook Group • Peer Supporters MuM-PreDiCT Study • PPI Group • Participants TBC	Refine and confirm dissemination strategy. Ensuring findings are accessible to intended audience. Develop recommendations for the NIHR PHR funder.

Table 4. Eligibility Criteria

Eligibility Domains	Inclusion Criteria
Sample	Women and birthing people who have current or prior experience of breastfeeding or chest feeding, may breastfeed or chest feed in future, or have not been able to breastfeed or chest feed. No age restrictions. Stakeholders involved with the development, delivery and/or funding of interventions (e.g. peer supporters).
Phenomena of Interest	Intervention participants' experiences and/or views of intervention. May relate to reach and recruitment; retention; interaction; and (dis)continuance. Non-participating stakeholders must provide reflections on the experiences and/or views of participants.
Design	Any study design using a research method collecting experiences and/or views of individuals defined by the sample.
Evaluation	Breastfeeding interventions: 1) Peer-led support: Support offered by trained women or birthing people who have themselves breastfed or chest fed or have the same socio-economic background, ethnicity, or locality as the individuals they are supporting. Can be delivered in any setting. 2) Community intervention: Non-hospital-based support provided through local and regional community networks. May be facilitated via professional health care agencies (e.g. community health visitors) or non-health care professionals. Interventions may operate through a number of mechanisms (e.g. increased parent-child bonding or knowledge development). Intervention outcomes must be specified as breastfeeding or chest feeding initiation, maintenance and/or (early) cessation.

Research Type	Any type of qualitative research.
Country	UK; England; Northern Ireland; Scotland; Wales
Years	No restriction on publication date.

Table 5. Example of Synthesis Summary Table

	Phases of Intervention Experience			
	Reach and Recruitment	Retention	Interaction	Sustainment
Themes	*Description and explanation of theme and related subtheme.* *Note of which characteristics are associated with theme and subtheme.*			

Supplement A: Example Search Strategy (Medline)

Ovid MEDLINE(R) ALL <1946 to March 15, 2024>

#	Query	
1	exp Breast Feeding/	44,968
2	exp Lactation/	49,040
3	(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,kf.	67,100
4	(nursing adj2 (baby or infant* or newborn* or mother* or parent* or birthing people or birthing person*)).ti,kf.	960
5	((infant* or baby or babies or newborn*) adj3 (milk or fed or feed* or lactat*)).ti,ab,kf.	26,375
6	lactation.ti,kf.	17,749
7	1 or 2 or 3 or 4 or 5 or 6	133,567
8	(interview: or experience:).mp. or qualitative.tw.	1,972,746
9	((("semi-structured" or semistructured or unstructured or informal or "in-depth" or indepth or "face-to-face" or structured or guide) adj3 (discussion* or questionnaire*)) or (focus group* or ethnograph* or fieldwork or "field work" or "key informant")).ti,ab. or interviews as topic/ or focus groups/ or narration/ or qualitative research/	253,859
10	8 or 9	2,027,297
11	exp United Kingdom/	393,442
12	(national health service* or nhs*).ti,ab,in.	286,666
13	(english not ((published or publication* or translat* or written or language* or speak* or literature or citation*) adj5 english)).ti,ab.	125,236
14	(gb or "g.b." or britain* or (british* not "british columbia") or uk or "u.k." or united kingdom* or (england* not "new england") or northern ireland* or northern irish* or scotland* or scottish* or ((wales or "south wales") not "new south wales") or welsh*).ti,ab,jw,in.	2,529,167
15	(bath or "bath's" or ((birmingham not alabama*) or ("birmingham's" not alabama*) or bradford or "bradford's" or brighton or "brighton's" or bristol or "bristol's" or carlisle* or "carlisle's" or (cambridge not (massachusetts* or boston* or harvard*)) or ("cambridge's" not (massachusetts* or boston* or harvard*)) or (canterbury not zealand*) or ("canterbury's" not zealand*) or chelmsford or "chelmsford's" or chester or "chester's" or chichester or "chichester's" or coventry or "coventry's" or derby or "derby's" or (durham not (carolina* or nc)) or ("durham's" not (carolina* or nc)) or ely or "ely's" or exeter or "exeter's" or gloucester or "gloucester's" or hereford or "hereford's" or hull or "hull's" or lancaster or "lancaster's" or leeds* or leicester or "leicester's" or (lincoln not nebraska*) or ("lincoln's" not nebraska*) or (liverpool not (new south wales* or nsw)) or ("liverpool's" not (new south wales* or nsw)) or ((london not (ontario* or ont or toronto*)) or ("london's" not (ontario* or ont or	1,818,142

	toronto*)) or manchester or "manchester's" or (newcastle not (new south wales* or nsw)) or ("newcastle's" not (new south wales* or nsw)) or norwich or "norwich's" or nottingham or "nottingham's" or oxford or "oxford's" or peterborough or "peterborough's" or plymouth or "plymouth's" or portsmouth or "portsmouth's" or preston or "preston's" or ripon or "ripon's" or salford or "salford's" or salisbury or "salisbury's" or sheffield or "sheffield's" or southampton or "southampton's" or st albans or stoke or "stoke's" or sunderland or "sunderland's" or truro or "truro's" or wakefield or "wakefield's" or wells or westminster or "westminster's" or winchester or "winchester's" or wolverhampton or "wolverhampton's" or (worcester not (massachusetts* or boston* or harvard*)) or ("worcester's" not (massachusetts* or boston* or harvard*)) or (york not ("new york*" or ny or ontario* or ont or toronto*)) or ("york's" not ("new york*" or ny or ontario* or ont or toronto*))))).ti,ab,in.	
16	(bangor or "bangor's" or cardiff or "cardiff's" or newport or "newport's" or st asaph or "st asaph's" or st davids or swansea or "swansea's").ti,ab,in.	73,476
17	(aberdeen or "aberdeen's" or dundee or "dundee's" or edinburgh or "edinburgh's" or glasgow or "glasgow's" or inverness or (perth not australia*) or ("perth's" not australia*) or stirling or "stirling's").ti,ab,in.	267,541
18	(armagh or "armagh's" or belfast or "belfast's" or lisburn or "lisburn's" or londonderry or "londonderry's" or derry or "derry's" or newry or "newry's").ti,ab,in.	35,481
19	or/11-18	3,240,034
20	(exp africa/ or exp americas/ or exp antarctic regions/ or exp arctic regions/ or exp asia/ or exp australia/ or exp oceania/) not (exp United Kingdom/ or europe/)	3,397,501
21	19 not 20	3,039,272
22	7 and 10 and 21	1,532
23	limit 22 to (ed=20171201-20240401 or dt=20171201-20240401)	650

Supplement B: Gantt Chart for Review Delivery

	2024						
	February	**March**	**April**	**May**	**June**	**July**	**August**
Protocol							
Submission to NIHR	■						
PPI Engagement							
Phase 1: Protocol	■	■					
Phase 2: Synthesis					■		
Phase 3: Dissemination							■
Searches and Screening							
Database searches		■					
Supplementary searches		■	■				
Screening			■				
Extraction and Appraisal							
Data extraction			■	■			
Quality appraisal			■	■			
Synthesis of Findings							
Synthesis of findings				■	■		
Publication and Reporting							
Draft of report						■	■
Submission to NIHR							■