

Review of Evidence - peer support for breastfeeding

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This review defines peer support and looks into how peer support schemes have been developed in the healthcare system. It looks at the available evidence on the effectiveness of peer support for increasing breastfeeding initiation and continuation. It also considers the effects of peer support for disadvantaged women and in terms of exclusive breastfeeding. Attention is paid to the important role peer support appears to play alongside other interventions aimed at increasing breastfeeding. The qualitative evidence is explored and evaluation challenges are addressed. As much further research is needed, there is a review of questions that are currently unanswered.

Background

'Peer support' is an approach in which women who have personal, practical experience of breastfeeding offer support to other mothers. This kind of mother-to-mother support can happen informally but most of the evidence is from evaluations of peer support schemes arranged within a healthcare setting.

Offering peer support for breastfeeding through the healthcare system began in America where a range of training programmes for peer supporters have been used, especially training developed by La Lèche League (LLL). Since the 1980s, this approach to providing support for breastfeeding women has spread to many parts of the world. Peer supporters have been working in the UK for more than a decade often trained by LLL leaders, or by health professionals trained by LLL. Increasingly, health professionals and NCT breastfeeding counsellors are devising peer supporter training and support schemes with the aim of responding flexibly to local needs.

The term 'peer support' is sometimes used only to refer to support offered within disadvantaged communities by local mothers, after a short training. However, the term can also be used to include other kinds of organised breastfeeding support from more extensively trained supporters who have personal experience of breastfeeding, such as NCT breastfeeding counsellors. NCT breastfeeding counsellors have all had personal experience of breastfeeding; they are explicitly woman-centred, and have a high level of embodied knowledge, as well as formal knowledge and skills enhanced through training. The requirement to have breastfed and take a woman-centred, non-directive approach to supporting breastfeeding, together with the unpaid, voluntary nature of much of their work sets them apart from health professionals. Breastfeeding counsellors trained by other voluntary groups such as LLL, Breastfeeding Network and the Association of Breastfeeding Mothers share some but not necessarily all of these characteristics.

Research studies and evaluations of schemes do not always make their working definition of peer support explicit. Some studies focus exclusively on mothers in disadvantaged communities who have had a short period of training, others include those with more extensive training. Similarly, the term 'counsellor' is used in some research and may be used to mean those with extensive training, such as NCT breastfeeding counsellors, or peer supporters who have had a short course of training.

The authors of a recent systematic review of interventions to promote the initiation of breastfeeding define breastfeeding peer supporters as 'trained and knowledgeable experts outside of a professional capacity... who have breastfed successfully themselves and have undergone some training on breastfeeding' who typically work 'in a voluntary capacity within their resident community'.¹ Raine compares peer supporters with doulas.²

The evidence

Two systematic reviews have looked at evidence about peer support programmes, concentrating on their effect on the initiation of breastfeeding in groups with low breastfeeding rates.^{3,1} However, only a limited number of studies met the quality criteria for inclusion, and they were almost exclusively quantitative in nature. The reviews concluded that breastfeeding initiation appeared only to make a measurable positive difference among women had already decided not to bottle feed. However, peer support interventions helped women to sustain breastfeeding. A further review by Sikorski and colleagues, which used a broad definition of 'lay' support including access to support from breastfeeding counsellors, found that this support only increased duration of breastfeeding where initiation rates were already high.⁴

One more recent randomised control trial, carried out in the UK, showed that peer support appeared to have a limited impact on the duration of breastfeeding in an area of low uptake. More women continued breastfeeding to six weeks but this effect was not evident at further time points.⁵

The box below is taken from the conclusions of a summary of review findings addressing the impact of peer support in relation to both initiation and continuation of breastfeeding.⁷

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Findings of Renfrew and Woolridge

Promoting Initiation

In terms of initiation, Renfrew and Woolridge found that **peer support programmes involving pregnant women and mothers in the postnatal period;**

- are especially useful for women on low incomes who have expressed a desire to breastfeed
- should be delivered by a trained 'counsellor' (a locally resident mother who has breastfed and received some training)
- or by mother-to-mother support groups led by a trained counsellor in women's homes or community centres

Continuation of breastfeeding

In terms of **supporting the duration of breastfeeding in the community**, the review concluded that peer and professional support both work, though there are some differences:

- peer support appears to increase exclusive breastfeeding but not necessarily overall duration
- professional support appears to increase overall duration, with less effect on exclusivity.

Supporting both initiation and continuation of breastfeeding

Multifaceted interventions beginning during pregnancy and continuing into the postnatal period seem to be especially effective, influencing both initiation and continuation. These interventions include peer support in combination with health education, media programmes, and/or interventions in the health service, such as training of health professionals and changes in government and hospital policies.⁷

Sikorski et al reach the following conclusions on the different strengths of health professional and voluntary support, on the basis of the quantitative evidence currently available.

‘There is clear evidence for the effectiveness of professional support on the duration of any breastfeeding although the strength of its effect on the rate of exclusive breastfeeding is uncertain. Lay support is effective in promoting exclusive breastfeeding while the strength of its effect on the duration of any breastfeeding is also uncertain.’⁴

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Supporting disadvantaged women

In a mapping exercise to explore initiatives intended to limit the impact of poverty and disadvantage on the health and well-being of low-income women and their babies, D’Souza and Garcia reached conclusions that reinforce those of previous reviews.⁸ They found that:

- support from a mother experienced in breastfeeding, complemented by professional services, is very likely to increase the duration of breastfeeding
- peer volunteers are particularly beneficial in *mediating* between low income mothers and healthcare professionals.

Interconnectedness of interventions

All these findings emphasize the interconnectedness of interventions involving mothers, peer supporters and health professionals; a message which is both interesting and important.⁸ The reviews suggest that peer support seems to work well when combined with other interventions, and may be a key component of the effectiveness of some multifaceted interventions, such as schemes combining peer support with a local media campaign.¹ Multiple intervention programmes associated with increased initiation often

included peer support, for example one of the more effective programmes involved antenatal educational sessions and contact with peer counsellors.⁶

Qualitative evidence

The systematic reviews are complemented by in-depth qualitative research. Hoddinott's study in the East End of London found that where low-income women had been able to see real-life breastfeeding, they felt more able to breastfeed with confidence. Time spent sitting with a woman learning a new skill, showing her what to do, preparing her for difficulties and building up her confidence was valued by women.⁹ This has been described as an apprenticeship model. It enables pregnant women and new mothers to spend time with an experienced and thus 'expert' breastfeeder from whom they can receive regular emotional support and encouragement. These findings point to peer support as a potentially helpful intervention.

Dykes evaluates the evidence from 26 peer support schemes in her report on the 79 Department of Health funded breastfeeding support projects. The majority of these used the LLL training programme.¹⁰ The qualitative evidence in the report suggests that women appreciate peer supporters' help. Women reported that they had continued breastfeeding at critical points because of having help from peer supporters and 'valued the experiential knowledge of peer supporters, role modelling and practical support', feeling they brought 'practical realism'.¹⁰

However, the size and scope of most of these projects meant that they were unable to provide statistical evidence of any change in breastfeeding rates locally. It is now increasingly recognised that in order for measurable change to occur in a particular aspect of social behaviour many other changes must occur first, such as changes in attitude, motivation, and access to information, encouragement or support. It is important to evaluate these developments in a local community as well as in individuals. The presence of groups of women in the local community with increased confidence in breastfeeding, may have an important effect on local women's attitudes and expectations. However, these changes are likely to be slow to take effect and be difficult, though important, to measure.

In addition to the impact of peer support programmes, other interventions taking place at the same time, such as local hospitals moving towards Baby Friendly status, make it impossible to attribute any measurable changes in breastfeeding rates to the influence of peer support alone. There is however some evidence from one of the support projects, evaluated by Battersby, for an increased rate of breastfeeding, at initiation and later points, as a result of peer support.^{10,11} As well as the methodological difficulties of determining cause and effect, researchers often face difficulties in obtaining reliable breastfeeding data for the local population and subgroups within it. Dykes concluded:

'With appropriate infrastructure, i.e. co-ordination, staffing, and funding, these small projects are likely to grow and develop and hold promise for increasing both breastfeeding initiation and continuation rates. Their capacity to empower those living within socially excluded communities should not be underestimated.'¹⁰

In addition to the support experienced by new mothers and the potential effects on breastfeeding, the effects for the peer supporters should not be overlooked. Where

investigated and reported, it has been found that peer support programmes enhance the personal growth and general confidence of mothers undertaking training and working in their local community supporting pregnant women and new parents.^{5,12,10}

Evaluation challenges

Finding out about how peer support works as an intervention is difficult because of the complex social interaction involved. This is very different from comparing alternative drugs or assessing the effect of a clearly defined clinical intervention.

‘(M)eta-analyses and systematic reviews of effectiveness rely heavily on controlled evaluation studies and statistically measurable outcome variables. In contrast, public health interventions to promote the initiation of breastfeeding are highly complex and relational, and almost impossible to capture in terms of quantitative outcomes alone.’⁶

In addition, while clinical interventions may work cross-culturally, peer support programmes may need to be tailored to fit in with the beliefs and normative behaviour in different geographical and cultural settings, to ensure that local needs are met.

In summary therefore, peer support is a complex social intervention carried out in different cultural settings and often alongside other interventions that may influence breastfeeding. In addition, it may be difficult to obtain reliable baseline data from which to measure any change in breastfeeding rates. Despite these methodological challenges, there is evidence that peer support makes a difference, particularly for low-income women, when offered alongside other interventions designed to increase breastfeeding, and in terms of the length of exclusive breastfeeding.

Unanswered questions

Given the challenges inherent in evaluating peer support for breastfeeding, there are - not surprisingly - many unanswered questions. Numerous issues need to be explored further, particularly in view of the probable expansion of peer support in this country, and the promising potential it offers for enabling more women to initiate and continue exclusive breastfeeding for longer, especially when introduced alongside other initiatives to promote breastfeeding.

Some of the most pressing questions are listed as bullet points below, followed by discussion on the available literature.

- How ‘equal’ do peer supporters need to be with the women they are supporting for acceptability and effectiveness?
- What is the best means of recruitment?

One paper suggested peer supporters should share the mother’s ‘social and cultural heritage’.¹³ A variety of criteria for selecting peers are described. In the UK, the most common route of entry has been recommendation by local health professionals, but one project also advertised locally for interested mothers.¹⁴

In many programmes it is clear that peer supporters have a different demographic profile from the women they support, for example having higher rates of marriage and post-school education than the mothers they are supporting.¹⁵ Qualitative research drawing on the experience of peer supporters in a bottle-feeding culture also indicates that women who breastfeed and those recruited as peer supporters are different from the other women around them, in terms of their attitudes.¹⁶

Deleted: .

- What are the best ways for peer support programmes to be delivered?
- When an opt-in scheme is available, what are the views of those *not* opting into receiving peer support?
- Do women feel under pressure or compromised when opt-out schemes are established?

Peer support schemes can either be set up as an opt-in or an opt-out service. The former is based on interested women in the area requesting support or going to the place where support is available. The Graffy et al trial used this model which relied on interested women proactively asking for support from a non-professional breastfeeding counsellor.¹⁷ The latter approach means that all eligible women are routinely allocated to peer support. Evidence suggests that opt-out schemes may be more effective in helping greater numbers of women to sustain breastfeeding. Graffy et al found that even women with specific difficulties were reluctant to take the initiative to contact a breastfeeding counsellor.¹⁷ On the other hand, the opt-out approach can be seen to compromise a women's autonomy to decide what services to access, and could potentially result in a feeling of unwanted moral pressure from peer supporters.

- How can programmes be sustained and renewed over time?
- What might the effects be of making payments to peer supporters?

There are some accounts in the literature focusing on this important question. For example, De Maza et al have described how an LLL project was sustained by encouraging decision-making among those involved, frequent workshops and high personal motivation.¹⁸ However, relatively little attention has been paid to the crucial question of sustainability and renewal. This is particularly pressing, as some of the project accounts reported by Dykes indicated that health professionals were concerned about having insufficient time to support the work.¹⁰ One of Dykes' recommendation is that there could be research into 'the development of mentoring systems for new peer supporters i.e. peer supporter-to-peer supporter'. The issue of paying peer supporters has received some attention but many questions remain as to how this may contribute to sustaining programmes over time.¹⁰

- What are the most suitable methods of training peer supporters?
- What theoretical underpinning is most appropriate for training programmes?

Research is needed into the most appropriate training for those who support breastfeeding mothers.⁴ It is possible to train peer supporters using a variety of different training packages. These may be based on different assumptions about breastfeeding or differing attitudes to women and babies. The objectives of training vary, as do the time

and other commitments required from those recruited. The wide variety of training packages being used currently involve different methods of facilitation, some using lectures while others concentrate on interactive methods; and some with input solely from health professionals, while others involve breastfeeding counsellors and other mothers who have breastfed.

Currently, there is little critical analysis available about what is learned and how it is learned. Also, little interest has been shown to date in detailing the knowledge of those delivering the training to peer supporters. Even less attention has been paid to their facilitation skills. Dykes concludes that there is a need for 'an evaluation of the effectiveness of various methods of preparing health professionals for a facilitative role in peer support programmes'.¹⁰

- Which communication skills models are most effective?

Primary research, using qualitative methodologies, is needed to explore the different elements of breastfeeding support strategies and the mechanisms by which support operates.⁴ Evaluations of peer support schemes are important but cannot be expected to address the fundamental questions that are central to supporting breastfeeding effectively. For example, descriptions of peer supporters giving 'advice'² are not questioned, problematised or explained. The word 'counselling' in many accounts is also used in a way that implies an advising model. Morrow et al are unusual in acknowledging different models of counselling and suggesting that their use be explored in research.¹⁹

- What opportunities are there to review personal or vicarious breastfeeding experience?

Few of the descriptions of peer support programmes discuss opportunities to review and reflect on personal beliefs and experiences. Dykes suggests that health professional peer support trainers should have such an opportunity to do this, but further research is required on the extent to which this is being done and what issues emerge.

- How do peers supporters', including and breastfeeding counsellors', relationships with local health professionals influence their opportunities to reach local women in need of support?
- How do women's relationships with local health professionals enhance or create barriers affecting their access to peer support?

One finding from several studies is that there are sometimes difficulties between peer supporters and those health professionals who might provide them with access to mothers.^{5,10} Dykes noted that peer support programmes where health professionals and/or qualified breastfeeding counsellors were available alongside peer supporters were particularly appreciated by women. Professionals 'adopted a "background" facilitative role but provided skilled evidence-based support when required'.¹⁰ The *complementary* use of health professional and peer support is described as promising by

Dennis²⁰ and another paper suggests that consistent information can be a positive result.¹⁴

Some of this material discussed in this briefing is explored in more detail in another publication.²¹

Key points

In summary, peer support programmes have been found to:

- help women to sustain breastfeeding;
- are especially useful for women on low incomes who have expressed a desire to breastfeed;
- enable peer volunteers to mediate between low income mothers and healthcare professionals;
- appear to increase exclusive breastfeeding but not necessarily overall duration;
- may complement the effect of professional support and seem to work well when combined with other interventions to promote or support breastfeeding.

There are many unanswered questions about how best to train peers supporters and sustain peer support schemes over time. As well as the need for further evaluation research to assess the utility of specific programmes of intervention, there is a need for primary research to explore some of the fundamental issues which affect the nature and intentions of interventions to support breastfeeding.

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