Breastfeeding peer support: lessons for design

In one of three linked pieces, Heather Trickey, from DECIPHer at Cardiff University, highlights findings that may give new breastfeeding peer support interventions the best chance of working

See also 'Breastfeeding peer support: what's available on the ground and where are the gaps?' by Aimee Grant, and Women's reflections on breastfeeding peer support' by Vanita Bhavnani.

In the UK most women stop breastfeeding before they plan to do so.[1] Failure to offer support in the hours and days after the birth means that many mothers do not get the help they need to establish breastfeeding. One way to provide more support is through training breastfeeding peer supporters – usually local women, who have had their own experience of breastfeeding, to offer a listening ear, information and practical help for overcoming breastfeeding difficulties.

This idea of lay and community support is recommended by the World Health Organization as part of national strategies to improve breastfeeding rates.[2] It is particularly relevant to the UK, which has one of the lowest rates

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of breastfeeding in the world.[3] UK national guidance also recommends breastfeeding peer support.[4]

Exactly what kind of peer support is best to introduce, however, is not clear. Experiments of breastfeeding peer support have produced mixed results. International reviews indicate that additional support for breastfeeding can be effective in high income country settings.[5] However, randomised controlled trials (RCTs) of breastfeeding peer support in the UK have shown little impact on breastfeeding rates,[6] though findings from a recent natural experiment have been promising.[7] Lack of evidence from UK experiments may be because these have tended to be based on interventions with a low intended number of contacts between mothers and peer supporters and have run into implementation problems.[8]

In the UK there is a very uneven landscape for infant feeding behaviours and infant feeding support – in other words, breastfeeding rates vary considerably[1] and not all maternity care facilities have achieved the same 'usual care' standard of support for breastfeeding.[9] Furthermore, the evidence for what is or is not effective is confusing, particularly because each intervention and its setting is contextually unique;[10] experimental studies tend not to take account of the way small variations can cause interventions to play out differently.[8] This means that UK providers and commissioners of peer support are left with many questions:

- Which kinds of peer support interventions have the best chance of working in which areas?
- How does the health care system need to adapt to the intervention?
- How should peer supporters be selected and trained, when and how (and how much) should they make themselves available?
- Which mothers should peer support initially be directed to?
- What are the processes by which we expect change to happen?
- Thinking about individual mothers, and thinking about the whole locality, what change is it reasonable to expect, and over what time scale?

Unpicking the evidence around breastfeeding peer support

To address these sorts of questions we have conducted a different kind of study – a realist review of breastfeeding peer support experiments delivered in high income country settings. Realist reviews don't ask 'Did the intervention work?' Instead they ask, 'How and why did the intervention work, or not work, in this context or environment, with this population?' And 'What transferrable lessons can I draw?'[11]

Our realist review included 15 breastfeeding peer support intervention cases delivered in the USA, Canada and the UK. All were intended to improve breastfeeding rates among mothers of full-term babies. We found that each intervention case was unique. Interventions varied according to the number of contacts and time points for delivery along the woman's pregnancy and postnatal journey. The interventions varied widely according to the motivation levels of women receiving support, the criteria by which peers were selected, the levels of training provided to peers, the healthcare settings and levels of social and economic deprivation of different areas.

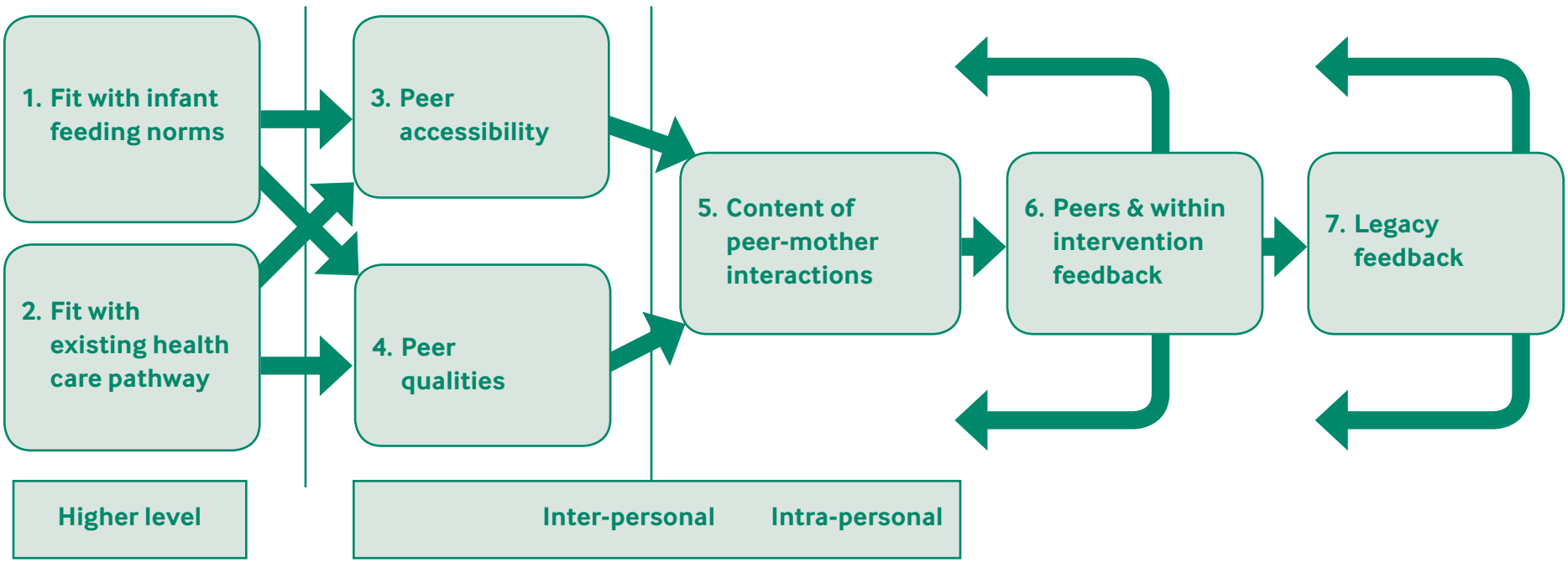
From our study, we have drawn lessons to give new breastfeeding peer support interventions the best chance of working. We hope these will be useful to anyone involved in developing and providing peer support, including volunteer breastfeeding counsellors and peer supporters, midwives and other health professionals, service providers and commissioners.

A full account of the review findings is in Trickey H, Thomson G, Grant A, et al. A realist review of one-to-one breastfeeding peer support experiments conducted in developed country settings. *Matern Child Nutr* 2017; in press.

Lessons for design and delivery

We found that one-to-one breastfeeding peer support interventions rely on a whole sequence of mechanisms – illustrated in Figure 1. An intervention will fall at the first hurdle if it does not consider upstream influences, such as local feeding behaviours or existing care pathways.

Figure 1: Areas for consideration in design for one-to-one breastfeeding peer support interventions



We identified seven areas for lessons for intervention design, indicated by the numbered boxes in Figure 1. Lessons for each of these areas are discussed below.

1. Fit with local feeding norms

In communities where formula feeding is socially normal it is probably unrealistic to expect a peer support intervention to change the minds of large numbers of women who were not already considering breastfeeding. In such areas, it may be fruitful to focus on making sure that women who do decide to breastfeed are well supported and have an experience from which they go on to tell positive stories about their experiences to others. If the aim is to reach a whole community, providers will need to think through how support can be inclusive without undermining a goal to encourage, enable and affirm (locally unusual) decisions to breastfeed – for example by including support for safe and responsive formula feeding and facilitating compassionate conversations between mothers who are feeding their babies in different ways.

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2. Fit with the existing health care pathway

Peer support interventions often rely on support from health professionals. Our review confirmed that it is unlikely that an intervention will work as hoped if maternity care professionals are ambivalent about breastfeeding or are not on board with the idea of working alongside peer supporters.[12] If health professionals do not buy into the intervention, referral pathways won't work and mothers will tend to receive mixed messages about the credibility of the intervention. Interventions are less likely to succeed in hospital settings where formula supplementation rates are high and health professionals themselves lack knowledge and skills to enable breastfeeding. In such settings peer support can end up being remedial rather than additional. An intervention is more likely to be accepted by health professionals if they have had a positive prior experience of working alongside volunteer breastfeeding supporters and if a respected health professional acts as 'champion' for the intervention. For effective and mutually acceptable alongside working, roles of peer supporters need to be well defined.

3. An accessible peer supporter

Help needs to be timely. Contact with mothers needs to reflect the 'pivotal points' where mothers run into difficulties and change their minds about breastfeeding.[13] Women from all backgrounds feel uncomfortable about approaching volunteers for help with feeding. Most leave it until problems become serious, and many simply never ask for help.

In the UK, it is very common for women to stop breastfeeding in the first two days,[1] during which time many women do not get the help they need to establish breastfeeding. Against a backdrop of NHS resource and time pressure, lack of support to establish breastfeeding represents a huge gap in the health care pathway. If volunteer peer support is intended to make a difference to the number of women establishing breastfeeding by filling this 'early days' gap, then intervention design will need to enable peers to achieve a proactive contact with the mother during this period.

4. A peer with the 'right' qualities

We were surprised to find that, for one-to-one peer support interventions, peers and mothers did not need to be matched socially or to have specialised breastfeeding knowledge to be perceived as friendly and competent by the mother. This may be because in one-to-one interventions mothers sometimes see peer supporters as paraprofessionals rather than just like them. Social similarity may be more important in group settings. There is some evidence that social similarity does help where there are specific cultural issues or anxieties about feeding, or a language barrier. Sometimes there may even be a downside to similarity, for example, if both peers and mothers have complex and unstable lives or many competing demands and responsibilities, then it may be difficult to recruit and retain peer supporters.

We were again surprised that extensive peer training did not emerge as important for helping mothers to initiate or continue breastfeeding. It may be that emotional support is key, or that what counts is having a way for mothers to access expert help from *somewhere* within the care pathway, with peer supporters providing a valuable referral point. Peer supporters benefit from opportunities to train and socialise with one another, and tend to be more

committed when they feel their support was valued and well integrated with other services.

5. Inside the peer-mother relationship

We confirmed that mothers value warm and supportive relationships.[14] However, we were not able to identify any aspects of training or ways of delivering support (e.g. face-to-face/telephone, long-term/short term) that were consistently associated with the relationships mothers believed were helpful in initiating or continuing breastfeeding. We found that relationships between peer supporters and mothers can deepen over time: having contact with the same peer supporter over several months can help mothers to revisit and affirm their feeding decision. Short-term support can also be experienced as warm and enabling. And just knowing that peer support is available when needed may help mothers to overcome breastfeeding challenges.

6. Motivation for peer supporters

Over time peer supporters tend to direct their energy and time to supporting mothers who are more motivated to breastfeed and who appear to value the support they receive. Peer supporters can become demotivated if their help is repeatedly rejected. Although understandable, such preference for responding to women who show obvious motivation can mean that an intervention aimed at encouraging women who are ambivalent about breastfeeding may not fully succeed. It's also worth noting that peer motivation is adversely affected when peers lack opportunities to develop their skills and share experiences with one another.

7. The legacy of breastfeeding peer support

Trials of peer support tend to look only at short-term impact on breastfeeding rates. It may be that peer support interventions can have a longer-term impact, for example, in raising awareness and acceptance of breastfeeding, influencing a whole community through visibility and changing conversations among partners, grandparents and community leaders, encouraging health professionals to improve their skills or creating a community of activists who campaign for local change. These kinds of outcomes may signal important steps on a causal pathway to improving breastfeeding rates in communities where formula feeding is the usual pattern.

Conclusion

The realist review provides an evidence-based guide to what's needed to give one-to-one breastfeeding peer support interventions the best chance of succeeding. One-to-one peer support interventions need to be relevant to the target population, properly embedded into existing health care pathways, and introduced in tandem with professional support.

The lessons from the review do not replace the need for evaluation, though they *do* suggest the need to re-think how evaluation of breastfeeding peer support programmes is done. Peer support experiments often just measure change in breastfeeding rates over a period convenient for data collection, without specifying clearly how change is expected to happen or to be sustained. More attention needs to be paid to intervention theory, design and implementation, bearing in mind the unique circumstances of each setting.

> Breastfeeding support can only be one cog in the wheel of change

The UK continues to have internationally low breastfeeding rates and very high rates of 'breastfeeding disappointment.'[15] Breastfeeding support can only be one cog in the wheel of change. Given a goal to improve UK breastfeeding rates, there is a pressing need to understand how all the cogs work together. There is a need to evaluate how and where peer supporters can contribute to sustained changes in attitudes and beliefs, in services and culture.

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