



Evaluation of Breastfeeding Network

Final Report

March 2016



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1. Introduction and context

Introduction

1.1 Breastfeeding Network (BfN) commissioned Blake Stevenson Ltd in July 2015 to undertake a range of activities which would support its understanding of its impact and would provide a basis for the further development of the organisation and the services it offers. The activities agreed included:

- a literature review encompassing previous research, project evaluations and key policies relating to breastfeeding and to peer support;
- the development of an organisational logic model and theory of change;
- evaluation of the impact of its services exploring the impact on mothers and health and social care professionals;
- evaluation of BfN's staff understanding and confidence of evaluating their own work; and
- development of an evaluation framework for BfN to use across the organisation's varied work.

Context

1.2 There is a global, UK, national and local context for breastfeeding. The World Health Organisation (WHO) states that breastfeeding reduces child mortality and has health benefits that extend into adulthood. On a population basis, exclusive breastfeeding for the first six months of life is the recommended way of feeding infants, followed by continued breastfeeding with appropriate complementary foods for up to two years or beyond.

1.3 In order to enable mothers to establish and sustain exclusive breastfeeding for six months, WHO and UNICEF (the United Nations Emergency Children's Fund) have set out standards. These are reflected in the UK Baby Friendly Initiative, an accredited programme for improving the role of maternity services which organisations, projects and wards can apply to achieve. This is designed to support breastfeeding and parent infant relationships by working with public services to improve standards of care.

1.4 The National Institute of Clinical Excellence (NICE) recommends exclusive breastfeeding for the first six months of a baby's life, and after that breastmilk alongside the introduction of solid food¹. Despite this, breastfeeding rates in the UK are among the

¹ Maternal and child nutrition. NICE 2008

lowest in Europe with around 74% of mother's breastfeeding at birth, dropping to 47% at 6–8 weeks².

- 1.5 However breastfeeding initiation rates in the UK are among the lowest in Europe and even when started, there are rapid discontinuation rates. Societal and work culture influences, lack of awareness of the benefits of breastfeeding and socio-economic factors are some of the issues affecting rates.
- 1.6 BfN has an approach of supporting mothers and their families and friends through information, practical guidance and support. The aim is to inspire a more positive attitude towards breastfeeding, equip mothers with information to make decisions, provide them with a supportive network, encourage them to be more confident, and empower them to breastfeed for as long as they choose.
- 1.7 The approach of using peer supporters is a key feature of BfN's work and the aim of this is to create a resource of mothers with experience who new mothers can relate to and which complements other support received by mothers who have babies and young children, such as that received from health professionals.
- 1.8 Previous research outlining good practice within peer support suggests that important elements of any project using this form of support are to listen actively, keep mothers at the centre, respect a mother and support her choices and share evidence to inform early parenting choices.
- 1.9 This evaluation sought to establish the context for BfN's work in terms of previous research and policy, before setting out a rationale for its approach to supporting breastfeeding mothers and their families, and mapping the change which takes place for the mothers who they support.
- 1.10 Using this material the evaluation then explored the impact of BfN services on mothers and their families, and how BfN services linked with other health and social care services. A further element of the evaluation looked at BfN staff members', Tutors' and Supervisors' understanding and use of evaluation within their current work.

Methodology and report structure

- 1.11 The methodology for the evaluation involved:
 - desk based research to provide information for the literature review;
 - development of logic model and theory of change based on the literature review and with comments from an Advisory Group co-ordinated by BfN;
 - an online survey for mothers and friends and family supporting them, with a link distributed to contacts through BfN projects (this resulted in 203 returns);

²National Child and Maternal Health Intelligence. Breastfeeding Profiles. PHE 2012

- follow up telephone interviews with a sample of mothers who were survey respondents (26 interviews);
 - telephone interviews with a range of social care and health professionals from around the UK based on contacts provided by BfN (13 interviews);
 - an online survey predominantly distributed to BfN Project Leads and Tutor/Supervisors but which attracted slightly wider completion (23 returns); and
 - two Focus Groups (Kilmarnock and Blackpool) with mums who had experience of using a range of BfN support (12 participants).
- 1.12 The main challenges faced during the evaluation were in timing the various elements of work so that they could inform the next stage within a relatively short timescale, and gathering a sufficient sample of health and social care professionals.
- 1.13 There were some constraints in the typical process of developing a theory of change given the UK-wide nature of BfN and its staff and its relatively limited time and resources. The initial model was drafted based on discussion with BfN staff, examined and adapted by the BfN Board and further refined by a working group comprising varied roles, before being finalised. The key themes of the model were then tested through the evaluation activities of surveys and interviews.
- 1.14 This report sets out the following main areas:
- the logic model and theory of change as summaries of BfN's work;
 - profile of respondents;
 - situations, experience and challenges relating to breastfeeding;
 - attitudes about breastfeeding;
 - knowledge and information;
 - support from other sources;
 - overall impact; and
 - BfN's core values and approach and peer support.

Literature Review

- 1.15 As part of our initial research into the effectiveness of current activity and future evaluation of The Breastfeeding Network (BfN) practices, we completed a literature review of relevant publications dated 1981 to 2016, from across the UK (Appendix 1).

1.16 In order to find the publications used in this review, we conducted a search using the IDOX information service, as well as Google Scholar and government publications and policies.

Purpose and scope

1.17 This literature review helped to establish the context of the evaluation and determine effective practice of peer support both within and outside of the BfN's remit. This assisted in the development of the logic model described in the next section and assisted with the development of the research tools. It also offers BfN a baseline document summarising relevant previous work in its field.

1.18 In particular, the literature review focuses on the following:

- the reasons for breastfeeding intervention;
- policy context;
- why peer support?;
- breastfeeding peer support approaches and considerations;
- the effectiveness of peer support;
- other notable research findings;
- good practice in breastfeeding peer support; and
- evaluative strategies.

The literature review is shown at Appendix 1.

2. Organisational models

- 2.1 The early work in the evaluation developed two models as a way of describing the place, activities and impact of BfN within the context of breastfeeding. The literature review provided a basis for this and BfN staff and advisors provided comment on early drafts. The resulting Logic Model and Theory of Change described and included below and overleaf.

Logic Model

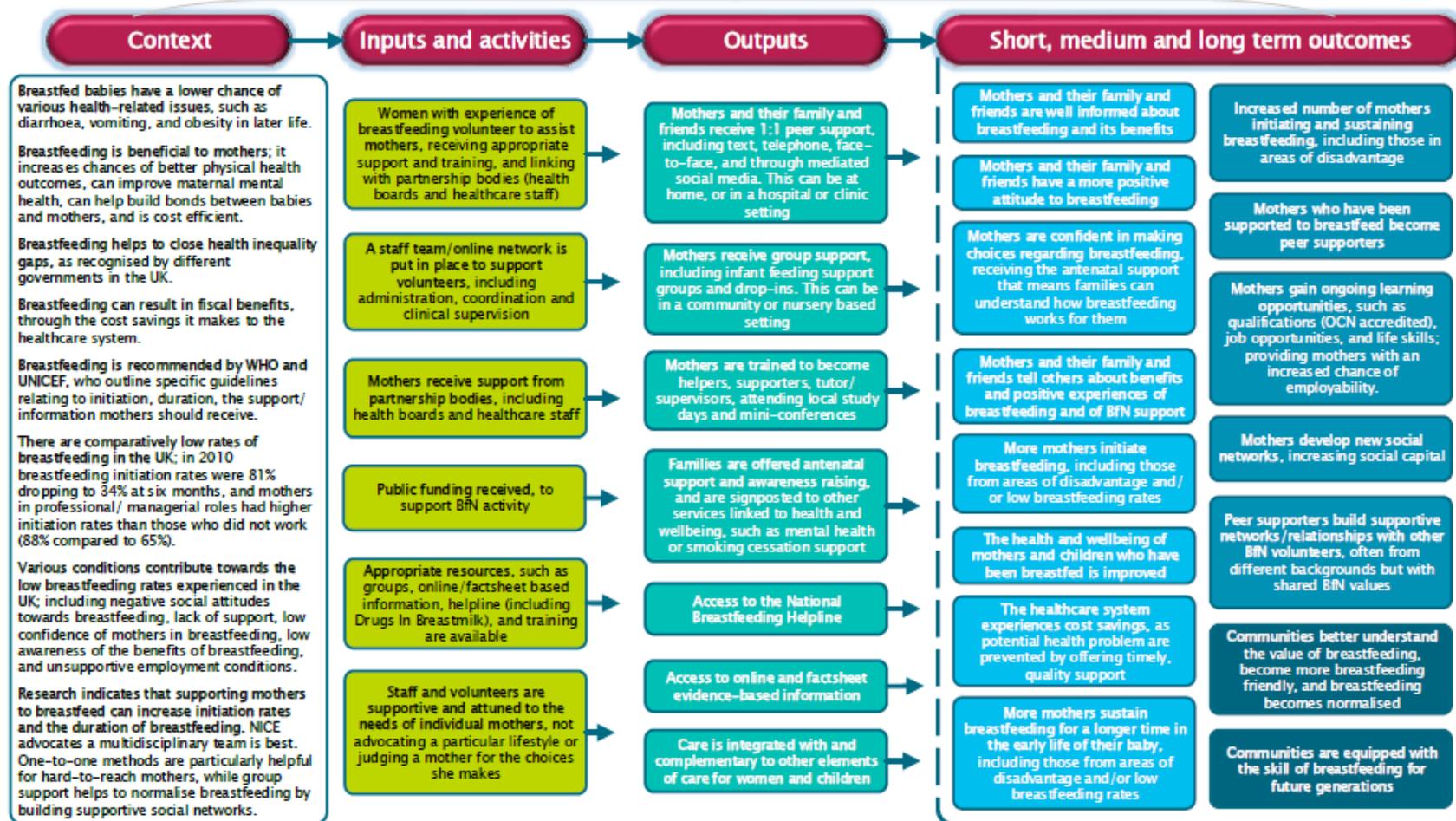
- 2.2 As noted in the previous section there are scientific, national and international contexts within which BfN is playing a part. Through the funding it receives it aims to create a resource of trained staff and volunteers and widely available information in order to inform and support mothers and their families and friends about breastfeeding. Ultimately they aim to inspire a more positive attitude towards breastfeeding, equip mothers with information to make decisions, provide them with a supportive network, encourage them to be more confident, and empower them to breastfeed for as long as they choose.
- 2.3 BfN's longer term aim is that through success in this influencing role, the reach of their activities will go beyond individual family situations, building a stronger network of mothers willing to become peer supporters, encouraging some mothers to pursue new learning opportunities and equipping communities with increased social capital and greater skills of breastfeeding for future generations

Logic Model

The Breastfeeding Network



Empowering mothers to breastfeed for as long as they choose, particularly in areas of disadvantage and/or where there are low rates of breastfeeding



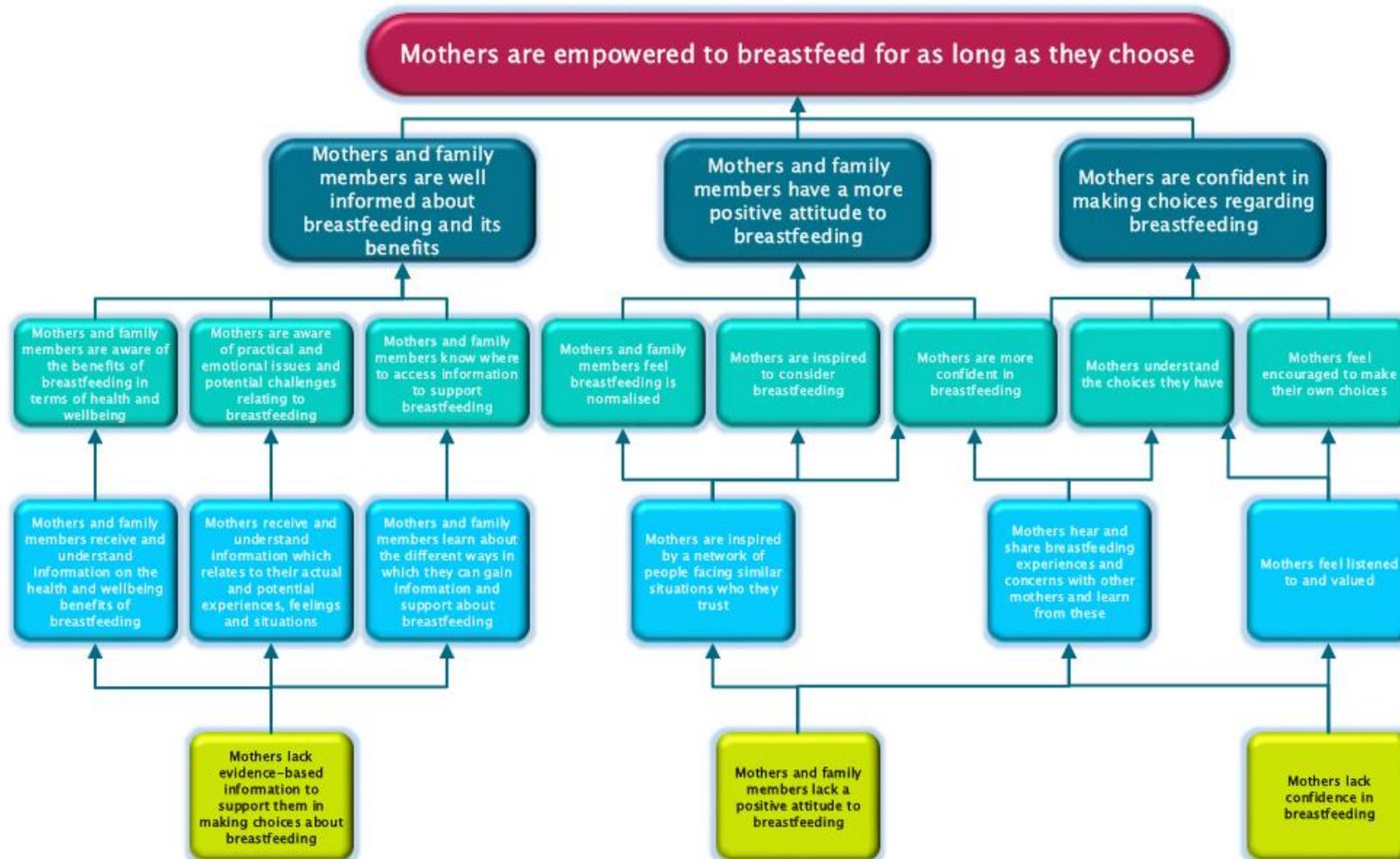
Theory of Change

- 2.4 BfN recognises that the mothers they provide support to may start out lacking information and confidence in issues relating to breastfeeding and may have a negative attitude about it.
- 2.5 Its aim is that individual mothers who its services support are empowered to breastfeed for as long as they choose.
- 2.6 As part of the evaluation a Theory of Change process was undertaken to create a change map showing how mothers might make this journey from a relatively negative and poorly informed starting point, to a point where they feel more positive about breastfeeding and where they are equipped to make decisions about it.
- 2.7 The process of developing this model and the constraints involved are described in the methodology section.

Theory of Change Map



The Breastfeeding Network



3. Profile of respondents and experiences to date

- 3.1 This section looks at the results received from the survey, interviews and focus groups with mothers and the interviews with health professionals. It begins by detailing the profile of those taking part and then explores the impact of BfN on people's attitudes, information and confidence relating to breastfeeding, linking in with the main areas outlined in the Theory of Change map.

Profile of respondents

- 3.2 The online survey had 203 returns. 198 (98%) were from mums and the others were partner/spouse, friend or doula. The age profile of the mums responding is shown in Appendix 2.
- 3.3 Respondents were from England, Scotland, Wales and Northern Ireland. The largest returns were from the London area (24, 12%), Reading/Slough (22, 11%), Birmingham / Midlands (20, 10%) and Kilmarnock (17, 8%). The location of all respondents is shown in Appendix 3.
- 3.4 85% (173) of respondents were currently breastfeeding. Of these respondents 66% (114) were also giving solids and 10% (18) were giving formula milk. Of those giving formula milk, 28% (5) had started doing so when at less than 1 week old.
- 3.5 In terms of the health and social care professionals who took part in the evaluation, we interviewed 13 people including hospital-based Infant Feeding Co-ordinators, staff from Children's Centres (management and outreach) and ward managers from various parts of England and Scotland. Their responsibilities included providing specialist advice on maternity wards and within the community, visiting and supporting breastfeeding mothers, co-ordinating breastfeeding support at a children's centre, supporting staff including midwives and maternity support staff, and working on the development of infant feeding policy. Their feedback on BfN and its services was based on their experience of working jointly with BfN to support mothers and the origin of their contact with BfN had often been through joint involvement on local breastfeeding strategy work leading to partnership working.

Why mothers decided to breastfeed

- 3.6 Many mums referred to their decision to breastfeed as being an 'instinctive' or the 'right' thing to do.

"It felt the natural instinctive thing to do, there wasn't necessarily any logic or reason behind the decision."

"I always thought it was the most natural and beneficial thing for a baby."

"I thought I would give it a go – I wasn't bothered either way before giving birth, but after a difficult start and it starting to work– I had to continue and I still don't want to give up."

- 3.7 Some noted specific health factors which they were aware of, while others were aware of health issues for their baby or themselves which had been involved.

"Natural and important to give baby the best start in life, good for baby's immune system and the best balanced nutrition."

"Breastmilk has all the required nutrients adapted to my baby's needs. No other milk type can compare to breastmilk.it helps my body create antibodies which are passed on to my baby to help him fight back if he gets sick."

"My baby has allergies and most formula would be dangerous and could make her very ill."

"To keep my endometriosis at bay for a while due to hormones for six months was a bonus but I would have breastfed anyway."

- 3.8 Some mentioned the importance of some practical factors involved in their decision to breastfeed.

"Health benefits and financial reasons as I have twins. I also wanted to breastfeed for bonding."

"I'm a wheelchair user who would have to rely on other people to prepare bottles. By breastfeeding I can be independent and give my baby something nobody else can."

- 3.9 Those who identified the 'most important reason' why they had decided to breastfeed or give their babies breastmilk was that it was 'good for their baby's health' (96, 93%).

- 3.10 However even when mums plan to breastfeed, this intention or desire is no guarantee that they will not encounter significant problems along the way.

"I foolishly assumed I'm a woman, I've got two breasts, it'll just happen." (Focus Group comment)

"Wanting to breastfeed is not enough, you need the support to make it happen."

"I always thought it was the most natural and beneficial thing for a baby and when mine was born I was determined to successfully breastfeed for as long as he would need/want it. Never anticipated how challenging it would be but the two conversations I had with volunteers during critical moments in the first two weeks helped me on a journey of which I am proud as it really benefited his overcoming silent reflux problems."

"I think it's the best food for baby. I don't like the idea of formula - I call it 'chemical milk'. I think it's much healthier, and I suppose it is more convenient although it was really really painful for the first three months."

Mothers who had stopped breastfeeding

- 3.11 We had responses from 30 mums who had breastfed or given their baby breastmilk in the past but did not do so any more. These included those who said that breastfeeding had been a very good experience (11, 37%), to difficult at first but got better (9, 30%) to very difficult (4, 13%). The majority (25, 86%) had breastfed for more than a year.
- 3.12 The main reasons for stopping breastfeeding according to this group was that their baby gradually decided to stop feeding (self-weaned) (11, 39%) or that the mum had decided to wean her baby (5, 18%) or that breastfeeding goals had been achieved (4, 14%). However just under a third (12, 29%) had stopped because of external factors such as returning to work, physical difficulties or needing to take medication. Whilst not the main reason why mums had stopped breastfeeding, other contributing factors included lacking confidence or other people reacting negatively in public situations. No-one said that family or friends thinking they should stop had been a reason for them stopping.
- 3.13 The majority of these mums with previous breastfeeding experience were therefore relatively positive about breastfeeding and the main difference between them and survey respondents who were still breastfeeding was that their breastfeeding journey was over because of the age and stage of their child rather than through any particularly negative feelings about breastfeeding. Further results have therefore been looked at as a combined group of women who are currently breastfeeding, and those who have breastfeeding experience in the past.
- 3.14 We had no survey responses from mums who had never breastfed or given their babies breastmilk.

Mothers' perceptions of their breastfeeding experience

- 3.15 Just over half of mums who were still breastfeeding said that their experience of breastfeeding to date had been good or very good (109, 53%), while a significant minority (81, 40%) described it as 'difficult at first but got better'. Less than 5% said it was 'still difficult' or 'very difficult'.
- 3.16 We asked what things mums and their baby had liked about breastfeeding. The most common answers related to the bond and unique relationship which they had found that breastfeeding had provided. Others spoke of health benefits and convenience. Some described the combination of all of these things.

"I feel it helps our bond and I like the feeling that I'm doing what's best for him. It's very convenient compared to formula feeding. I love the way he looks at me when he's feeding."

“All of it. The bonding, the simplicity, the calming effect, the fact that it is best, always adapted perfectly to baby and it’s easy.”

“Breastfeeding developed such a bonded relationship with my daughter which continues to this day and has, in my belief, already kept her stronger and healthier.”

3.17 Some mothers recognised the benefits but also noted that these came at a personal cost.

“The ease of it. But I found it completely draining and exhausting.”

4. Experience of BfN and its services

Making contact with BfN

4.1 The evaluation reflects feedback from women who have used BfN in a range of ways, with many having contact in more than one of these ways. More than half of survey respondents (120, 59%) had contact with BfN through breastfeeding/infant feeding groups. However other methods of contact experienced included telephone conversation (74, 36%) and text message conversation (40, 20%). The majority of the online/social media contact was named as being through Facebook. The full list is shown in the table below.

Contact with BfN	203 100%
Breastfeeding/infant feeding groups	120 59%
Telephone conversation	74 36%
One-to-one support from a peer supporter	60 30%
Hospital	56 28%
Home visit	54 27%
Online / social media	51 25%
Text message conversation	40 20%
Baby clinic	24 12%
Antenatal clinic	15 7%
Other	9 4%

4.2 The make-up of the focus groups was similarly varied. Even within two groups totalling 12 women it reflected those whose first contact with BfN had been during pregnancy, on a maternity ward, at home after discharge or within an infant feeding support group. The support experienced ranged from text support, to 1:1 home-based support to regular attendance at a weekly group.

4.3 Our survey found that issues relating to feeding position and attachment for feeding and painful breasts or nipples were the most common to have been discussed with BfN by over half the respondents. BfN clearly provides support on a diverse range of issues as medication,

to baby's sleep, returning to work meeting other mothers and mental health all featured. Appendix 4 shows the issues which mums had discussed with BfN.

- 4.4 It was most common for respondents to have received support when their baby was over 6 weeks old. This was true for more than two thirds (138, 69%) of respondents. In contrast less than a fifth (28, 14%) had received support during pregnancy, nearly a third when they were in hospital (64, 32%) or in the first week after discharge (63, 32%).
- 4.5 The most common way for people to have found out about the support offered by BfN was online/social media (58, 29%). The role of different health professionals (including midwives and health visitors) in signposting people to BfN is important (60, 30%) while BfN's direct approach to mums is also important (28, 14%). Beyond that family and friends and posters/fliers/leaflets also have an influence on mums finding out about BfN. The results for this are shown in the table below.

Finding out about BfN support	<i>203</i> <i>100%</i>
Online information / social media	58 29%
The Breastfeeding Network approached me	28 14%
Midwife	28 14%
Health visitor	28 14%
Family member or friend	18 9%
Local Mum who recommended Breastfeeding Network group/project	17 8%
Poster/flyer/leaflet	9 4%
Ante natal class	5 2%
Other health professional	4 2%
Other	8 4%

- 4.6 The evaluation had little contact with mothers who said that they had not planned to breastfeed at the outset. Only 4 respondents categorised themselves as being unsure about breastfeeding or had not been planning to breastfeed before their involvement with BfN. More than half (109, 54%) were already breastfeeding when they had contact with BfN. Around one third of respondents were trying to breastfeed but finding it difficult (73, 36%).
- 4.7 This matches comments from the Focus Group where mums said that they had already intended to try to breastfeed without BfN's involvement and the support they received came later. This included some women who had made the decision to breastfeed in spite of a lack of breastfeeding support or role models from within their family and friends. Therefore we found only a handful of examples of BfN services impacting on initiation.

"I was unsure when pregnant and was planning to combined feed. Attending an informal discussion with a BfN supporter at my local children's centre I was inspired to try exclusively breastfeeding."

- 4.8 The starting point of many mums' contact with BfN was at a point of difficulty. Out of the 26 women we interviewed more than half used phrases like "pretty dire", "isolated" and "suffering quite badly." Others had approached BfN as they were seeking more information on breastfeeding or on particular issues such as medication.
- 4.9 This range of starting points was true for those mums attending our focus group (Kilmarnock) who were asked for a word or phrase to describe their situation before contact with BfN. The majority were facing a difficult situation, while others who were seeking information described themselves as "hopeful", "curious" or "learning." The results are shown below.

A word cloud of phrases describing mothers' situations before contact with BfN. The words are arranged in a roughly circular pattern. The phrases include: desperate, lacking confidence, concerned about flashing, looking for encouragement, anxious, teary, wanting somewhere safe to go, told I wasn't able to breastfeed, housebound, learninghungry, hopeful, very tiring, struggling, depressed, curious, and in pain.

- 4.10 The impact of BfN's various services was in supporting mums to address these difficult issues or in providing the information that people were seeking and this is described further in the next sub section.

Impact of BfN in sustaining breastfeeding

- 4.11 Mothers reported that support from BfN made them feel more confident to breastfeed (128, 63%), made them feel that they were not on their own (139, 68%), and made them feel happier and more relaxed about breastfeeding (112, 55%). BfN's support also played a part in helping mums to feel more confident about breastfeeding in public (79, 39%).

4.12 We received a huge number of quotes from mums regarding the importance of BfN support in helping them to sustain breastfeeding over time. These are just a few examples:

"I would never have continued to breastfeed if I hadn't received support from the group I attended and [the BfN staff member named] who was fabulous....I doubted everything I was doing and the Health Visitor's comments were making me doubt myself even more [first baby was premature and wasn't gaining much weight]. I ended up feeding my first for 2years 2months and still feeding my second at almost a year."

"There is no way I would have managed to breastfeed at all without BfN. They initially suggested a tongue tie when the midwives had dismissed my pain. They then supported me both before and after the tie was divided. They continue to support me now, though knowing that I am part of a much bigger community. Feeding at 2+ years was not something I would ever have dreamed of."

"The help was invaluable, they have built my knowledge, skill and confidence on breastfeeding. With the provision of home visits, texts, calls and groups I have never felt alone in this."

4.13 The evaluation found examples showing that the different forms of support offered by BfN from face to face peer supporters, to groups, to text messaging and online support could all impact positively on mums' confidence or ability to breastfeed.

"I had a look at the Facebook page. They had just set up a new page rather than a public page. I messaged the page to say 'my GP has prescribed this – is it safe, are there alternatives?' It was really really good – I thought it might take a couple of days but I got a response in a couple of hours. I was really reassured that the drugs prescribed would be fine – it felt like I was talking to a real person – they said 'I'm a specialist in this and know about it'."

"The support I received from BfN whilst I was in hospital helped me to establish breastfeeding. My baby was poorly from birth and without their support I'm sure I would have had to resort to formula."

"I couldn't have talked to someone on the phone. I would have started crying. I can't speak when I cry, but I can cry when I text. Without text support I would just have dealt with it. I'd have been in pain."

"I used the drop in session almost every week for the first few weeks after birth and it helped me to find practical solutions to issues we were having."

"I had struggled with the traditional breastfeeding position and so was using the rugby ball position which was difficult when out. The one-on-one help I got at the breastfeeding drop-in showed me that I COULD also do the traditional method and this gave me much more confidence to be out at nursing times."

4.14 We also asked health and social care professionals to comment on the feedback they had received from mothers. This was very positive, with BfN volunteers seen as being friendly and easy to talk to. They noted that the varied services of home visits and breastfeeding groups were valued (although also noted that groups were not a format that suited everyone). Some talked of mums who would not have sustained breastfeeding if they had not had BfN support. One spoke of mothers receiving *“ten minutes of support over the phone”* and that this had been *“enough for them to breastfeed exclusively for six months.”*

“Very helpful and friendly, approachable.”

“They do a really good job, they are passionate and the mums appreciate it.”

4.15 In terms of their own experience of BfN, the health professionals who we interviewed all commented positively. They commonly described BfN services as being responsive (*“quick to pick up problems”*), confidential and involving people who *“know their remit”*. Others commented that there was a shared vision with all working to Baby Friendly standards *“working towards the same goal and supporting mothers’ choice.”*

Breastfeeding Network’s impact on duration of breastfeeding

4.16 Whilst BfN had not influenced the decision of many of the mums in the evaluation with regard to initiating breastfeeding, the organisation’s impact was much clearer in relation to breastfeeding mums reaching a new understanding about the benefits of breastfeeding babies beyond six months. There was evidence from the survey, the interviews and the focus groups of mums who had intended to stop breastfeeding after a few weeks or months but who had then breastfed for longer.

4.17 This change had taken place because of the example of other mums at groups and because of new knowledge gained about WHO guidance. These things combined meant that they were inspired and had confidence in trying to continue breastfeeding, and confidence in explaining their decision to others who questioned it. As one focus group mother (whose baby was nearly a year old) said, *“The support is really kicking in now – now more than ever.”*

“When I first came to the group there was a mum breastfeeding an older baby. I thought “I won’t be doing that.” But now my son is nearly one and I’m really enjoying still feeding him.”

“My son is 11 months and I think I would be beginning to feel that I should stop and be feeling uncomfortable feeding in public now without BfN support. However because I am regularly in the company of people who are feeding beyond one year I feel confident to continue and know that it still has massive benefits for both him and I.”

4.18 One health professional confirmed that this area was one where mums knowledge and then behaviour could change, identifying that *“some mums think breastfeeding is only for the first six months”* leading to them training staff so that they could encourage mums to breastfeed for longer.

Challenges faced during breastfeeding and BfN's impact on these

- 4.19 We asked mums what challenges they had faced in breastfeeding. The top five answers all related to a range of physical issues (finding it tiring, position and attachment problems, discomfort). More than half of respondents (122, 61%) said that they had experienced some physical problems.
- 4.20 A lack of confidence had been a challenge for just under a third (59, 29%) of mums. Around a quarter (46, 23%) of mums identified that breastfeeding in public can be a challenge, although far less (17, 8%) said that people had reacted negatively to them when they were breastfeeding in public. Results showed that there was a wider challenges with other people in the community disapproving of breastfeeding (28, 14%) and returning to work (30, 15%). Other challenges faced during breastfeeding included mums needing to take medication (59, 29%) and dealing with medical problems (30, 15%) which suggests that BfN is a resource within a wider context of health and wellbeing for women. The results are shown in Appendix 5.
- 4.21 Some comments below illustrate the individual challenges faced but also highlighted that a mum might experience a range of challenges in the course of her breastfeeding journey.

"Difficulties to work feeds and expressing around shifts at work. Partner's family unsupportive making comments about breastfeeding making thing unnecessarily hard for ourselves. Poor latch, small babies who tired easily and constant pressure from midwives to top up in first few weeks made me doubt my ability to feed."

"I found breastfeeding more daunting at night as my nipples were cracked etc., so the pain was excruciating. I also found it emotionally draining as I couldn't work out what I was doing wrong despite trying lots of different positions."

"Was I producing enough milk? How often should I be feeding and how long for? Latch problems, fussing at breasts, expressing."

"First ten days extremely difficult due to extreme pain - led to severe post-natal depression."

"Even though I strongly support breastfeeding I still feel a bit embarrassed to feed in public sometimes and anxious in case people make comments. I try to feed in public as much as I can to normalise it."

- 4.22 Out of this diverse range of challenges, the clear majority of mums (163, 82%) said that BfN had helped them to address the challenges they faced. The main categories of how this help had manifested itself were advice on physical positioning/latching, moral support and reassurance, information and advice (for example on medication) and signposting (for example when GP support was needed).

"Initially they helped me to get baby to latch on with a near 3 hour home visit, this was invaluable for us, it was the day all changed for us. That visit just made it all click, having someone there taking the time to really help."

"Giving me confidence feeding in public."

"I was given patience, reassurance and understanding."

"Support with knowing rights re breastfeeding and return to work."

"BfN helped find ways to cope with nightfeeds and tiredness."

"Pointed me in the right direction to seek help to deal with allergies when feeding."

"Referred us to hospital for check-up and snipping procedure."

"Physical positioning, moral support, signposting, information and advice."

"It kept me breastfeeding despite multiple issues at the same time. I was in pain and isolated. They helped my technique but also encouraged me to get medical attention. They also improved my understanding of feeding so I was able to better manage my multi issues in the future."

4.23 We asked the same focus group women who had given us a relatively negative set of words describing their 'before' situation to give a word or phrase for how they felt after receiving BfN support. The results are shown below. In addition our telephone interviews established the contrast for mums after receiving support with phrases including "*totally different*", "*less alone*", "*much happier and still going*", and "reassured."

A word cloud of positive feelings and phrases. The words are arranged in a roughly circular pattern. The most prominent words are 'happy', 'confident', 'sense of community', 'knowing there's a safety net', 'relieved', 'easy', 'empowered', 'informed', 'less self conscious', 'sense of achievement', and 'friends'. The words are in various colors including green, yellow, red, and blue.

Other forms of support during breastfeeding

4.24 95% of mums had received support relating to breastfeeding from someone else in addition to BfN, with partners, friends and family and midwives and health visitors being the most common sources of support. In addition to the support categories set out in the table overleaf, mums also mentioned other (not BfN) breastfeeding support groups, lactation consultants or breastfeeding counsellors.

Source of support on breastfeeding (additional to BfN)	201 100%
Partner/husband	121 60%
Midwife	104 52%
Friends or other family members	103 51%
Health visitor	94 47%
Private lactation consultant	35 17%
Maternity care assistant	34 17%
GP	21 10%
No-one else	10 5%
Someone else	33 16%

4.25 Mums' experience of other support and their ability to compare it with that received from BfN varied widely. We had descriptions of other breastfeeding support being "awful", "less realistic" or "less knowledgeable" than BfN, while others were positive and were able to describe the nature and value of support they had received from other sources:

"My husband was with me all along, encouraging me to go to meetings and helping me gain confidence. He was there during the night feeds to support me mentally and emotionally."

"My midwife was fantastic – she came to see me in her own time to help me get feeding established. Without her I doubt I would have started feeding at all."

4.26 Some felt it was difficult to compare BfN with other support received while others said it had been complementary or as one mum said, they "*worked in tandem*". The overall picture of the value of other was therefore very mixed, compared to the clear consensus that the support from BfN had been positive, whether it was the only good support received or if it complemented other support.

"The environment of BfN was more of community feel where you could ask advice but also listen when it was being given to others and sharing experiences."

"Good start at hospital but I'm glad this was able to be followed up with help at home otherwise I would find it very difficult to continue."

"Not anywhere near as helpful as BfN. Family was motivational and GP/Health Visitor quite brief in understanding."

"More day to day support from my husband and friends whereas BfN was more for specific questions and queries."

4.27 One mum said that she had had valuable face to face support about breastfeeding from elsewhere but that *"...the BfN phone line and Facebook were very valuable as I didn't have to wait 'til a session or appointment."*

4.28 Mums at the focus group described how they would have used other supports such as GPs and health visitors for 'medical issues' but that the advantage of BfN is *"being able to phone ten times and nothing's noted down"*. In contrast they said that *"phoning your health visitor ten times and you are a pest"* and you *"feel like a hassle."*

"[BfN support] stopped me phoning the psychiatrist in the Community Mental health team – I would have phoned them otherwise."

Consistency of information given to breastfeeding mothers

4.29 We asked all of the professionals whether the information given by BfN was consistent and complementary with that from their own organisation. Many respondents highlighted that this was a crucial area and one which BfN was getting right; *"they've worked hard to ensure that the advice is consistent"*, while one respondent noted that working to Baby Friendly Standards might assist in all groups involved with mums providing a more consistent message.

4.30 Respondents noted that differences that can emerge over time as advice evolves on different matters. One example given was where health professionals and BfN had differing views on the issue of bed-sharing.

4.31 GPs were named in this response as one group who might offer different (and according to one interviewee 'questionable') advice as *"they get no formal infant feeding training"*. One example given of this related to whether breastfeeding mums could take particular medication when they were experiencing various health issues, and some respondents noted the incorrect advice which they had experienced GPs giving in these situations.

"Sometimes they [health professionals] get a bit ingrained in the NHS way, so it's good to have a new way of doing things."

- 4.32 We received very positive comments from mums regarding the value of BfN information relating to drugs. The comment below shows the potential strength of the impact of this information on an individual mum but also that there can be a further impact to the health professionals who mums have contact with.

"I'm a chronic migraine sufferer and would have found it extraordinarily difficult to continue our natural-term nursing journey without the drugs in breast milk fact sheets and information from [named person] which empowered me to not only gain control but also to educate people at my local GP's practice and other mums."

Influence of family and friends in breastfeeding

- 4.33 The support of those people who are closest to mothers who are trying to breastfeed is not always helpful. Mothers reported many instances where they felt pressured to stop breastfeeding because of early problems, pain and a lack of milk for a new baby, because of a family history of formula and bottle feeding, or because of people's attitudes and understanding of when a baby 'should' move to a bottle or to solids.

"My family were against it. It was a completely new thing to them."

"Family members were concerned for me. They said I should give it up for myself – I felt under pressure – with BfN support I could argue my case better."

"Do you want me to leave the room? When are you going to put him on a bottle?" It's not prejudice just a lack of knowledge"

"When my baby had lost 10% of his body weight and was not latching on properly I had my family and friends telling me I should change my mind and get formula milk. I locked myself in a room with baby and a volunteer on the phone for over an hour until he calmed down, latched and fed to his heart's content. It almost felt like a miracle and I will be forever grateful to the wonderful volunteer who helped us that day."

- 4.34 In some instances mothers felt more informed and able to present their side of the argument better. There were also references to BfN staff or volunteers speaking directly to and positively influencing family members, such as *"...also they've been good at talking to my family about it my mother-in-law had never breastfed so it was good they could speak with her."*

- 4.35 A fifth of mums (39, 20%) told us that BfN had helped them to change the attitudes of family and friends. Mums described feeling informed and empowered and because of this they had seen family members or friends changing negative opinions or being more educated about issues (even if they hadn't been negative).

"It empowered me with info enabling me to educate them."

"Spoke to my mum and armed me with facts I was able to share and change their mind (thank you so much)."

“Although my husband was supportive, learning about the benefits led him to actively encourage me to continue breastfeeding for the time I did.”

I was able to educate them on the benefits of breastmilk versus formula which had previously been used by my in-laws family for convenience. I was put under pressure to formula feed but knowing the benefits of breastfeeding I was able to stand my ground and do what I feel was best for my baby.”

“Why feeding beyond one [age] is still important and beneficial. I am also able to be confident with my choices and so any opinions don’t get to me now.”

4.36 In contrast one mum noted the negative impact of breastfeeding on her friendships because of different attitudes, *“Now he’s a lot older I’ve lost friends as they think it’s perverted and should only be done for the first 3 months”.*

4.37 We received some comments noting that the positive impact had gone further in that it had influenced the breastfeeding behaviour of other people, showing that mums who are supported to breastfeed can impact on others in the community.

“After seeing my success in breastfeeding and how it doesn’t have to take over your life, my friend who is pregnant with her second child (who didn’t breastfeed her first) has decided to give it a real go this next time round.”

“They are much more on board now and breastfed their own children in more positive way.”

4.38 Since starting to breastfeed, one respondent has set up her own online support network which has over 1,000 members; *“Setting this up was in part due to BfN – I wouldn’t have done it without them, they’ve helped me and other women a lot.”*

4.39 Mums in one focus group also drew attention to the fact that messages in the wider community were ‘bottle-focused’ noting examples of TV programmes (for example Peppa Pig) where the baby is given a bottle, a picture book where a baby is given a bottle but the image of someone breastfeeding was under a flap, and that within social media *“there’s an emoji for bottle feeding but not for breastfeeding.”*

Support from groups – social value

4.40 The group support offered by BfN was highlighted by many as being a crucial element in supporting their breastfeeding journey, bringing them into contact with a like-minded, accepting community. There were examples where the impact of the community of support provided could be far reaching for the individuals, in terms of their social circle of support, their reduced isolation and their mental health.

“As a new mum I had none of my own family living close and having worked full time had no other friends with young babies. BfN gave me a place to belong and a feeling of

community. I think their support helped me fend off feelings of depression and helped me cope so much better as a mum. The groups were a real lifeline for me.”

“Seeing mums going through the same things during the meetings helped me to not feel alone any more.”

4.41 Mums described how Facebook could also provide a form of community, which provide some support in between groups or if they were unable to attend a group.

“Just reading the Facebook page regularly made me realise all the things I felt were normal and that I was not alone.”

4.42 However it was noted that this community was less regulated and so could also be unhelpful.

“Too many opinionated people. I have witnessed some new mothers being put off by comments made on social media/FB groups and then unfollow the group meaning they do not receive the support they need when they need it (eg 3.30am) and ultimately finish their journey early.”

Importance and impact of peer support on breastfeeding mothers

4.43 We asked the mums who had said that they had received 1:1 support from a peer supporter about the importance of this support being from a mother had breastfed. The vast majority (46, 94%) said it was very important or quite important as shown in the table below.

The importance of BfN support being from mothers who have breastfed	60 100%
Very important	37 62%
Quite important	19 32%
Not important	4 6%

4.44 Mums identified the additional value that they believed comes from someone who has a full understanding of breastfeeding because they have themselves breastfed. This appeared to be important to mums as because it increased their trust that the supporter fully understood their situation and that this came across in how the supporter was able to listen, understand, reassure and guide.

“It is not just a practical activity. It needs someone who has experienced the emotions to help.”

"Because she obviously knew what she was talking about and it gets very tiring taking advice from people who clearly have no experience of the situation they're advising you on."

"You trust them more because you know they have been through the same journey."

I was seen by a health visitor who hadn't breastfed, and she was not empathetic or understanding at all. She showed no education on the 'other' benefits other than nutritional, encouraged weaning etc... I believe to support a breastfeeding mother it is imperative that the supporter has herself also breastfed."

"As with most things if someone has experienced or seen something for themselves their understanding is generally better."

- 4.45 The professionals we interviewed all recognised advantages which they felt that peer support brought which were mainly about the fact that BfN brought a personal experience of breastfeeding, and that as a peer they had a refreshingly different status which could complement the support received from health professionals; *"Somebody who's done it, who'll listen and is empathetic"* while another commented that *"these are women who have all breastfed their own children"* and that they are *"on the same level"* and able to work on a *"mother to mother basis"*. This respondent also noted that peer supporters could dedicate time to breastfeeding support, compared with midwives who had many competing tasks to perform. One respondent noted that because people have different preferences of being supported by professionals, by parents or by a mix of the two that *"it's good to give mothers a choice."*

"A lot of research shows that peer support is influential."

"They get mothers speaking to other mothers. They are likely to talk to other mums who understand the trials and tribulations."

"...as a parent it's nice for them to know that they [BfN supporters] have been there, as they're the best people to offer support."

Drawbacks with peer supporters

- 4.46 Many respondents did not see drawbacks with peer supporters. Of those who did, some drew attention to potential drawbacks rather than ones they had specifically experienced. These included that peer supporters might take a view too firmly based on their own personal experience, that if not fully or recently trained then they may not be up-to-date with important information, and if they are too opinionated about breastfeeding, continuity between different peer supporters was also highlighted.

"It can be difficult to leave your own experiences behind and if not kept up to date can pass on outdated information. (comment from a mum who had been a peer supporter)."

"I had different experiences based upon who helped me. The girl that came to my house was lovely but when she left I felt I was trying a new position that neither my baby nor I felt comfortable with. That next week I went to a walk-in clinic and the women told me that my position was fine.....I left with more confidence than the first encounter."

"They can have slightly different opinions on some matters; feeding on demand, cry-it-out method etc."

"As they are volunteers there is not always continuity so you may see lots of different people which can be difficult, especially if you feel you've built up a relationship with one or a few people. Some volunteers are more knowledgeable and supportive than others."

- 4.47 One health professional commented on her experience that a lack of consistency could equally come from healthcare staff; *"You can't stop people giving their opinion, even though I'm in charge of training!"*
- 4.48 In terms of disadvantages of peer supporters, professionals commented on actual disadvantages experienced but also perceived ones but which they had not been directly encountered.
- 4.49 Some commented on practical issues of BfN volunteers who themselves are mums and can have childcare issues, or who are unable to sustain their volunteer involvement because of family situations. It was noted that this can lead to turnover of volunteers and a potential lack of consistency.

"It can be that the passion is there to start with – but they are volunteers and do have their own life. They are quite often busy with their own little people and coming out in the evening after getting their own little ones to bed – the initial enthusiasm can dwindle."

- 4.50 A further comment received was that any disadvantages was down to individual peer supporters, for example some mums might perceive the support being *"a bit in-your-face"* depending on how it was delivered. One respondent commented that there was a need for more parents who spoke different languages although note that BfN were *"making progress on this."*
- 4.51 Another disadvantage suggested was that some agencies could have concerns about how adequate the training of volunteers was and about potential inconsistency between peer supporter advice and professional advice. However this respondent noted that they knew it to be of a high standard and that with supervision BfN volunteers were being supported and were *"constantly getting updates"*.

Application of BfN's values in practice

- 4.52 We asked mums a question which related to BfN's values and the way the organisation wants its services to be experienced by mums and others who use them. We found that over 90% of people strongly agreed or agreed that they had felt listened to and respected, that mums were

at the centre of the support offered and that the choices were respected. Results are shown in the table overleaf.

How does it feel to receive support from BfN?	Total				
		Strongly agree	Agree	Disagree	Strongly disagree
I felt listened to	197	143 73%	50 25%	1 1%	3 2%
It felt like Mums were at the centre	198	118 60%	68 34%	9 5%	3 2%
I felt respected	198	141 71%	53 27%	3 2%	1 1%
I felt that the choices I made were respected	198	133 67%	58 29%	6 3%	1 1%
I did not feel pressured to do anything	197	123 62%	63 32%	8 4%	3 2%

“Non-judgemental and supportive representatives helped me feed through tongue tie issues and shields and eventually resolved both. I didn’t think I’d feed past a week but have managed 8 months so far with no end in sight.”

“Everyone was kind considerate and supportive throughout a difficult time.”

4.53 We asked health professionals to comment on Breastfeeding Network’s aim to empower mums to breastfeed for as long as they choose. All of those we interviewed believed that this was an approach which BfN and its peer supporters were successfully implementing. One highlighted the fact that *“some mums are cautious and sensitive”* and therefore it was important to *“be careful not to be vigilantes for breastfeeding”* as some will choose not to breastfeed and some will combination feed. However respondents felt that BfN did recognise this.

“When people speak to peer supporters or other mothers, they see that it’s possible to get through the difficulties – it enables them to go for as long as they want to instead of when they have to stop.”

“BfN is good at letting mothers finish [breastfeeding] when they want to, and also supporting them in the transition to other feeding.”

"It's definitely for as long as they choose, but they [BfN] are also good as saying that it's OK if you don't achieve breastfeeding for as long as you want to."

4.54 One respondent commented that she had seen a change over the years with BfN. She believed that BfN were now supporting choice for mothers having previously been stronger on *"pushing breastfeeding"*. She commented that supporting choice was needed *"above all else"* and was unsure if the change towards this which she had seen with BfN was because of individuals or because of a change in the overall organisation.

4.55 We also asked health professionals about BfN's aim of empowering mums particularly in areas of disadvantage and/or where there are low rates of breastfeeding. Most noted that this was work in progress for BfN with a few examples of success where peer supporters do manage to get some women who wouldn't normally breastfeed to do so and for longer than they might otherwise.

4.56 Some noted the work which BfN were doing in relation to this aim, naming activities in locations including schools, nurseries and Children's Centre. One also noted that *"empowerment is also through things like social media"*. They commented on the approach being taken in communities, *"working on the cultural side of things trying to make it culturally more OK to breastfeed"* noting that this can take place where *"there is a strong bottle feeding culture in the area"*.

4.57 There was recognition that some change could happen in these targeted communities but that issues of social disadvantage relating to teenage mums, deprivation and substance misuse meant that the scale of the challenge was identified as being large, although there was recognition that an advantage of BfN was that their peer supporters were more community-based than maternity services, while the value of peer support itself was also identified

"I think it's really difficult and there's not a huge amount they can do."

"Some of the girls [peer supporters] are working in the health clinics in those areas – they know the mums."

4.58 One hospital-based professional noted that *"initiation rates for breastfeeding are very high anyway in our hospital but it's in sustaining breastfeeding where BfN was important."* She went on to note the practicalities faced by some mums; *"We have 3 hour discharge sometime – they might have fed once or not at all – that's terrifying."*

4.59 The very small number of negative comments received from mums related to particular instances where mums had not been contacted when in need, where a root cause of a problem had not been identified or where they felt that their situations had not been understood and the wrong advice given (this related to two comments from mums who were exhausted or were experiencing mental health problems). Whilst small in number these comments do show that when support is not well delivered or well received it impacts strongly

on the individual, on their perception of the organisation and on whether they would recommend its services to others.

"It didn't help me. I met someone in hospital from BfN and was told someone in my local community would contact me – no-one did. I've since seen the rep from the BfN at my local children's centre and overheard her giving dubious information about tongue-ties and feeding."

- 4.60 We found that virtually all mums completing the survey would recommend breastfeeding to other people (198, 98%). The majority (173, 82%) said that they had passed on information about breastfeeding to other people. This ranged from their own experience, to signposting people to online information and to local groups, to reassurance and encouragement. Some noted that they had now become peer supporters.
- 4.61 The majority of the mums who said they would recommend breastfeeding (162, 83%) said that the experience of receiving support from BfN had made them more likely to recommend breastfeeding.
- 4.62 When asked how their breastfeeding experience would have been different without BfN support we received over 100 free text responses. Most identified that they believed they would have given up much sooner, would have been lonely or isolated, would have been in more pain for longer, would have given in to pressures from others (in relation to feeding decisions), would have had undiagnosed medical conditions (for baby or mum), and would not have fed for as long because of a changed attitude to breastfeeding an older baby.

Health and social care professionals' views on other impacts and on future developments

- 4.63 Whilst all of the comments on current experience of working with BfN were very positive, three of those interviewed did talk of earlier times when working relationships had been more difficult. However where this was mentioned, health and social care professionals were also able to qualify why this had happened, for example because of clashes with individuals rather than the overall programme, or because constructive working relationships took time to develop. One noted that over time *"mutual respect"* had developed and now there was a view that *"we're all working to the same aim."*
- 4.64 We asked health and social care professionals whether they had learned from BfN and whether they could provide examples of this. Half of the respondents said that there had been learning for them or their staff as a result of BfN involvement. Some spoke of inviting BfN to team meetings to keep them updated with developments in breastfeeding. One Infant Feeding Co-ordinator said how BfN's involvement had given her a different perspective and had shown her the benefits of *"a hands-off approach...let the mums take the lead."* Another said that she had sent two of her workers on a BfN course, and they came back *"buzzing"* about what they had learned.

- 4.65 Another commented that a BfN workshop in supportive language had changed the content of the training she delivered for staff and enabled them to consider the impact of statements that they commonly heard midwives or relatives say. This respondent also noted that this training would be passed on to doctors in the future who it was noted might receive minimal if any such content in their years of training.
- 4.66 Where staff said that they had not gained new knowledge or skills from BfN some qualified this by saying that this was because they believed their own training to be comprehensive. Those who said that their practice had not changed were still positive as this comment shows, *“Not as yet but it’s good to have the extra knowledge.”*
- 4.67 Professionals were asked how the impact of BfN’s support could be strengthened. The most common answers were more funding and a wider roll out of services. One highlighted that if peer support is in a local ‘framework of care’ then it should be funded. This respondent commented that she had seen mothers receiving inequality in service because of a change in funding preventing mothers from receiving a good quality BfN service which had previously been there.
- “It [peer support] should be the standard.”*
- “We could not cope without them.”*
- 4.68 Overall professionals appeared to be very satisfied with a good quality service and could see the need for more of it. They therefore believed improvements would come not from changes to the service itself but from improved security of funding for what was already there and increased funding to enable more to be delivered. When asked what would happen for the mums discharged from hospital without BfN support one health professional said *“earlier cessation of feeding and more hospital readmissions”*, while another commented that without BfN support, *“breastfeeding rates would be shockingly less.”*

5. Conclusions

- 5.1 BfN is delivering services in an internationally recognised context of improving maternal and infant health. Relating to this, health policy throughout the UK reflects the desire at government level to improve relatively low breastfeeding rates, while research shows the impact which peer support can have on encouraging women to breastfeed. Based on this context there is a clear rationale for the type of support offered by BfN as part of a drive to inform and support women to breastfeed, partly through involving those with experience of breastfeeding as peer supporters, thereby growing a stronger community base for breastfeeding.
- 5.2 The Theory of Change map sets out the fact that mothers can be lacking in information, confidence and a sufficiently positive attitude to either initiate or sustain breastfeeding, and highlights the role of guidance, support and encouragement in empowering them to breastfeed for as long as they choose.
- 5.3 In relation to the Theory of Change map, we found clear evidence through this evaluation that mothers who need information relating to breastfeeding, who have particular attitudes about breastfeeding, or who lack confidence in breastfeeding experience personal change in these areas as a result of BfN services. We found mothers increasing their understanding of the benefits of breastfeeding, feeling listened to and valued, being inspired and encouraged to deal with challenging situations and gaining confidence in breastfeeding. All of these things enabled them to be able to make choices and be more empowered to breastfeed for as long as they choose.
- 5.4 The evaluation established the merits of various BfN services which to some extent can be tailored to the issue mothers are facing and the amount of support and type of support they need. Whilst we did not establish BfN's role in supporting mothers to opt for breastfeeding in the first place rather than bottle feeding, we did find that BfN could strongly influence the practical actions of those mothers who had decided to breastfeed, impacting on their decision-making at challenging times. Mothers were able to recount specific challenges which they had experienced, often very early in their breastfeeding journey, which they believed would have resulted in them stopping breastfeeding, but which they had been able to address with information and support from BfN. In addition to this we found examples of BfN activities influencing the attitudes of mothers who had thought that they would breastfeed for a particular length of time, but who had subsequently breastfed for longer, inspired by information and examples received from other breastfeeding mothers. BfN's role in sustaining breastfeeding was therefore clear.
- 5.5 The role of peer supporters appeared to be key in this as these individuals had time to get alongside mothers (at home when this was required), a level of understanding based on personal experience and practical guidance which worked. In addition we found examples of

the value of online information and support and of the supportive community of a breastfeeding group which allowed problems to be shared and encouragement to be gained.

- 5.6 The health and social care professionals also highlighted the value of peer supporters in complementing their own work and in providing a crucial form of support which was valued and accepted by mothers. Overall we found health and social care professionals able to define the importance of BfN's role in supporting mothers, enabling them to sustain breastfeeding for longer, and in filling a vital gap with a professionally managed service which other forms of current support do not have sufficient resources to fill. They wanted the services they had experience of to continue, and ideally wanted them to expand to serve new areas and new mums.
- 5.7 BfN has strong set of values which are fundamental to the organisation's desire to listen to and respect each individual mother and her choices. We found evidence from mothers and from health professionals that these values are generally being demonstrated in the services which people have used.
- 5.8 In summary the evaluation established BfN's position within a large and detailed context whilst also finding evidence of its positive and crucial impact on many individual mums and their varied breastfeeding journeys, many of which would have been significantly shorter without BfN. It also showed the desire of those working strategically and daily to support breastfeeding, that BfN services grow to match the demand and thereby help to meet policy intentions in this area of health and wellbeing.
- 5.9 The challenges for BfN for the future include working with partner organisations to secure resources for peer support to be made available in order to support the empowerment of mums to make choices about feeding. In relation to this the evaluation has assisted BfN to establish a Logic Model and to test out its first ideas of a Theory of Change. These two models help to show BfN's relevance within the wider context of breastfeeding and to establish the key impacts that its services has on mums. BfN has the opportunity now to explore how these models might be further developed, and how they can be used to promote the organisation's work and the impact it achieves, as well as exploring their use as a basis for ongoing evaluation of services.

APPENDIX 1 – LITERATURE REVIEW

Introduction

This paper comprises a literature review of relevant publications dated 1981 to 2016, from across the UK focused on breastfeeding and peer support. It is based on a search using the IDOX information service, as well as Google Scholar and government publications and policies. Our search included key terms such as, “peer support”, “initiative”, “breastfeeding”, and “good practice”. Among the variety of research papers and policies generated by this search, we reviewed 44 ranging from local case studies, to wider, systematic-review level evidence as well as relevant government policy documents. The literature review summarises and appraises these in the following headings:

- The reasons for breastfeeding intervention
- Policy context
- Breastfeeding peer support approaches and considerations
- Good practice in breastfeeding peer support
- Evaluative strategies

The reasons for breastfeeding intervention

The literature reviewed comprehensively assesses the benefits of breastfeeding, as well as the reasons for intervention. Renfrew et al (726:2007) discuss how a changing policy climate has led to greater emphasis on the importance of breastfeeding, which accepts that breastfeeding is integral to addressing inequalities in health outcomes.

This conflicts with the breastfeeding landscape across the UK – which has one of the lowest initiation rates in Europe – in part due to societal and work culture influences, training and organisational issues, and potentially unresolved health problems among mothers (Renfrew et al, 726:2007). Indeed, in *Changing norms: addressing breastfeeding inequalities* (12:2009), the author refers to The Information Centre’s 2005 Infant Feeding Survey, which found that 88% of mothers in professional/managerial occupations had initiated breastfeeding, compared with only 65% of mothers who were not in work. In addition to evidencing disparities in breastfeeding among socioeconomic groups, the same survey highlights geographic differentials: the survey found there to be a lower rate of breastfeeding initiation in Scotland (70%) compared to England and Wales (77%).

Policy context

The underlying themes of breastfeeding-related policy across the England, Scotland, Wales, and Northern Ireland are broadly concurrent, reflecting a shift in global policy attitudes towards

understanding the importance of breastfeeding to the health outcomes of both mothers and babies.

Global policy

The *International Code of Marketing of Breast-milk Substitutes* (Global Health Organisation, 1981) marked a turning point in the way breastfeeding and breastmilk substitutes should be understood internationally. The protection of breastfeeding over other forms of infant nutrition underpins the elements of the Code: “the aim of this Code is to contribute to the provision of safe and adequate nutrition for infants, by the protection and promotion of breast-feeding” (8:1981).

The *Innocenti Declaration on the Protection, Promotion and Support of Breastfeeding*³ was established and adopted by WHO/UNICEF policymakers in a meeting on breastfeeding held at Ospedale degli Innocenti (Italy) in 1990. By recognising the health, social, and economic benefits of breastfeeding, it declares that, “all women should be enabled to practice exclusive breastfeeding and all infants should be fed exclusively on breastmilk from birth to 4–6 months of age”. The declaration also takes into account some of the psychological and social factors influencing breastfeeding rates among mothers: “Efforts should be made to increase women’s confidence in their ability to breastfeed. Such empowerment involves the removal of constraints and influences that manipulate perceptions and behaviour towards breastfeeding”.

There have been a number of changes to global policy which meet with the goals of the *Declaration*. This includes the World Health Organisation’s *Global Strategy for Infant and Young Child Feeding* (2003), which recognises both the short and long term impact of breastfeeding: “the lack of breastfeeding...are important risk factors for infant and childhood morbidity and mortality...the life-long impact includes poor school performance, reduced productivity, and impaired intellectual and social development (v:2003)”.

Attitudinal changes reflected in global policy making have already filtered down to changes in global industries at a multinational level. Central to this has been the development of the Access to Nutrition Index (ATNI), an independent benchmarking tool that rates leading food and beverage manufacturers on their “nutrition-related commitments, performance and disclosure globally” (3:2016). In addition to the 2016 Global Index publication, a separate pilot study and ranking of breast-milk substitute manufactures has been launched; acknowledging that the development and marketing of breast-milk substitutes, particularly in developing countries, is highly sensitive in light of the growing evidence base for the benefits of breastfeeding.

England national policy

The importance of breastfeeding appears in various England national policy documents. “Ensuring every child has the best start in life” is seen as one of the seven main priorities to protecting and improving the nation’s health (Public Health England, 2014); and breastfeeding is understood to be an indicator of healthy lifestyles and reducing health inequalities in the most recent *Public Health Outcomes Framework* (Department of Health, 2013).

³ <http://healthydocuments.org/children/healthydocuments-doc33.pdf>, accessed 13th October 2015

The *Healthy Child Programme: Pregnancy and the First Five Years of Life* (Department of Health, 2009), outlines in more practical terms the way in which rates of breastfeeding should be increased and the associated benefits measured. It also refers to the importance of; “providing peer support – especially during the early weeks – to establish and continue breastfeeding”, in order to support the Government’s indicator for breastfeeding (8:2009). Such recent policies and papers suggest the importance of peer support programmes to increasing rates of breastfeeding among particular socioeconomic groups (in Grant and Ogden, 1:2012).

Meanwhile, *Start 4 Life*⁴ translates this national-scale guidance into practical advice directed at new mothers, to inform and assist them to breastfeed. On another practical level, the *Health Visitor 4 5 6 Model*⁵ acknowledges breastfeeding as one of the six high impact areas that enable Health Visitors to assist in improving access, experience and outcomes, reducing inequalities in health, at both an individual and community level. Breastfeeding is also a key feature of maternity services policy, particularly in light of the Department of Health’s *Maternity Matters* (2007) strategy; which has meant, for example that breastfeeding assessment now forms a necessary part of the Maternity Pathway⁶.

In contrast, *The Early Life Nutrition Report*, produced by the Scientific Advisory Committee on Nutrition (SCAN) in 2011, introduces some of the concerns with determining the precise impact breastfeeding has on health outcomes in later life. While acknowledging that there is, “an extensive body of evidence [supporting] the consensus that not breastfeeding increases the risk of illness in both mothers and infants” (104:2011), it concludes that, “there is insufficient information about the influence of these early differences on later body composition and metabolic function” (104:2011). This information deficit is a recurrent theme throughout various facets of breastfeeding, which is discussed in a later section of this review.

Scotland national policy

Over the last decade, there has been a notable focus on early years in Scottish Government policy, due to a recognition that it leads to improved physical and emotional health throughout an individual’s life. In its examination of integrated provision of health care services for children and families in the wider context of Scottish policy, the publication of *Health for all Children 4: Guidance on Implementation in Scotland* (Hall 4) in 2005 has resulted in significant changes to early years policy across Scotland. Specifically, Hall 4 has led to the development of successional child health and care policies, including *Better Health, Better Care* (2007), *Achieving our Potential* (2008), the *Early Years Framework* (2009), and the *National Parenting Strategy* (2012). These exemplify the Scottish Government’s commitment to supporting children and families through

⁴ <http://www.nhs.uk/start4life/breast-feeding>, accessed 13th October 2015

⁵ http://www.ihv.org.uk/uploads/iHV_A5_456%20model_V7%20WEB.pdf, accessed 14th October 2015

⁶ <https://www.england.nhs.uk/wp-content/uploads/2012/07/comm-maternity-services.pdf>, accessed 15th January 2016

the crucial early years of a child's lifetime – including from a nutritional perspective – and coincide with the *Breastfeeding etc. (Scotland) Act 2005*⁷.

These policies have translated into guidelines and frameworks for associated health services. The Early Years Framework outlines the universal pathway of care (2011), which has been informed by the *Getting it right for every child (GIRFEC)*⁸ approach for improving the wellbeing of children. Building on these principles, *Improving Maternal and Infant Nutrition: A Framework for Action* (2011) envisions that, “all women receive the support they need to initiate and continue breastfeeding for as long as they wish” (8:2011), in recognition that: “the benefits of breastfeeding go beyond the nutritional value of breast milk” (19:2011), and, “an association between maternal deprivation and breastfeeding” (33:2011).

Welsh national policy

A Strategic Vision for Maternity Services in Wales (2011) discusses the [then] current provision of maternity services and the future needs, recognising that, “a particular priority is optimising nutrition from birth” (5:2011). Like England, the Welsh government also use *Start 4 Life*⁹ as a means of translating national-scale guidance into practical advice to inform and assist new mothers to breastfeed.

Northern Irish national policy

The Northern Irish Department of Health, Social Services and Public Safety (DHSSPS) has developed a number of frameworks that detail the value of breastfeeding to public health. *Breastfeeding – A Great Start: A Strategy for Northern Ireland 2013–2023* (2013) details four core outcomes that Northern Ireland seeks to achieve in relation to breastfeeding: (i) supportive environments for breastfeeding exist throughout Northern Ireland; (ii) health and social care has the necessary knowledge, skills and leadership to protect, promote, support and normalise breastfeeding; (iii) high quality information systems in place that underpin the development of policy and programmes, and which support Strategy delivery; and (iv) an informed and supportive public (6–8:2013).

In *A Fitter Future for All: Framework for Preventing and Addressing Overweight and Obesity in Northern Ireland 2012:2022* (2013), the DHSSPS also refer frequently to the importance of breastfeeding in addressing overweight and obesity experienced among adults.

⁷ http://www.legislation.gov.uk/asp/2005/1/pdfs/asp_20050001_en.pdf, accessed 14th October 2005

⁸ <http://www.gov.scot/Topics/People/Young-People/gettingitright>, accessed 14th October 2015

⁹ <http://www.nhs.uk/start4life/breast-feeding>, accessed 13th October 2015

Why peer support?

In a study of peer support service in North–West England, Thomson et al (2015) incorporates Cindy–Lee Dennis'¹⁰ definition of peer support: “the provision of emotional, appraisal, and informational assistance created by a social network member who possesses experiential knowledge of a specific behaviour or stressor and similar characteristics as the target population”.

In the context of breastfeeding across the UK, peer support is a form of mother–to–mother assistance used to increase the prevalence of breastfeeding, with the intention of facilitating the best health outcomes for mother and child. This, explains Thomson et al, is because peer support can be used to develop social capital within a community: networks and relationships that can influence knowledge sharing in employment, education or health outcomes (2:2015).

Peer supporters

Based on the literature included within this review, the exact terminology used to describe the various roles within peer support schemes varies by programme or scheme. While peer support can be used to describe assistance given by any mother–to–mother relationship, a peer supporter tends to be someone who has already experienced breastfeeding and is now using their knowledge to assist others (Grant and Ogden, 5:2012). Invariably, peer supporters are volunteers – though in some cases they are paid – who have undergone some kind of training, and they may be coordinated or led by a volunteer coordinator. This review found there to be numerous terms used to describe peer supporters (such as “bosom buddies” in Jackson, 2004), so in order to avoid confusion, the following sections will use the term ‘peer supporter’ exclusively.

As later discussed, peer support has been popularised as a result of potential evidence to suggest it is effective in overcoming barriers that otherwise prevent mothers from certain deprived socioeconomic backgrounds initiating and continuing breastfeeding. Peer support schemes can be funded and organised in a variety of ways, for example local health boards or initiatives (such as Community Health Partnerships), local councils, National Childbirth Trust (NCT), the Association of Breastfeeding Mothers (ABM), or the BfN.

Breastfeeding peer support approaches and considerations

There exist a number of potential breastfeeding peer support approaches, which can be broadly divided into two categories, according to *Northern Ireland: what is the evidence?* (4:2004); support for individuals, and support delivered to groups. Using information gathered by Grant and Ogden in *Devon Best Practice for Breastfeeding Peer Support* (10–14:2012), the most

¹⁰ Dennis, CL. (2003) Peer support within a health care context: a concept analysis. *Int J Nurs Stud.* 2003; 40: 321–9

prevalent, specific methods are outlined below. Each method presents a unique set of considerations, which form the foundation of effective practice.

Groups

The most frequently cited (or evaluated) approach considered by the publications in this review is group peer support intervention. Groups are often considered the most effective method of providing peer support, in part because they can be a vehicle for connecting other services that contribute towards successful breastfeeding interventions. Grant and Ogden (10–11:2012) explain that a group is more likely to be sustainable if peer supporters feel a sense of ownership over the group. This can be initiated by enabling peer supporters to run the groups with a committee/constitution (like a community group), and allowing them to choose a name for the group. Ensuring peer supporters wear particular tops/badges when at the groups compounds a sense of ownership, as well as making them identifiable to new attendees. Thomson et al even suggest that wearing tops or badges outside of the group meetings can be useful in attracting interest from other members of the community, who otherwise might have trouble accessing peer supporters (9:2015).

Grant and Ogden (10–11:2012) also explain that flexibility is important to the success of peer groups; peer supporters should attend on a rota basis to ensure their volunteering availability is met, and they should be willing to adopt other supporting roles (i.e. librarian) where necessary. Above all, they suggest warmth and friendliness expressed by peer supporters is integral to the effectiveness of the group.

In addition to the practice of peer supporters, Grant and Ogden (10–11:2012) describe a number of practical considerations which contribute towards the effectiveness of peer support groups. For example, an absence of chairs at meetings means that mothers are encouraged to sit on cushions on the floor which in turn means that they are better able to: “provide protection from boisterous toddlers running around, this helps to encourage biological nurturing” (11:2012). Additionally, providing hot drinks can help women breastfeed as it encourages the release of the hormone Oxytocin.

One-to-One Support

Dowling and Evans (31:2013) view the development of one-to-one support as being particularly important to addressing low breastfeeding rates among women in disadvantaged areas; partly due to negative perceptions these women have about peer support groups, and because they may find it difficult to attend groups. This concept is discussed further in the next section.

Grant and Ogden develop this, suggesting that one-to-one support could be offered: at children’s centres, home visits, telephone support in late antenatal/early postnatal stages, and accompanying women to breastfeed in public to help them overcome feelings of embarrassment (12:2012).

Hospital Visits

While this can only be undertaken by volunteer peer supporters upon completion of specific additional training, hospital visits can prove valuable in encouraging breastfeeding uptake by hard-to-reach groups, by ensuring consistency in support following a mother's time in hospital through to when she returns home. Employed peer supporters can undertake this enhanced service as part of their employment working in partnership with local acute trusts (Grant and Ogden, 12–13:2012).

Antenatal Education Sessions

These sessions are useful to deliver standard UNICEF BFI information to mothers, which has been found to increase rates of breastfeeding initiation and the duration of breastfeeding among women on low incomes (Grant and Ogden, 13:2012). The value of this standard approach is in avoiding conflicting information being given, but key to the quality of information delivered is the training provision for staff. Peer supporter involvement in such information delivery requires additional training.

The effectiveness of peer support

Does peer support work?

A number of the publications included in this review report positively on the effectiveness of breastfeeding peer support programmes. Jones (32:2012) reports that in a particular area of Brighton and Hove, there was a 6.4% increase in breastfeeding rates at six to eight weeks as a result of a peer support scheme. In addition, Jackson (2004) found 88.9% were still breastfeeding six weeks after attending the West Howe breastfeeding support group. Similarly, Ly (2009:12–13) describes the success of a peer support programme in North Lanarkshire called Community Mothers; the exclusive breastfeeding rate at six weeks for mothers taking part in the programme was 54%, significantly higher than the 18.75% on average in Lanarkshire.

The Bemerton Heath Breastfeeding Support Group project report (2002) also found breastfeeding rates to be higher among women who became involved in the peer support group. For instance, 64% of all those who had attended the group were still breastfeeding after six weeks. The authors note a number of key factors contributing towards the effectiveness of the group, including its access and availability, the knowledge and understanding given by buddies (peer supporters), the supportive atmosphere of the groups, and the sense of community generated by the scheme (29–33:2002).

While the evidence presented in Ingram's evaluation of peer support in Bristol (2013) gives a more modest picture of the quantitative effects of peer support on rates of breastfeeding, the author emphasises the psychological impact from peer support interventions. Ingram explains that peer support has been instrumental in increasing women's confidence to breastfeed (8:2013).

In *Northern Ireland: what is the evidence?* (2004), the authors also describe the effectiveness of peer support evidenced in Sikorsky et al's (1999) systematic review. Sikorsky et al found peer support to be effective in promoting exclusive breastfeeding, albeit it was unclear of the effect it had in lengthening the duration of breastfeeding. Sikorsky et al also found intervention involving face-to-face support was more effective on the duration of breastfeeding than mainly telephone support.

A study of peer counselling in deprived areas of Glasgow (McInnes et al, 2000) initially established a more mixed picture of the effectiveness of peer support. While statistical analysis found no significant differences, a reanalysis of the results to take account of socioeconomic status found that significantly more women had initiated breastfeeding at delivery having taken part in the counselling. This effect appears to be diminished by six weeks after childbirth, yet there continues to be a statistically significant effect among women who had initially shown an interest in breastfeeding and had then become involved in the peer support intervention. As described in *Northern Ireland: what is the evidence?* (2004), this Glasgow study concluded that stand-alone interventions can only be considered effective in ante- and post-natal periods for women who expressed intent to breastfeed, but not those who wished to bottle-feed.

Nonetheless, Thomson et al.'s (2015) evaluation of peer support service in North West England finds peer support to be highly effective in the context of social capital. In particular, bridging social capital and outreach work with mothers from different ethnic backgrounds (particularly those with Eastern European and Spanish culture heritages) was assisted by the active recruitment of volunteers from these cultures (8:2015). In spite of this, they suggest, "more focused efforts to engage women from different cultural ethnic backgrounds...are warranted", as these groups remain difficult to reach by the service (12:2015).

The 2013 NHS Health Scotland review of peer support evidence looks at evidence for peer support beyond individual case studies, recognising that while, "outcomes of individual primary outcome studies are important, these may be atypical". They suggest that such bias can be reduced by looking at "highly processed evidence", which their review chooses to focus on (10:2013).

By adopting this approach, the 2013 review concludes that, "overall, recent review-level evidence indicates that peer support is an effective intervention for breastfeeding. They caveat this with further key messages, suggesting that peer support needs to be treated as a "transactional activity" between peer supporter and breastfeeding mothers, and that support requires adequate definition and guidance in accordance with ethical principles, in order to be successful (8:2010).

Variations by method

In extension to Thomson et al's findings, the majority of publications included in this review also conclude that it is important for peer support schemes to be flexible and tailored to specific mothers in order to be effective.

In general, it appears peer support groups work well for a large proportion of mothers: groups use the power of community (Anderson et al, 33:2002) to normalise breastfeeding (Dowling and

Evans, 24:2014). Grant and Ogden discuss this in more detail: “groups were more popular because they normalised breastfeeding in a social environment...provided flexibility, a sense of control, and a diversity of visual images and experiences, which assisted women to make feeding-related decisions for themselves” (Hoddinott, Chalmers & Pill, 2006, in Grant and Ogden, 3:2012).

Dowling and Evans describe this normalisation as particularly important for communities where breastfeeding is not widely accepted, due to societal pressures. They suggest that the peer support becomes a vehicle for “promoting cultural change” (20:2013) as they say: “peer support was clearly recognised by participants as important in contributing to changing cultural attitudes and beliefs about breastfeeding – and thus to improving breastfeeding continuation rates” (20:2012).

While it seems group peer support works well for a large proportion of mothers, an almost equal proportion of the publications suggest alternative approaches (e.g. one-to-one) could be more successful in increasing the incidence and duration of breastfeeding among the most difficult to reach mothers. In their study of peer support in Wiltshire, Dowling and Evans found that young women were a particularly hard to reach group, and from their interviews it emerged: “Some felt that young women might respond better to one-to-one buddying and emphasised the importance of antenatal contact and of building relationships before the birth” (32:2014).

If nothing else, one-to-one support can prove valuable in encouraging mothers who might be shy or nervous about attending a group to make the initial contact. In her evaluation of the West Howe breastfeeding support group, Jackson concluded: “taking that first step and attending the group initially was felt by many of the women to be the most difficult barrier to overcome for young, unsupported mums in the area... the [peer supporters] aimed to increase outreach working and encourage new mums to attend by visiting at home and offering to accompany them to the group” (32:2004).

The multifaceted approach

Given that they establish that peer support needs vary between mothers, the majority of publications in the review discuss the importance of multifaceted interventions to maximising the effectiveness of peer support schemes. Grant and Ogden state clearly: “Peer support programmes are best used as part of a multi-faceted approach and are not a stand-alone intervention” (16:2012); and Dowling and Evans recommend a mixed method approach that incorporates flexible and tailored options (2013:60–64).

The authors of *Northern Ireland: what is the evidence?* describe more specifically what a multifaceted (or mixed method) approach might entail: “Findings from before and after studies indicated that successful multifaceted interventions tend to include education about breastfeeding and structural changes to the health sector, combined with peer support programmes and/or some kind of media activity” (11:2004). Furthermore, Dyson et al (2005) in Grant and Ogden (2:2012) argue: “Each locality is likely to find that they need to develop their

own tailored package of interventions, selecting the appropriate mix of services and outcomes”. This, along with other methods of good practice, are discussed in the section that follows.

A recently published Special Issue of *Acta Paediatrica* brought further focus to the impact of breastfeeding on maternal and child health (2015), which included an exploration of the effectiveness of interventions when delivered in different settings. This article – a systematic review and meta-analysis of interventions to improve breastfeeding outcomes – explored the importance of concurrently delivering interventions in a variety of settings, and found: “greatest improvements in early initiation of breastfeeding, exclusive breastfeeding and continued breastfeeding rates, were seen when counselling or education were provided concurrently in home and community, health systems and community, health systems and home settings, respectively” (114:2015).

Conflicting evidence: problems with conducting trials

Undoubtedly there is commonly found evidence and conclusions that suggest peer support is an effective method of increasing the initiation and duration of breastfeeding among mothers in the UK. Nonetheless, the tentative presentation of a number of the aforementioned research findings point towards underlying questions about the availability of robust research findings in peer support trials. For example, this is exemplified in Wade, Haining and Day’s investigation of the additional benefits of breastfeeding, in which the authors concede that the implications of their study are limited by the small sample size and potential subjectivity of the breastfeeding supporter (Wade, Haining and Day, 2009).

Hoddinott et al.’s examine a number of breastfeeding intervention trials (2011) – including but not limited to peer support – concluding that, “the current paucity of high-quality research to inform UK breastfeeding policy and practice needs to be addressed” (225:2011), in reference to problems with the trial duration, sample size and sample selection in research conducted to date.

At the same time, the authors still find a modest case to support a multifaceted approach to intervention as they conclude that, “on balance, the problem of non-significant outcomes appears to be related to the choice of intervention and how it is delivered rather than the trial design” (225:2011). This builds on their acknowledgement that, “absence of evidence for a particular intervention is not the same as evidence of absence of an effect, not only for methodological quality issues but also because the intervention may need to be combined with other interventions to be effective” (225:2011).

Jolly et al.’s (2012) meta-regression analysis of peer support for breastfeeding continuation found more specific variations in the effectiveness of peer support. They examined the effect of timing, intensity and setting of peer support on breastfeeding, finding breastfeeding peer support interventions to only increase breastfeeding continuation in low or middle income countries – and not high income countries like the UK. They suggest that this is because services that support breastfeeding are already well established in such countries. As a result, the authors emphasise the importance of evaluation of new peer support services that might be established in high income countries.

The 2013 Scottish review of peer support evidence also acknowledges that there are still issues with the evidence base for breastfeeding peer support; including gaps in relevant primary studies of areas of interest, interpretation issues, and, “gaps in strong scientific evidence, the feasibility and desirability of adopting a purely evidence-based approach to health improvement and reducing health inequalities are limited” (10:2013). However, based on the wide-ranging, extensive review of highly processed evidence, it still recognises, “activities that lack a strong evidence base may have important contributions to make to the overall impact of a package of interacting activities that together comprise a complex intervention” (10:2013).

Other notable research findings

Throughout this review, a number of further considerations have emerged, which could prove useful to bear in mind during the design of research into the effectiveness of current activity and future evaluation of BfN practices. Of these considerations, the most relevant are detailed below.

Reaching the women least likely to breastfeed?

A major concern presented by certain publications is that peer support groups are struggling to reach their target group: women least likely to breastfeed without intervention. This has proven problematic to groups in a number of ways, firstly in instances where mother’s attending groups from outwith the target community has resource gap for mothers from targeted communities. For instance, problems were caused in the West Howe group by the attendance of mothers outside of West Howe community, as one interviewee describes: “I find it quite uncomfortable when a mum who lives within the area wants to borrow a sling, or wants to borrow a particular video and it’s on loan to someone outside of the area” (peer supporter: Jackson, 14–15:2004).

Dowling and Evans’ (2013) evaluation of Department of Health funded peer support projects in Wiltshire details other issues that mean that groups may not always reach the targeted group of mothers. Aside from issues with the perception of peer support groups (as described below), the Wiltshire evidence suggests that there can be a cycle of poor attendance, where mothers are disinclined to attend ‘groups’ when they find there to be few regular attendees (34:2013).

Perceptions of peer support groups

Dowling and Evans (2013) also found there to be perception problems with peer support groups which could be limiting uptake and therefore, effectiveness. The nature of the perception problem varied greatly according to the peer support group in focus. For instance, mothers who might otherwise consider attending a group may be put off by the location. Depending on funding and organisation, peer support groups are sometimes held at Children’s Centres; Dowling and Evans discuss some of the perception issues this has caused in peer support groups across Wiltshire: “It was felt that Children’s Centres might have negative associations for some women, particularly those who had existing contact with social or health care services in relation to family issues” (35:2013).

In addition, Dowling and Evans found some women to be wary of peer support groups as they viewed them as “middle class”, and also discovered, “peer supporters and stakeholders were keen to emphasise that they felt it important to change the image of groups as being for women with problems” (28:2013). This is interesting to consider, given that other findings in this literature review indicate a degree of tension in determining whether peer groups should be exclusive to women experiencing breastfeeding difficulty, as later discussed.

Challenges in partnership working

A number of publications examined in this review detail the challenges encountered through peer supporters and medical professionals working together. In her examination of peer support in Bristol, Ingram reports that this was initiated by confusion by midwives on the exact role of peer supporters (7:2015), as echoed by Grant and Ogden (1:2012). Thomson et al discuss this further as they describe, “tensions in inconsistent advice across the peer–health–community professionals and the potential negative impact on a women’s self–efficacy to breastfeed” (10:2015). This “stepping on other people’s professional toes” (10:2015) was particularly profound when communication between parties was poor, and when services overlap.

The potential disparities in the purpose and remit of peer supporters compared with other healthcare professionals – in terms of the issues they attempt to address and their approach in doing so – can also bring challenges to partnership working. The authors evidence this with an interviewee discussing babies’ weight gain: “There’s been a few instances where really the babies have needed a top up as well because they’ve lost so much weight, but they haven’t been advised to do that because, obviously, it’s not really down to the peer supporters to do that” (11:2015).

While some of these issues can be resolved throughout the course of partnership working, a number of peer supporter providers place strict guidelines on partnership working relationships throughout training, in order to prevent potential challenges arising. For example, at the initial stages of commissioning peer support, Breastfeeding Network emphasise, “Breastfeeding peer support should be multifaceted...It is not an alternative to health professional support but a valuable part of breastfeeding support service¹¹”.

Breastfeeding and bottle feeding

There is much discussion within the publications of the interplay between breastfeeding and bottle feeding, particularly in terms of whether peer support groups are exclusive to breastfeeding mothers as previously discussed, and also with regards to a mother’s decision to wean or give a bottle to her baby. On the one hand, Grant and Ogden suggest that making the group exclusive to breastfeeding mothers – thus excluding mothers who bottle feed – helps encourage uninterrupted positivity around breastfeeding (11:2012). However, in their evaluation of peer support in Wiltshire, Dowling and Evans (2013) find that some stakeholders feel a ‘mixed group’ approach would be more likely to increase the rates of breastfeeding. One study

¹¹ <https://www.breastfeedingnetwork.org.uk/commissioning-peer-support/>, accessed 15th January 2015

participant describes this as a “slow change without the pressure”, which would have a knock-on effect for subsequent children (47:2013).

In her examination of West Howe Breastfeeding support group, Jackson describes how some interviewees find the tension between breastfeeding and bottle feeding “intimidating”, as one mother explained: “There is a danger that you can be made to feel like you have failed if you want to switch to a bottle or wean a bit earlier than they advise. Support has to be given to all women whatever their decisions about feeding. You don’t want to feel guilty about giving up breastfeeding” (24:2004). This is made particularly difficult in instances where women have formed a strong social network at their group, and so might feel uncomfortable about leaving.

Societal responsibilities in breastfeeding

In early 2016, the Lancet published a series of papers discussing an array of issues relating to breastfeeding, ranging from global trends in breastfeeding to the effectiveness of interventions. This series drew attention to societal responsibilities in breastfeeding promotion. In “Why invest, and what it will take to improve breastfeeding practices?” (491–504, 2016), the authors conclude that one of the six key action points that policy makers should address, is that societies should foster positive attitudes towards breastfeeding since, “negative societal attitudes....are all too common. Breastfeeding is generally thought to be an individual’s decision and the sole responsibility of a woman to succeed, ignoring the role of society in its support and protection” (500:2016). This focus on societal roles in breastfeeding promotion brings a fresh perspective to both the complexity and determinants of success in breastfeeding interventions.

Good practice in breastfeeding peer support

This review has established some of the complexities involved in establishing, defining, and evidencing effective peer support practice. While there remains clear discrepancies in the strength – and even direction – of findings from peer support reviews to date, there are a number of recommendations and suggested approaches arising from this work, which could help establish good practice in breastfeeding peer support. Whilst other good practice examples are present in research, the themes described below are the major ones.

According to NICE guidance, peer support breastfeeding schemes should, “be integrated with other elements of care for women requiring support for breastfeeding” (Grant and Ogden, 4:2012). The findings of their evaluation further evidence that it is: “essential that the peer support programme is ran as part of local breastfeeding strategies and as an integrated service that complements health services and children’s centre services in order to be highly effective” (15:2012). In effect, peer support should be able to connect all services that a breastfeeding mother might require for successful breastfeeding, particularly if it is to assist mothers from difficult to reach backgrounds experiencing multiple deprivation: groups should work as a “hub” for all other conjoining services (Grant and Ogden, 16–7:2012).

- **A mixed, multifaceted and responsive approach**

As Dowling and Evans describe: “a mixed method approach, providing flexible and tailored options, is the best way to meet the needs of all women” (2013:60–64), so that it can be, “responsive to the needs of women and their babies” (NICE guidance in Grant and Ogden, 4:2012). This can also include making a range of resources available to women involved in peer support, such as libraries and bra loaning (Grant and Ogden, 16–17:2012; Anderson et al, 14:2002).

- **Skilled and appropriate providers/facilitators**

Both the formal training and soft-skills of the volunteers and staff involved in coordinating and delivering peer support programmes is an integral determinant of its success. Grant and Ogden suggest the importance of training at a practical level: “high quality, effective peer support programme also requires externally verified accredited training...this works as a key quality control measure” (4:2012). Further, mothers should be able to access a professional with the appropriate skills to meet specific needs, such as healthcare professionals and lactation consultants (Anderson et al, 14:2002). Anderson et al also discuss the importance of the behaviour and attitude of peer supporters, “with emphasis on social support and friendship”, creating an atmosphere of, “praise and encouragement” (14:2002). These measures combine to ensure that both the physical and emotional needs of a mother encountering peer support are met.

- **Community ownership**

Anderson et al find this to have been particularly important to the effectiveness of the Bemerton Heath Breastfeeding Support Group. According to publication incorporated in this review, developing a sense of community ownership is predominantly a result of enabling local people to organise peer support [groups] – for instance, the name, time, location – and is important to attracting local mothers to the peer support schemes. This can also involve, “recruiting peer supporters from within the targeted community” (Grant and Ogden, 16–17:2012).

While Dowling and Evans also find it to be important that peer supporters come from within the target communities in order to maximise effectiveness, they recognise some of the potential issues in achieving this as an interviewee describes: “it kind of contradicts the whole idea of peer support, when it’s meant to be someone living in your area but it’s chicken and egg, can’t draw on someone who doesn’t exist” (35:2013). Likewise, they say that in communities where negative views of breastfeeding are particularly entrenched, recruitment of peer supporters is likely more difficult.

- **Effective marketing and branding**

While this applies more to groups than other forms of support, numerous publications have highlighted perception issues that might be overcome by tailoring the ‘branding and marketing’ of the peer support to their target audience (for example, Dowling and Evans, 60–64:2013).

Evaluative strategies

The evaluative strategies adopted in the publications examined by this review are wide reaching, incorporating qualitative and quantitative questionnaires (using various mediums), and focus groups.

Potentially, the information most applicable to the evaluation in this study can be found in Fife Breastfeeding Support Project (Anon, page 8). Evaluation of the support service is conducted using questionnaires, distributed to mums by support workers; and respondents are asked about a range of issues, including:

- “How useful they found being contacted within a few days of discharge”;
- “Whether they were aware of the service before they were called”;
- “Whether they had any further support from a support worker, and how helpful it was”;
- “The impact of support workers on their intention and duration of breastfeeding”;
- “Whether they had used any other breastfeeding support services”;
- “How useful they found the resources they were given”;
- “Who and what had been most and least supportive in their breastfeeding attempts”;
- “How they are feeding their baby now, including whether they were still breastfeeding at six weeks”;
- “Any other comments and suggestions for improving the service for other mums and better enabling them to breastfeed for longer”.

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APPENDIX 2 AGE PROFILE OF MUMS RESPONDING TO SURVEY

Age category	Number of responses / % of total
	195 100%
16-25	19 10%
26-35	120 62%
36-45	55 28%
46-55	1 1%
56 or over	- -

APPENDIX 3 LOCATION OF RESPONDENTS TO ONLINE SURVEY

Post town	Number of responses	Total	%
London / Ilford	24 / 1	25	12
Reading / Slough	21 / 1	22	11
Wolverhampton / Birmingham / Walsall / Dudley / Coventry / Shrewsbury / Northampton	7 / 4 / 3 / 3 / 1 / 1 / 1	20	10
Kilmarnock	17	17	8
Portsmouth / Southampton	13 / 2	15	7
Chester	13	13	6
Paisley / Glasgow / Motherwell	6 / 3 / 1	10	5
Stevenage / Watford / Hemel Hempstead	7 / 2 / 1	10	5
Bristol / Bath / Gloucester / Swindon	6 / 1 / 1 / 1	9	4
Ipswich / Norwich	8 / 1	9	4
Leeds / Bradford / Halifax / Sheffield / York / Hull	2 / 2 / 1 / 1 / 1 / 1 / 1	8	4
Manchester / Blackburn / Blackpool / Preston	3 / 2 / 2 / 1	8	4
Plymouth / Exeter / Truro	3 / 2 / 1	6	3
Swansea / Carmarthen	4 / 1	5	2
Liverpool / Wigan	2 / 1	3	1
Colchester / Chelmsford	2 / 1	3	1
Cleveland / Darlington	2 / 1	3	1
Guildford / Tonbridge / Redhill	1 / 1 / 1	3	1
Brighton	2	2	1
Dartford	2	2	1
Aberdeen	1	1	0.5
Belfast	1	1	0.5
Bournemouth	1	1	0.5
Cambridge	1	1	0.5
Derby	1	1	0.5
Edinburgh	1	1	0.5
Llandudno	1	1	0.5
Oxford	1	1	0.5
Peterborough	1	1	0.5

APPENDIX 4 ISSUES DISCUSSED BY MUMS WITH BfN

Issues discussed with BfN	203 100%
Positions and attachment for feeding	131 65%
Painful breasts or nipples	108 53%
General support and encouragement	106 52%
Illness or medication	93 46%
Expressing	77 38%
Frequency of feeding	72 35%
Baby's weight gain	58 29%
Meeting other mothers	54 27%
How I am feeling	54 27%
Breastfeeding out and about	48 24%
Introducing solid foods	47 23%
Baby's sleep	45 22%
Returning to work	34 17%
Bonding with my baby	27 13%
Breast refusal	26 13%
Stopping breastfeeding	19 9%
Mental health	15 7%
Other	12 6%

APPENDIX 5 CHALLENGES FACED IN BREASTFEEDING

What challenges have you faced with breastfeeding	201 100%
I experienced physical problems eg cracked nipples	122 61%
It can be tiring	104 52%
It can be uncomfortable	93 46%
Baby wouldn't latch on sometimes	74 37%
It can be physically difficult	68 34%
Needed to take medication	59 29%
I have lacked confidence with breastfeeding at times	59 29%
It can be embarrassing to breastfeed in public	46 23%
I found it difficult/didn't come naturally	45 22%
My friends or family don't think I should breastfeed	37 18%
Baby was unable to feed sometimes	35 17%
Returning to work made it more difficult	30 15%
Medical problems	30 15%
Other people in the community disapprove of breastfeeding	28 14%
It can be embarrassing	25 12%
Other people have reacted negatively to me when I have breastfed in public	17 8%
I had another baby	14 7%
Other	13 6%
We haven't had any challenges	9 4%
I found other feeding options easier	5

	2%
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