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The dynamics of peer-to-peer care: Peers as radical care practitioners

JaneMaree Maher
Monash University, Australia

Danielle Abbott
The Australian Centre for Social Innovation, Australia

Tanya Zivkovic
The University of Adelaide, Australia

Abstract

Hi'ilei Julia Kawehipuaakahaopulani Hobart and Tamara Kneese (2020) define radical care as 'as a set of vital but underappreciated strategies for enduring precarious worlds' (16). Yet they sound a note of caution when they argue that 'because radical care is inseparable from systemic inequality and power structures, it can be used to coerce subjects into new forms of surveillance and unpaid labor' (16). This article explores scaffolded peer-to-peer programmes as a form of radical care. In these programmes and approaches people are connected in non-hierarchical structures of mutual support and care that locate lived experience, rather than solely professional accreditation, as powerful, inclusive and collaborative expertise. The often implicit and traditional hierarchies of care are challenged in this structuring; we argue that the dynamic and horizontal structure of peer care practices can subvert and ultimately enrich circulating discourses of self-care, commodified care and the neoliberal devolution of responsibility for health and well-being to individuals.

Keywords

radical care, peer-to-peer, family, reciprocity, care, vulnerability

Corresponding author:
JaneMaree Maher, School of Social Sciences, Monash University, Clayton, Victoria, Australia.
Email: JaneMaree.Maher@monash.edu

> Vulnerability is not exactly overcome by resistance, but becomes a potentially effective mobilizing force in political mobilizations. (Butler, 2004: 14)

In *Precarious Life: the Powers of Mourning and Violence* (2004), Judith Butler seeks to rethink the relationship between vulnerability and precarity. In a series of essays responding to the 'unbearable vulnerabilities' of a post-9/11 world, they turn towards the fundamental dependency on others that characterises life, recognising that dependencies and relationalities cannot be willed away. Annemarie Mol (2008) similarly reminds us that we are always already part of multiple collectives; though these are not always visible or valued, we are 'entangled' with them. The centrality and immutability of connection, understood by Butler (2012) as always already binding us to each other, even when such obligations are not 'chosen', inform our consideration of peer-to-peer programmes in this article and how we propose such programmes can enable care practices that can be read as radical. We argue that the settings, practices and conditions of peer-to-peer programmes, while in some ways distinct from the larger political movements Butler is exploring, are grounded in profound recognition of dependencies and relationality and that they politically mobilise, in interesting and subversive ways, the strength and power in shared vulnerabilities. In creating conditions that allow for 'good care', following Mol (2008), such programmes generate radical practices of care – practices that are multilayered, involve multiple actors, and rely on co-production drawn from professional competencies and lived expertise.

In this article, we examine one specific Australian example of a scaffolded peer-to-peer programme, to illuminate the ways in which such programmes can affirm vulnerability and dependency as positive resources. These resources are then used in design and scaffolded through diverse situated knowledges: lived experiences, collective capacities and professional input. In this peer-to-peer programme and arguably in other such programmes, one's story of overcoming 'hardship' can be reframed and reimagined into a set of useful strategies of care that can be shared in practical, useful and non-judgemental ways to ignite real change in others. In these relational radical practices of care, vulnerability is reimagined as resource, and then turned, through careful specification (Mol, 2008), to good care.

We begin by outlining the concept of, and framework for, peer-to-peer programmes especially as they are emerging in neoliberal contexts where health, well-being and security are framed as individual responsibilities. We then examine how the framing and practices of such programmes can reconstitute care and expertise, generally so mired in patriarchal structures, in gendered, classed and raced inequalities, and economic precarity, in radical and non-hierarchical ways. We give a brief account of our selected programme example – Family by Family – focusing on the multiplicity of actors, relationships and collectives involved. We argue that such programmes are clearly alive to the complexities of 'systemic inequality and power structures [that] can be used to coerce subjects into new forms of surveillance and unpaid labor' (Kawehipuaakahaopulani Hobart and Kneese, 2020: 16), but in their insistence on the relocation of expertise, they create reciprocity, capacity and hope rather than critiquing,

responsibilising or coercing individuals towards a pre-existing or externally determined model of health or well-being.

Peer-to-peer: New paradigms

Peer-to-peer support and programmes take many forms and occur in many different social contexts and settings. They have long established histories in substance abuse, in patient care in both clinical and non-clinical settings, in mental health support, and have emerged more recently in online communities of care (Gillard et al., 2015; Kelly et al., 2020; Kingod et al., 2017). One of the more established instances is Alcoholics Anonymous (AA) and Al-Anon, focused on creating peer support through lived experience of substance abuse (AA) (Kelly et al., 2020) and then extended to partner/family/intimates peer support groups (Al-Anon).

The diversity and reach of peer-to-peer programmes currently on offer globally and in Australia is extensive (TACSI, 2023); recognition of the value of lived experience and the contraction in many countries of social and care structures has driven extensive mobilisation of such programmes. While the structure, temporalities and connective frameworks in all these offerings differ, at the core of all peer-to-peer interactions are relationships of 'trust based on shared lived experience' (Gillard et al., 2015). In peer-to-peer programmes, the aim is to mobilise the expertise in the lives of those often identified as 'vulnerable' to rebuild social capital in the survivor and to create a framework for 'feeling with' the peer who is seeking support (Dennis, 2003; Kawehipuaakahaopulani Hobart and Kneese, 2020; TACSI, 2023). Dennis (2003) has argued that despite the diversity and complexity of peer-to-peer programmes, there are consistent attributes that can be identified: these include emotional support, informational support and appraisal support – that is, support to evaluate more holistically and offer reassurances in the face of ongoing challenge and complexity. Dennis's review stresses the efficacy of the 'mutual exchange of wisdom' (Borkman, 1976 cited in Dennis, 2003: 326) that creates empathy and assistance in the peer exchange. Types of support prioritised are practical assistance, side by side in context learning and support to navigate formal systems and services.

Yet the caution sounded by Kawehipuaakahaopulani Hobart and Kneese (2020) is an important one. They highlight the ways in which self-care has become a critical part of a neoliberal responsibilisation of individuals in the context of reducing social and collective resources. The discourses of childhood obesity have provided fertile fields for the operation of this responsiblisation where maternal care, family decision making and public health critiques of poor 'choices' have been central (Maher et al., 2012; Warin et al., 2008; Zizzo et al., 2021), while structural and social inequalities that influence health outcomes have been obscured. This emphasis on choice and individual responsibility is replicated across multiple diverse domains of health, wealth and social capital (Fraser, 2016; Fraser and Seear, 2016; Mol, 2008). The observation that care has normative assumptions (gendered, given freely through love, 'associated with kindness, dedication, generosity' (Mol, 2008: 5)) built in that make it ripe for co-optation (Kawehipuaakahaopulani Hobart and Kneese, 2020) is even more salient when embedded in these broader social settings of responsibilisation and individualisation.

The growth of peer-to-peer programmes that give care is in part driven by the austerities of reducing health and welfare provision in Western democracies. For such programmes to escape or avoid co-optation, the meaning and outcomes need to extend beyond the provision of care itself. They need to avoid the assumption that the connections and interdependencies of care are necessarily fruitful, even if, as Butler (2012) suggests, such interdependencies are in effect the 'social conditions of political life' (150). For Butler (2012), our ethical obligations, generated by proximity, precarity and vulnerability, are solicited and created prior to any active choice. In attending then to the design, practice and ambitions of peer-to-peer programmes, we recognise the 'already bound' nature (2012: 144) of our social worlds. We consider how specifically in our selected exemplar Family by Family, there is work to reconstitute concepts of care, to reframe and rethink the 'individual' who is positioned as the recipient of care, and to mobilise and sustain with care the ways in which we are exposed to each other (Butler, 2012). Such exposure, and its embedded precarity, as Butler (2012) recognises, is not always comfortable, but we suggest that the framing, multiplicity and multidirectional flows of care in Family by Family create conditions for practices and experiences of radical care that nourish and protect the vulnerabilities and precarity of its participants.

Reconstituting care as collective

> Care is central to life, and yet is all too often undervalued, taken for granted and hidden from view. (Harding et al., 2016: 1)

Reflecting on the 'discursive explosion of care' during the COVID-19 pandemic, Chatzidakis et al. (2020a, 2020b) argue that 'care' was previously not cited as a social, cultural or political keyword, despite the fact that 'the meanings and practices of "care" have always constituted an inescapably pivotal cultural arena' (2020a, 2020b: 890). Acknowledging the many decades of work of feminists and activists seeking to address the systemic neglect of care – as work, as labour, as resource – they nonetheless suggest that it required a global pandemic to make 'care' visible at the centre of our social systems, where in fact it had always been. This contention may or may not be accurate; Mol (2008), for example, considers that the rich traditions of care in Western societies have already been well traced as she wrote *The Logic of Care*. Notwithstanding diverging temporalities, the history of feminist and activist interventions and assertions around the centrality of care is important for a number of reasons. The gendered inequalities of care, local, national, transnational and global have always meant that caring for care is feminised work, much as care itself is feminised. For a considerable number of decades, discourses of care deficit, global care chains (Ehrenreich and Hochschild, 2003), care crises, interrogations of the care temporalities of intensive mothering (Hays, 1997) and the economies of paid and unpaid care (Bryson, 2007) have been at the centre of feminist theorising of the social. A shared dynamic in these interventions has been a determination to confront and challenge the persistent gendering of care that creates temporal, social and economic costs for the providers even as it sustains existence and being. In many instances, feminist interventions have worked to illuminate how the changing 'legal,

social and political responses to care needs and care provision' (Harding et al., 2016: 2) interact, shape and constrain the practices and provision of care.

As Beasley and Bacchi (2005) have observed, there is great value and importance in feminist assertions of the ethical value of care, but risks that in such assertions, the specificities of care – the doing, the costs, the assumptions – may be obscured or essentialised. They argue for the importance of a political analysis of the settings and practices of care, suggesting that 'care ought to be seen as an important social practice, which should be considered in political deliberations' (2005: 55). Fraser (2016) cautions that the ways in which capital is used to create a 'value' for care contributes to its destabilisation; she highlights the inherent contradictions that emerge when social reproduction coexists in capital. Mol (2008) similarly urges the importance of disentangling care from concepts of tenderness and dedication, in order to be better able to see the practices, specificities and outcomes of care structures and settings. It is therefore with attention to the relevant political contexts and with caution about co-optation that we turn now to our selected peer-to-peer programme to consider if and how peers giving and receiving care in such a context might be considered to be radical practitioners.

Synthesising feminist paradigms of care and peer-to-peer support

Family by Family (TACSI, 2023) is a peer-to-peer programme founded in Adelaide, Australia more than a decade ago. The programme links families in community/local contexts to support them to make the 'changes they want to make as a family'. Families come into the programme as either 'Seeking Families' – those who are seeking support to make a positive change in their lives, or 'Sharing Families' – those who can give support based in and on the expertise and resilience of their lived experiences, and consider they have something to share. The needs and goals of each connection are articulated by the Seeking Family and supported by the Sharing Family: family members of any age can be and are involved as active members of Seeking and Sharing Families. Commonly cited goals are more resilience in the family group, better connections to relevant services or community, and sometimes support through specific family issues such as financial insecurity or family violence.

The Family to Family connection is called a 'Link Up' and is supported by Family Coaches (a cohort of trained professionals who sit in the background and support the relationship between the families). Family Coaches are local and embedded within community and context. Sharing Families are trained and supported through an ongoing group supervision and coaching model. Seeking Families are given choice and control throughout the entire process, including which Sharing Family will support them (rather than the professional determining this match), their change goal, what they want to work on and how they want to get there, where they meet, and both families are given decision-making agency to stay connected post the formal programme. A Link Up can run for 10, 20 or 30 weeks depending on the change goal set (defined by those involved in the process). Further choice is given to families about where they meet weekly across the course of the Link Up; this could be over a meal, in the park, or doing the shopping together. Sharing Families support Seeking Families to connect to local and community organisations if this assists them to work towards their goals; often this support includes the

Sharing Family drawing on their own lived experience of navigation to help shortcut Seeking Families to better outcomes or de-jargoning the formal service systems to be better understood and engaged with by the Seeking Family. Every member of the Sharing Family is considered a 'Peer Mentor', including children, who are provided with their own 'Kids' Coaches'. In the same way, every member of the Seeking Family is considered in the goal setting that supports whole families to work towards the change they want to make. This approach we would argue has the elements that Mol (2008) suggests work to enable 'good care', where the practices in place (specificity, co-design, recipients of care as active not passive) create 'situations of choice' rather than choices.

The Family by Family programme emerged through a co-design process where the expertise and competencies of those with lived experience and professionals were mutually valued and important; the strengths and potential that emerge from such 'co-production' (as defined by Siira et al., 2020) have been identified as consistently important in the programme's success and value (Curtis, 2012; Warin, 2018; Zizzo et al., 2021). As Warin (2018: 120) observed:

> The Family by Family model thus acknowledges the experiences of families in the community, and the power of sharing a deep (and tacit) knowledge of the challenges of everyday lives.

Family by Family exemplifies the critical elements of peer-to-peer programmes outlined by Dennis (2003) but in its collective settings, i.e. through the rubrics of 'family and community', it reinforces and perhaps extends the interdependencies and relationalities that distinguish peer-to-peer programmes. We would go further and argue that its configuration exemplifies what Kawehipuaakahaopulani Hobart and Kneese (2020) have identified as important in radical care: that the 'self' to be cared for is not an individual self but rather a 'situated self' interconnected into many different and complex networks. Following Mol (2008), it actively recognises the variety of collectives in which we are all situated as resource and capacity. This programme mobilises inter- and intra-family skills and capacities, and locates the living, experiencing community as a resource for all participants. Each actor, at every layer (within each Family, in Coach and Family supervisions, and in the Coaching cohort), is engaged in material, reciprocal and, arguably, radical practices of care. Yet, in the articulation of family-specific and family-centred goals that is central to the Link Ups, there is recognition that interdependencies, vulnerability and precarity, while constitutive (Butler, 2012), need to be carefully considered and managed.

Many Seeking Families have goals related to health and well-being and it is useful perhaps to focus here more fully on the link between health and the radical care practices that we argue underpin Family by Family. Mol (2008) argues for the complex and important link between care and contemporary settings of health and disease. Kawehipuaakahaopulani Hobart and Kneese (2020) argue that radical care has always included health advocacy and food justice programmes, given the critical role that the skewed distribution of resources plays in sustaining social inequities in health and well-being. In an analysis of obesity prevention interventions in Amsterdam, Vogel (2021) explores different types of interventions in the Amsterdam community and identifies

the successful ones as initiatives that come from the 'situations, concerns and abilities of neighbourhood communities' (2021: 1073). In line with Warin's (2018) observation that the provision of nutrition information is not the same as exchanges in kitchens that support everyday change, Vogel (2021) cites the mundane practices that facilitate the translation and take-up of policy objectives rather than the implementation of policies.

Importantly and usefully in Vogel's analysis (2021), health is not located in individual bodies, but rather exists collectively, across bodies, materialities and environments (see also Mol's (2010) discussion of the collectivities in a patient–doctor interview). Such a formulation resonates with peer-to-peer programmes such as Family by Family where location, neighbourhood and collectives (within family structures, within communities, across layers of service provision) are mobilised. This location-specific approach to peer-to-peer creates a framework for 'situated caring' (Vogel, 2021), a marker of peer programmes where lived experience, vulnerability and resource, not deficit, are identified and mobilised. The mundane practices of care that contribute to this larger, interdependent formulation of 'health', we would argue, confront and subvert the potential co-option of care in a number of significant ways.

In these reimaginings of care, vulnerability, collectively, interdependency and the marks and perhaps scars of lived experience become resources; complexities provide opportunities and openings and communities are made resilient by active recognition of, and care for, the interdependencies of vulnerability and precarity. As Zizzo et al. (2021) have argued and as Butler (2004) identified, vulnerability can be rethought and remade as resource; which means that the flows of caregiving, care receiving, and the inequities in whose caring is recognised (Kawehipuaakahaopulani Hobart and Kneese, 2020) are challenged. Situated acts of care, emerging relationally, not predefined but through negotiation (Vogel, 2021) or the creation of 'situations of choice' (Mol, 2008), such as the 'goals' identified by Seeking Families in Family by Family, make co-optation harder. The positioning of vulnerability as relational and social (Butler, 2004; Zizzo et al., 2021), as a part of the ethical obligations to others that are a condition of existence (Butler, 2012) rather than as attributable to an identity or assigned to types of bodies or identities, means such practices are less readily captured into broader, potentially exploitative, political systems (Beasley and Bacchi, 2005) or forced population-based collectives (Mol, 2008).

Indeed, it is in the exposure of vulnerabilities and the retelling and revisioning of biographical hardships that radical care is enacted. Referred to in the programme as 'scaffolded support', Sharing Families are carefully trained by Family Coaches in how to narrate their adversities and demonstrate lived experience of crisis while offering creative solutions and strategies to Seeking Families living through 'tough times'. And over the course of a 'Link Up', Coaches hold regular sessions with Sharing Families that are designed to support them as they assist Seeking Families to tackle what they consider to be their most pressing problems. In this process, families' problems are shared and addressed collectively, and they are situated interdependently in the relational contexts of lives, neighbourhoods and communities. So, being unable to feed the family or put a roof over one's head is recognised as a consequence of other social problems (e.g. food insecurity, housing unaffordability, income inequality), rather than an individual

issue of failing to care for the self or one's family. These consequences and 'choices' are situated and made collective rather than individually assigned.

Scaffolded by layered relations of care that wrap around Coaches and Sharing and Seeking Families, the programme provides assistance to those who are often overlooked or blamed by neoliberal institutions, assisting them at critical junctures to remake their social worlds. To some extent, Family by Family comes to 'stand in' for these failing infrastructures of care. And practitioners may also, as the name suggests, assume family relations, acting as surrogate kin. Many of the families who seek assistance through the programme do not have regular contact with or receive practical support from their own extended families, who may live elsewhere (especially in the case of 'new arrival' migrant families) or who may themselves be struggling to manage their own health, households and finances, in intergenerational cycles of poverty and hardship produced under conditions of late capitalism. In creating alternative models of kinship, Family by Family enables what Chatzidakis et al. (2020a, 2020b) refer to as 'promiscuous care'. Expanding AIDS scholar Douglas Crimp's notion of promiscuity in relation to care, support and 'kin' relations within the gay HIV community in the 1980s and 1990s, 'promiscuous care' here relates to relations of intimacy and care beyond 'the family' and 'the market' and acts of care that cannot be singularly defined or costed. In stark contrast to neoliberal self-care or reductive models of care narrowed to biological kin or effective individual choice from a range of discrete market options on offer, Family by Family practitioners exhibit forms of care that are outward-looking, multidirectional and collective, created specifically in the context of each Family by Family journey and which often surpass state provisions that prove increasingly inadequate in their capacity to care (Kawehipuaakahaopulani Hobart and Kneese, 2020).

Family by Family emerges then as both a result of and a response to the dismantling of state responsibility and its associated 'crisis of care' (Fraser, 2016). Locating this crisis in the social contradictions of neoliberal capitalism, feminist political theorist Nancy Fraser argues that our contemporary dysfunctions of care entail a systemic exhaustion of the resources available within public systems and in domestic spaces for sustaining social connections. Marked by decreased state provisions and increased household debt and precarity, the current regime of capitalism, what Fraser (2023) refers to as 'cannibal capitalism', destroys its conditions of possibility by destabilising the (gendered) relations of care and social reproduction on which it depends. With fewer provisions available, families and communities are increasingly positioned as unable to care for themselves or for others; the boundaries of exposure and interdependency (Butler, 2012) are obscured for the well-resourced and made painfully visible for those situated further down the social hierarchy. The well-resourced can address the disappearance of care, while those most exposed lack any viable means to outsource care.

Family by Family, in its mobilisation of families who have faced the challenges and deficits wrought by contemporary social conditions as experts, offers possibilities for care in the context of this care gap. It moves away from definitions of care tied to failing and starved systems and allows 'care' to be thought by those who have received almost none from such systems. And while this peer-to-peer programme will of course be affected by these conditions, following Mol (2008), it is possible to argue the logic of care, and the practices that reflect, enact and share that care, mobilised here, differ profoundly from the

exhausted and limited choice model. As such, both Seeking Families and Sharing Families, themselves comprised of unwaged (and mostly women) volunteers who commit their household's time and expertise, do, in part, embody the systemic inequalities that underpin this current crisis of care, but they also step away and begin a different conversation born of proximity and some shared experience. Butler (2012) describes the complex forms of ethical solicitation to responsibility that prefigure choice and responsiveness; their attention is primarily on those solicitations as they engage us across distance. In Family by Family, proximity is central, but arguably the ethical solicitation is to respond outside conventional and delimited models of care. While the crisis of care requires deep structural transformation and cannot be resolved locally by community peer-to-peer programmes, Family by Family's enactment of 'radical care can present an otherwise, even if it cannot completely disengage from structural inequalities' (Kawehipuaakahaopulani Hobart and Kneese, 2020: 3).

Conclusion

> Theorized as an affective connective tissue between an inner self and an outer world, care constitutes a feeling with, rather than a feeling for, others. When mobilized, it offers visceral, material, and emotional heft to acts of preservation that span a breadth of localities: selves, communities, and social worlds. (Kawehipuaakahaopulani Hobart and Kneese, 2020: 2)

The winnowing out of state provision of care and the relentless responsibilisation of individuals as agentic actors in contemporary Western societies present critical challenges to sustainable and liveable lives. Such lives are always already bound together (Butler, 2012), despite the unwillingness of contemporary political systems and structures of care delivery to acknowledge this exposure to the other. However, the recognition of lived expertise, of shared vulnerabilities as resource, and of the potential enabled by active reciprocities in family, community and professional knowledges are also a part of this landscape. Family by Family – created and pioneered in the families, communities and professional settings it serves – is a peer-to-peer programme that, we argue, exemplifies such potential. This programme creates conditions that allow for 'good care', following Mol (2008), which include simple and 'mundane' exchanges, such as a shared picnic at a local park, and deep knowledge that allow families to confront, challenge and make the best use of 'exhausted' social services. In its relationally defined goals and modes of responsiveness, it steps aside from reliance on failing models of care provision. We argue Family by Family and other programmes of its ilk can generate radical practices of care – practices that reinforce 'feeling with' and being present in the everyday needs, capacities and possibilities of those often incorrectly designated as without resource.

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