

Breastfeeding peer support in Wiltshire: An evaluation

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Contents

| | |
|---|----|
| Executive summary | 4 |
| Part 1: Background and context | |
| 1.1 Introduction | 7 |
| 1.2 The evaluation | 7 |
| 1.3 The importance of breastfeeding | 8 |
| 1.4 Breastfeeding in the UK | 9 |
| 1.5 Breastfeeding in Wiltshire | 10 |
| 1.6 Breastfeeding policy and guidance | 11 |
| 1.7 The importance of peer support for breastfeeding | 12 |
| Part 2: Design and methods | |
| 2.1 Introduction | 17 |
| 2.2 Design | 17 |
| 2.3 Methods | 17 |
| 2.4 Recruitment and sampling | 18 |
| 2.5 Data collection | 18 |
| 2.6 Analysis | 20 |
| 2.7 Ethics | 20 |
| Part 3: Findings | |
| 3.1 Introduction | 21 |
| 3.2 The value of peer support | 21 |
| 3.3 The perception of peer support | 28 |
| 3.4 Reaching the women least likely to breastfeed | 31 |
| 3.5 The provision of peer support | 35 |
| 3.6 Ante- and post-natal contact | 48 |
| Part 4: Discussion | |
| 4.1 Introduction | 53 |
| 4.2 Are peer supporters being drawn from disadvantaged communities? | 53 |
| 4.3 Are women being offered contact prior to birth? | 55 |
| 4.4. What other issues affect the provision of peer support in Wiltshire? | 55 |
| 4.5 Summary of enablers and barriers | 58 |
| Part 5: Conclusion and recommendations | |
| 5.1 Conclusions | 60 |
| 5.2 Limitations | 61 |
| 5.3 Recommendations | 62 |
| References | 65 |

Executive summary

Introduction

This evaluation was commissioned by NHS Wiltshire to consider how the implementation of breastfeeding peer support in Wiltshire might be improved. The focus was three areas known to have significant deprivation and low breastfeeding rates – Trowbridge, Salisbury and Westbury. The underlying aim was to consider the effectiveness of peer support, how accessible it was to women in these areas and to those least likely to breastfeed, including young women.

Work to support and promote breastfeeding in Wiltshire is underpinned by the Wiltshire Breastfeeding Strategy, a three-year plan aiming to increase the number of women initiating breastfeeding and breastfeeding at six to eight weeks, and to increase breastfeeding at six to eight weeks among women living in the most deprived communities.

Breastfeeding is a public health priority in the UK, widely acknowledged to be important in improving public health and reducing health inequalities. Increasing breastfeeding duration in lower income groups and amongst younger women is seen as a key target in reducing health inequalities, and has been particularly emphasised by the Department of Health (DH).

In Wiltshire, DH funding to increase breastfeeding initiation and duration was used to support a number of activities, including establishing and maintaining breastfeeding peer support. A specific, peer support intervention was initiated in order to target areas of significantly lower prevalence of breastfeeding, involving ante- and post-natal text and telephone contact.

Design and methods

The evaluation was influenced by realist evaluation and qualitative methodology. One-to-one semi-structured interviews were carried out with a range of stakeholders and breastfeeding women. Two focus groups were carried out with breastfeeding

peer supporters in two out of three identified evaluation areas. Stakeholders were identified by the commissioner of the evaluation and health visitor and midwifery managers. The intention was that other participants were recruited via the peer support co-ordinators in each area. This was straightforward in one area but problematic in the other. Breastfeeding women were eventually recruited through an alternative route, resulting in interviews with women who had also recently trained as peer supporters. We reflect on the implications of this. Although we were able to speak to two health visitors, no midwives took part in the evaluation.

Findings

Thematic analysis identified five themes: the value of peer support, the perception of peer support groups, the provision of peer support, reaching the women least likely to breastfeed and ante- and post-natal support. These are discussed in depth, supported by extensive quotations from participants. The passion and commitment of the peer supporters was evident throughout. Peer support was strongly valued for providing social support, as well as help with specific breastfeeding problems. It was seen as normalising breastfeeding and as providing support which was often not available culturally and socially. Women valued the opportunity to meet other mothers who recognised the importance of breastfeeding and of parenting in this way. Participants recognised that peer support was perceived by many as only for those with breastfeeding problems, and for older, 'middle-class' or 'hippy' women. Groups were not felt to be an appropriate way of offering support to all women and alternatives were suggested.

Peer support provided in Children's Centres was sometimes seen as problematic, particularly for those from disadvantaged areas and young women. It appears to work best where there is clear local leadership from someone passionate about breastfeeding, who offers practical and other support to the group and to the peer supporters. Peer support is not felt to be successfully reaching the women least likely to breastfeed and this is recognised as a challenging issue. Difficulties include recruiting peer supporters when breastfeeding rates are very low, the need for a range of methods of support, and strongly held family and cultural beliefs about infant feeding. Findings relating to the ante- and post-natal contact intervention are

primarily in relation to the importance and value of ante-natal contact and the peer supporters' feelings about carrying out this additional role.

Discussion

The discussion focuses on relating the findings to the original objectives of the evaluation. A range of factors which appear to result in few women from disadvantaged communities and young women accessing peer support are considered, including cultural norms and the perception of groups. During data collection the planned intervention had not yet been successfully implemented; we make only some general comments about the perceived importance of this and the implications for peer supporters. Issues which affect the provision of peer support are discussed including the location and running of groups, the strong perception of peer support groups as being for breastfeeding problems and the importance for breastfeeding women of the social support they provide. Local leadership is identified as extremely important in the running and maintenance of groups. Examples of good practice in the provision of groups as well as the benefits of peer support for the supporters are also highlighted.

Recommendations

A number of recommendations are made. These include: developing a range of models of peer support in order to reach women from groups not currently accessing the established groups; overtly recognising the importance of groups in providing social support and in providing some elements of lost cultural/societal support; sharing ideas and learning from good practice by contact with those working elsewhere in rural areas and with young women; ensuring that there is appropriate local leadership to enhance the work of the peer supporters and contribute to a supportive infrastructure; engaging in further strategic work in order to fully engage both GPs and midwives and recognising that further work on marketing is needed in order to counter the negative perceptions of groups that prevent some women from accessing support. Further research and evaluation priorities are identified, including an evaluation of the fully implemented text/telephone contact intervention.

Part 1: Background and Context

1.1 Introduction

This section of the report describes the background and context to this evaluation of breastfeeding peer support in Wiltshire. This includes both relevant local information as well as outlining the national and local policy context.

1.2 The evaluation

Towards the end of 2010 the University of the West of England, Bristol (UWE) was approached by NHS Wiltshire and asked to undertake an evaluation of their breastfeeding peer support intervention project. Following further discussions and the drawing up of a project proposal the work commenced in January 2012. After successful application for ethical approval, data collection was carried out from May 2012 to February 2013.

In Wiltshire at this time, Department of Health funding to increase breastfeeding initiation and duration was being used to support the implementation of UNICEF Baby Friendly Initiative (BFI) Community Accreditation, including establishing and maintaining breastfeeding peer support. Alongside other activities, including providing training to all health visitors throughout 2011, peer support projects were being established in Children's Centres in identified areas across Wiltshire. All work to support and promote breastfeeding in Wiltshire is underpinned by the Wiltshire Breastfeeding Strategy. This three year plan aims to increase the number of women initiating breastfeeding in Wiltshire by 11%; to increase the number of women breastfeeding at six to eight weeks in Wiltshire by 8%; and to increase breastfeeding at six to eight weeks among women living in the most deprived communities in Wiltshire by 6% (all by 2014). This last aim is underpinned by the intention to halve the gap in breastfeeding between women in the least and most deprived areas in the County.

The agreed aim of the evaluation was to consider how the implementation of the breastfeeding peer support scheme might be improved. We were asked to focus in

particular on peer support in three areas in Wiltshire – Trowbridge, Salisbury and Westbury – places with significant deprivation and low breastfeeding rates.

The objectives of the evaluation were:

1. To compare how the initiative is working in practice with how it is intended to work.
2. To identify enabling factors for the intervention – both those in relation to the context of the intervention and those in the intervention itself.
3. To identify barriers to successful implementation of the intervention.
4. To recommend how to improve implementation of the intervention by developing enabling factors and addressing barriers.

Early project meetings also identified the importance of assessing how well recently initiated ante- and post-natal text and telephone contact was working and whether it was impacting on women accessing peer support. The underlying focus of the evaluation was to consider the effectiveness of peer support in some of the most deprived areas of Wiltshire, considering how accessible it was to women in these areas and to those least likely to breastfeed, including young women.

This evaluation was commissioned by the Public Health Department of NHS Wiltshire. During the time of the evaluation, following recent structural and administrative changes to the NHS, this department became Wiltshire Public Health and is now embedded within Wiltshire Council. Work to support and promote breastfeeding in Wiltshire continues to be underpinned by the Wiltshire Breastfeeding Strategy, with oversight of this from within Wiltshire Public Health. Peer supporters and peer support projects continue to be funded and supported as they were at the time of the evaluation.

1.3 The importance of breastfeeding

Breastfeeding is widely acknowledged to be important in improving public health and reducing health inequalities. It has been shown to contribute to health improvements in a range of important areas of public health, including obesity, diabetes and coronary heart disease. A large body of research evidence demonstrates a range of short and long term health and developmental benefits to babies – including a

reduced risk of adverse outcomes such as gastrointestinal disease, respiratory disease, necrotising enterocolitis and otitis media, as well as contributing to improved cognitive development (Horta & Victora, 2013; Ip *et al*, 2007). This evidence supports the recommendation that all babies are exclusively breastfed for six months (WHO, 2003), with breastfeeding continuing beyond this time alongside appropriate foods. Breastfeeding is also beneficial to women's health, contributing to reductions in the risk of ovarian and breast cancer (Vergnaud *et al*, 2013; Ip *et al*, 2007).

Recent research commissioned by UNICEF (Renfrew *et al*, 2012) demonstrated that improving breastfeeding rates could lead to considerable cost savings to the NHS in relation to hospital admissions and GP consultations as well as saving lives by reducing the incidence of sudden infant death syndrome (SIDS). Two of the key messages from this work are that low breastfeeding rates in the UK lead to an increased incidence of disease, with significant costs to the Health Service and that investing in supporting women to breastfeed will lead to increased quality of life for both women and children (particularly by reducing rates of breast cancer in women and acute and chronic diseases in children).

1.4 Breastfeeding in the UK

Breastfeeding is a public health priority in the UK. In the UK rates of initiation of breastfeeding are high but fall rapidly with only 55% of women breastfeeding at six weeks, 34% at six months (McAndrew *et al.*, 2012). UK Government policy follows that of the WHO/UNICEF in recommending that all babies are exclusively breastfed (receive only breastmilk) for six months although latest figures show that only 23% of babies in the UK are exclusively breastfed at 6 weeks, less than 1% at 6 months (McAndrew *et al.*, 2012).

There is a clear relationship between socio-economic status and breastfeeding with significant lower rates amongst women living in the most deprived areas compared to those in least deprived areas, and between women of higher educational attainment and lower. This is seen both in data collected in local areas (Oakley *et al.*, 2013) and in the national Infant Feeding Survey (McAndrew *et al.*, 2012). In addition, younger women are much less likely to breastfeed than older women

(McAndrew *et al.*, 2012). Increasing breastfeeding duration in lower income groups and amongst younger women is therefore seen as a key target in reducing health inequalities and has been particularly emphasised by the Department of Health (Dykes, 2005). The reasons for the variation in breastfeeding rates are complex and multi-faceted, including social and cultural factors as well as the level and quality of support available to pregnant and breastfeeding women. Interventions at different levels from the individual to policy making and wider society are important in promoting change to support breastfeeding (Labbok, 2008).

Since 2004 English Primary Care Trusts (PCTs), and now Local Authority Public Health departments, have been required by the Department of Health to collect and submit breastfeeding data in relation to breastfeeding status at birth and at the 6-8 week review. Exclusive breastfeeding rates have also been collected since 2006. These data are released quarterly by the DH. PCTs had Public Service Agreement (PSA) targets to increase breastfeeding initiation rates year on year. Although data coverage and consistency varies, this information can now be used to look at breastfeeding rates across and within an area, and to do this in relation to measures such as the Index of Multiple Deprivation and a range of sociodemographic factors (Oakley *et al.*, 2013).

1.5 Breastfeeding in Wiltshire

Readers are referred to both the Wiltshire Breastfeeding Strategy, 2011-2014 and the Breastfeeding: Agreed Data Set (Frost, April 2013) for further detail on breastfeeding in Wiltshire. The summary here is primarily drawn from those documents. As in the Data Set, figures discussed here are related to Department of Health Statistical Releases on Breastfeeding for England for comparable periods (this data is collected in a different way to that in the Infant Feeding Survey; the resulting headline figures differ slightly).

Wiltshire has breastfeeding initiation rates that are higher than national and regional averages and has maintained these higher rates since 2007/2008. Over 80% of women in Wiltshire breastfed at initiation in the third quarter of 2012/2013, compared to 78% in the South West and 73.6% in England. Within the County breastfeeding initiation rates vary between maternity service providers with the lowest in Salisbury

Hospitals NHS Foundation Trust and the highest in Great Western Hospitals NHS Foundation Trust. By six to eight weeks fewer babies are breastfed in Wiltshire (46.6%) than in the South West (49.4%) or England (47.2%). Drop off rates are also higher (and have increased from previous years).

There is a recognised gap in both initiation and six to eight week rates between the most and the least deprived areas in Wiltshire with a significantly lower proportion of women initiating breastfeeding in the most deprived areas (by deprivation quintile). 6-8 week rates of breastfeeding are lowest amongst mothers aged 15-19 (19%) and 20-24 (23%); significantly lower than older mothers. Drop-off rates in these age groups are also high, double that of mothers over 30. As noted above, the Wiltshire Breastfeeding Strategy specifically aims to address these issues, including increasing breastfeeding at 6-8 weeks among women living in the most deprived communities in Wiltshire by 6% (all by 2014). This last aim is also underpinned by the intention to halve the gap in breastfeeding between women in the least and most deprived areas in the County.

1.6 Breastfeeding policy and guidance

A number of key documents demonstrate the importance of breastfeeding as a government priority, including the *Healthy Child Programme* (DH, 2009), *Healthy Weight, Healthy Lives* (DH, 2008), *Improving the nutrition of pregnant and breastfeeding mothers and children in low income households* (NICE, 2008a) and *Healthy Lives, Healthy People: Our Strategy for Public Health in England* (DH, 2010). Currently the importance of peer support is recognised both by NICE, through commissioning and other guidance (2008a, 2008b), and the in the UNICEF BFI Information on BFI Community Accreditation (UNICEF BFI, 2013). Breastfeeding initiation and breastfeeding at 6-8 weeks are included as Health Improvement Indicators in the *Public Health Outcomes Framework* (DH, 2013). Other important policy drivers which impact on this work are the *Health Visitor Implementation Plan 2011–15* (DH, 2011), with the delivery of the Health Child Programme one project within this.

1.7 The importance of peer support for breastfeeding

What is breastfeeding peer support?

Breastfeeding peer support is 'An approach in which women who have personal, practical experience of breastfeeding offer support to other mothers' (Phipps, 2006:166). Different models of peer support are discussed in the literature and used in practice, including one-to-one (face to face and/or telephone) and group support (run by/overseen by NHS and/or charities). The term is usually used to refer to a systematic approach (Kaunonen et al., 2012), building in a more formalised way on the type of mother-to-mother support successfully offered by organisations such as La Leche League (LLL), the Association of Breastfeeding Mothers (ABM) and the National Childbirth Trust (NCT). Many peer supporters are volunteers, although in some areas peer supporters are paid, or there is a combination of paid and unpaid supporters, with different degrees of involvement and responsibility. What we know from the literature

Peer support is recognised as an important and effective method of supporting breastfeeding women, as part of a wider breastfeeding strategy within a co-ordinated programme of interventions (NICE, 2008b). This necessitates partnership working between a range of statutory, voluntary and community services. Peer support is particularly recognised as important in socially deprived communities and in places where breastfeeding is not culturally accepted (Dykes, 2005). The importance of Children's Centres in promoting breastfeeding in these areas has also been recognised (Condon and Ingram, 2011). Peer support may also have additional benefits on top of any increase in breastfeeding rates, including increased self-esteem and confidence and improving parenting skills and family diet (Wade *et al*, 2009) and offering opportunities for increased social contact (Alexander *et al*, 2003)..

Previous evaluations of peer support programmes (Alexander *et al*, 2003; Ingram *et al*, 2004; Hoddinott *et al*, 2006) have found them to be effective in increasing breastfeeding prevalence in areas of social and economic deprivation and low breastfeeding rates. The Alexander *et al* study is interesting in this context as it evaluated a group in Salisbury ('Bosum Buddies') which was the predecessor to a group in one of the areas in this current evaluation. One systematic review (Jolly *et*

al, 2012), however, concluded that peer support does not increase breastfeeding continuation in higher income countries, such as the UK. This was suggested to be because of existing post-natal support, and highlighted the need for further research. Antenatal peer support and its influence on breastfeeding initiation was examined in a systematic review by Ingram *et al* (2010) who conclude that universal peer support did not appear to improve rates, although targeted peer support may do.

Breastfeeding peer support has been funded by the DH as part of the Infant Feeding Initiative. An evaluation of 26 DH funded breastfeeding peer support projects emphasised the importance of peer support in giving positive role models and in enabling the shifting of local cultural norms around breastfeeding (Dykes, 2005). This work also identified a series of steps, necessary to implement successful peer support schemes. These included:

- Having an in-depth understanding of the local culture before setting up groups (including exploring local beliefs about infant feeding, identifier key influencers on infant feeding practices and understanding constraints on women initiating and continuing with breastfeeding).
- Building on existing infrastructure (to learn from previous experiences and avoid reproducing either successes or failures).
- A comprehensive planning period involving all key stakeholders including, if appropriate, community and religious leaders. The avoidance of reliance on one key coordinator was emphasised.
- Engaging peer supporters, with clear processes for recruitment, selection, training and support.
- Managing the interface between peer supporters and professionals, important in order to have good relationships between the two groups and to ensure that women are referred to peer support. Concurrent training of health professionals is recognised as important.
- Marketing of the peer support programme in order for it to be acceptable in the community and to maximise uptake. The use of a brand name was considered effective and the marketing important at all levels including key stakeholders and health professionals.

- Having a supportive infrastructure, including having multiple access points to peer support such as a range of places in which drop-in peer support is available, including postnatal wards and antenatal clinics. Peer support was most successful when linked to other activities such as baby clinics. Other aspects of infrastructure include having a telephone and home visit system, paying peer supporters expenses and offering support with childcare.

This work also emphasised the importance of having a clear evaluation strategy when implementing peer support programmes and of obtaining and maintaining funding.

What is known about how and why peer support works comes from a range of research studies, using different methodologies. From qualitative research we know that women value support from those who have similar experiences, social support, opportunities to ask questions and to overcome problems (Thomson et al., 2012). From systematic reviews of the evidence we know the importance of continuous breastfeeding support, that peer support works best alongside professional support and the importance of training. Face-to-face support has been found to be more successful than telephone support and reactive support less successful than on-going support (Kaunonen et al, 2012; Renfrew et al., 2012). Schmied *et al* (2010), in a metasynthesis of the evidence from a range of methodologies, emphasise the importance of *how* the support is delivered, particularly in relation to person-centred communication skills. They found that health service support was inadequate, both because of health professional practices and time-pressures.

There is recognition in the literature that peer supporters also gain from the process of training and working as peer supporters. Kempenaar and Darwent (2013) found that, in a group of Scottish women, undertaking peer support training significantly improved breastfeeding knowledge and attitudes towards breastfeeding. Training can increase both knowledge and confidence (Ingram *et al*, 2004) but can also blur the boundaries between peer supporters and professionals, particularly when peer supporters perceive that they have greater knowledge than health professionals (Dennis, 2002).

What happens in Wiltshire?

In Wiltshire breastfeeding promotion and support activities are overseen via a multi-agency steering group, co-ordinated by NHS Wiltshire's Breastfeeding Lead. Due to the complicated nature of provider boundaries, in addition to recent organisational change, this group has been important – drawing together the Breastfeeding Strategy for Wiltshire and continuing a commitment to sharing good practice and working to ensure that women receive consistent breastfeeding messages.

Across Wiltshire the different providers of maternity services are at varying stages of UNICEF BFI accreditation, having either achieved full accreditation (Salisbury Foundation Trust), Stage 1 or the Certificate of Commitment. Achieving UNICEF BFI accreditation contributes towards the standardisation of advice given to breastfeeding women both ante- and post-natally. During the time that the evaluation took place work continued in all areas towards full accreditation. When UWE was first approached work was also underway towards UNICEF BFI Community Accreditation – activities involved delivering training to health visitors and other frontline workers, including Children's Centre staff. Providing breastfeeding peer support also contributes towards this work.

Breastfeeding support occurs across Wiltshire in a number of ways, both through statutory and voluntary agencies. Breastfeeding is a Children's Centre target and they are required to promote and support breastfeeding (alongside other work with mothers and children in deprived areas). Specific activities to increase targeted breastfeeding support across the county included the appointment of two breastfeeding peer support co-ordinators, the setting up of breastfeeding peer support groups in a greater number of Children's Centres and the enhanced delivery of peer support training to increase the number of peer supporters available to work in groups.

A specific focused breastfeeding peer support intervention was also initiated in order to target peer support in areas of significantly lower prevalence of breastfeeding. This intervention included objectives relating to the provision of peer support and to partnership working. It aimed to increase the number of trained and peer supporters through the delivery of accredited training and to subsequently support them in their

work. Specifically the intervention aimed for midwives to signpost women to a group at 28 weeks of pregnancy, for midwives to signpost again at delivery, and for ante- and post-natal contact to be made with women by peer supporters, using texting and telephone calls. Four named Children's Centres were identified to participate in the intervention, three of which are in the areas covered by this evaluation.

When this evaluation commenced attendance at peer supporter groups varied considerably. Some, where there had previously been well-established groups, regularly saw 10-20 attendees, whereas others had very low attendance, with one or two women attending at most. Towards the end of the data collection women were interviewed who talked about attendance at previously successfully groups dropping off and some groups closing. Telephone call discussions with a small number of stakeholders immediately prior to report writing (see Part 2) revealed that there were no peer support groups running at all in one of the evaluation areas.

During the time of the evaluation peer support training was bought in from the NCT. On-going training is now provided via an arrangement with the Open College Network, using a workbook adapted from one produced by a peer support trainer working for Sirona Care and Health. Wiltshire and Sirona both deliver peer support training, using different models and targeting different groups, sharing good practice, ideas and resources. The training consists of attendance at 10 weekly sessions of two hours each and completion of the workbook and is equivalent to three credits at NVQ level 3.

Part 2: Design and methods

2.1 Introduction

This section of the report outlines the design of the evaluation and the methods used to collect data.

2.2 Design

The methodology for the evaluation was influenced by ideas from realistic evaluation and qualitative methodology.

Realist evaluation (Pawson and Tilley, 1997; Pawson 2013; 2006) argues that social programmes (in this case breastfeeding peer support) are driven by an underlying vision of change – a ‘programme theory’ of how the programme is practiced.

Realistic evaluation aims to recognise complexity, reframe questions, and support development. The key question for the evaluator is therefore ‘What works for whom, in what respects, and how?’ In this evaluation key questions included: Are peer supporters being drawn from appropriately diverse sections of the community, particularly from the more disadvantaged communities the intervention specifically seeks to target? If not, why not? What are the factors that may impede more disadvantaged women getting involved? Are women being offered contact prior to birth as planned? If not, why not? If so, are they taking up the offer? If not, why not?

2.3 Methods

A qualitative approach to data collection and analysis was adopted. This involved data collection methods which enabled the exploration of the delivery of the peer support intervention. These are ‘flexible and sensitive to the social context in which data are produced’ and ‘involve understandings of complexity, detail and context’ (Mason, 2002:3).

Data was gathered primarily using one-to-one semi-structured interviews with a range of stakeholders and with breastfeeding women. Two focus groups were also

carried out with breastfeeding peer supporters in two out of three of the identified evaluation areas.

2.4 Recruitment and sampling

Recruitment of participants took place in several ways. Appropriate higher level stakeholders – including heads of service, infant feeding coordinators and Children's Centre managers - were identified by the commissioner of the evaluation, asked to make contact to arrange interviews. In the same way, managers of midwives and health visitors in the three evaluation areas were asked to identify members of local teams and ask them to make contact. All were provided with information about the project, including the participant information sheet. The two peer support coordinators, one working in the area which included Trowbridge and Westbury and the other working in Salisbury, acted as gatekeepers for meeting breastfeeding mothers and peer supporters, including setting up interviews and arranging focus groups. Some breastfeeding women contacted the principal investigator (SD) themselves to arrange interviews, others were arranged through the peer support coordinator.

Arranging interviews with breastfeeding mothers and a focus group in one evaluation area was straightforward. Due to a number of factors outside the investigator's control, arranging interviews and a focus group in the other two areas proved very problematic, leading to a protracted data collection period and the interviewing of fewer breastfeeding women in the areas originally identified. A number of alternative recruitment strategies were attempted over a number of months with success eventually achieved by accessing new peer supporters via a training event. This resulted in the final interviews being carried out with breastfeeding mothers who were also trained peer supporters, which was not the original intention.

2.5 Data collection

Interviews were carried out from May 2012 to February 2013. Focus groups with peer supporters took place in July and November 2012. The timescale for data collection was longer than originally planned due to unexpected difficulties in recruitment, explained above.

Twelve interviews were conducted with a range of stakeholders working in or across the three evaluation areas. These people occupied different positions in relation to the provision of peer support and included:

- Two service leads
- Two infant feeding coordinators
- Two health visitors
- Three Children's Centre managers
- Two peer support coordinators
- the professional responsible for coordinating the Community BFI accreditation activities across Wiltshire.

Despite attempting to set up interviews with midwives in the evaluation areas it was not possible to speak to any midwives about breastfeeding peer support. Interviews were carried out in a range of places at the interviewees' convenience, including NHS premises, Children's Centres and UWE.

Seven interviews were conducted with breastfeeding mothers. Four of these mothers had also recently trained as peer supporters, but the focus was on their experiences of receiving support. Two mothers were interviewed who lived outside the evaluation areas (but who had received their peer support training within one of the areas). Four interviews were carried out in interviewees' homes and three in Children's Centres. One mother was breastfeeding twins, the focus of the analysis of this interview is on her experiences of peer support, rather than specifically on those related to breastfeeding twins.

A topic guide was used for all interviews with open-ended semi-structured questions allowing for full responses. Interviews lasted between 30 and 60 minute; all were audio recorded, notes taken and partially transcribed.

Two focus groups with breastfeeding peer supporters took place, in two out of the three identified evaluation areas. Both took place in Children's Centres. One peer supporter participant was also working in the third area but there were no other peer supporters working there at that time. Focus groups were audio recorded and notes taken.

Due to the protracted nature of data collection telephone/email contacts with four stakeholders took place later, during the report writing stage. The purpose of these was primarily to clarify how the texting/telephone contact with breastfeeding women had progressed and to obtain up-to-date information on peer support numbers and training issues. Although these and other attempts were made to obtain up-dated information at the time of writing, this was not always possible. This inevitably means that what is written here does not always reflect the current provision of peer support in all the areas considered and that some of the recommendations have already been discussed or implemented.

2.6 Analysis

All data were analysed thematically by the principle investigator (SD) with coding processed and collated using NVivo 8. A sample of transcripts was independently coded by the second researcher (DE). Themes and analyses were then related to the project objectives by the team.

2.7 Ethics

The team were committed to carrying out the evaluation to the highest ethical standards and planned the project to minimise any risks to participants. The evaluation received favourable ethical approval from the Faculty of Health and Life Sciences Ethics Committee at the University of the West of England, Bristol. The study did not require approval from the National Research Ethics Service (NRES) as it was classed as a service evaluation.

Part 3: Findings

3.1 Introduction

This section of the report outlines the findings of the evaluation, presented thematically. Discussion of these in relation to the objectives of the evaluation follows in the next section.

The main themes under which the findings are discussed are:

- The value of peer support
- The perception of peer support groups
- The provision of peer support
- Reaching the women least likely to breastfeed
- Ante- and post-natal support.

The first two themes are important in understanding why peer support might or might not work for some women, and in some situations. The last three are important in furthering understanding about the delivery of the peer support projects in the three evaluation areas. Issues relating to the broader understanding of peer support are thus addressed before issues of implementation.

3.2 The value of peer support

All who participated clearly expressed the belief that breastfeeding peer support is valuable and its continued provision important. This theme was discussed in five main ways:

- The importance of social support
- Mother-to-mother support
- Normalising breastfeeding
- Breastfeeding as a way of life
- Promoting cultural change.

Social support/more than problem solving

Whilst there was recognition of the value of peer support in helping women to resolve breastfeeding problems, participants were also very clear that peer support was about much more than this, and the value of social support was referred to repeatedly. Some women emphasised the importance of the social contact over and above any help that they had received with specific breastfeeding issues. Others felt that they had received both types of support and that, although they could find social support elsewhere, the peer support group worked for them because this was where they got both. Social support for some women was initially the most important aspect of their attendance but this meant that they were then able to ask for help with breastfeeding problems, if they occurred.

...[we] try to get across to families that you don't have to come with a problem, things crop up, breastfeeding strikes, feeding babies with teeth, those sort of things that you don't necessarily think about at the beginning...[SH9]¹

Being able to leave their homes and meet other mothers when their babies were very young was described as 'a life saver!' [BM6], with attending the group becoming part of a weekly routine. The social element of the support offered was felt to be particularly important for isolated women, but it was recognised that it was difficult to achieve this in areas where few were breastfeeding.

There was also a recognition that this type of social support contributes to the normalisation of breastfeeding (discussed further below).

...although everyone talks about breastfeeding I don't think actually that many people do it...[BM 3]

...it works because the women form a bond and they get something more out of it than just help with breastfeeding. Several of the mums I've spoken to have said that it's the only place that they been able to go where everyone

¹ Participants are identified throughout by the use of SH (stakeholder, numbered 1-12), BM (breastfeeding mother, number 1-7) and PS (peer supporter, focus group 1 or 2).

else is breastfeeding and they haven't felt uncomfortable about breastfeeding...[SH 1]

The value of this support continues as babies grow older, with the opportunity to share experiences and be with other women caring for children in similar ways. Some described a sense of camaraderie as being important, a feeling of all going through something together. It was also noted that, unlike other groups women might attend where there was an emphasis on the baby/child, these groups focused on the mother:

...it was more focused on you and I think that's actually quite valuable for the mum, to feel like that's a group for her as well as for the baby...[BM5]

As time went on some were unclear whether it was acceptable to use the group more for social than breastfeeding support. One mother had asked:

...am I allowed to still come because I can breastfeed alright now?...[BM3]

Providing social support was felt by one stakeholder to be a less important role for the groups, as well as difficult within the context of limited resources:

...when there's a pressure on the service you almost need to signpost those mums and say, well if you haven't got any breastfeeding issues...maybe now's the time to move onto a mum and baby group...[SH5]

This stakeholder felt that the peer support group should be primarily offering breastfeeding advice; all others acknowledged the important role of both:

...there's a lot of room for a lot of social support for very isolated women...they want something they can dip in and out of...they go somewhere to do something because the establishment tells them to...have their child weighed etc etc but actually the spinoff is they get to see other women...we're not fulfilling that need for women...[SH3]

The importance of support from other mothers

All participants emphasised that what works and is important about peer support is that it is provided by other breastfeeding mothers. Many of the breastfeeding mothers and peer supporters talked about it in these terms:

...somebody who just understands the mechanics of it...they might have all the knowledge in the world about breastfeeding but if they've never actually done it...they just don't get that connection...[BM3]

The experience of having mothered a breastfed baby was seen as a key element of the support provided. Important issues identified were the ability both to give practical tips but also:

...moral support, someone who knows what it's like...[BM3]

Some felt that women should be from the same economic/social background, most felt that this is not so important.

...it's more that they've breastfed...[BM7]

...what matters is that people are welcoming and accepting and that there are people to talk to who have breastfeeding experience...[PS1]

Normalising breastfeeding

Participants talked about the importance of peer support groups in helping to normalise breastfeeding. This was particularly important in areas where few women breastfed, and for those who came from families for whom breastfeeding was not the norm. One woman described being surrounded by people who were not supportive of her decision to breastfeed:

...the longer I breastfed for the more abuse I was getting from my partner's family...[BM1]

(this was when she had been breastfeeding for a relatively short period of time). She liked being with people for whom breastfeeding was normal:

...being around like-minded people, other people in the same frame of mind. People who were saying that it was the natural way to feed a baby...[BM1]

This was also recognised by those promoting the groups:

...it's nice to come into a room where everybody values what you're doing and appreciates where you are coming from...[SH9]

Breastfeeding was also normalised by attending a group with women who had different aged children; the value of this was emphasised:

...there will always be someone that bit ahead of your child's development who you can talk to and ask, how did this go?...[PS2]

...someone might be a month ahead, and that's the way you learn. People have just dealt with these problems, and you pass it on...often three or four weeks down the line is the stumbling block for breastfeeding...[SH9]

Seeing women at different stages in their breastfeeding journey was particularly important initially, when women did not have much breastfeeding knowledge:

...coming along to groups like this where you spoke to people it did work for and who might have had difficulty in the early days, and who say 'stick at it, it does get easier' and it does...[BM4]

... comparing notes with people going through exactly the same thing – it was nice to see there is a light at the end of the tunnel and people have experienced it getting easier...[BM4]

...[I] wanted to meet other bf mums...to make sure they were experiencing the same things I were at the time..[BM6]

One woman talked about wishing she had gone to a group sooner, so that she could have been equipped in advance with knowledge about potential difficulties; others noted this too:

...giving people the tools to deal with something that they haven't yet come

across but might come across at a later stage...[SH5]

...I kept thinking 'is this right?' and they tell you it is and they tell you why...[BM3]

Many emphasised the importance of seeing others breastfeed in enabling women to carry on breastfeeding, particularly during difficult times or when they were unsure if their experience was 'normal'. In particular it was useful to see that others struggled but resolved problems and carried on breastfeeding. Being able to see that what she was experiencing (lengthy feeds/difficult night-time feeding) were phases that others had passed through helped one mother::

...I will get there, I will do that...and now I do! And it's great...[BM3]

One stakeholder felt that the perception of groups as about breastfeeding difficulties (discussed further below) meant that women might give up breastfeeding without being able to see or experience it as a normal and pleasurable experience:

...it's a shame if the mums only see that there are problems with breastfeeding, it's a shame that they don't come along to the groups and see that there are mums who have got through that phase and are enjoying breastfeeding and finding it much easier...[SH1]

Others identified the value in seeing women breastfeeding at different ages, particularly older babies and children, both to see this as a possibility and because it is not commonly seen or experienced as socially acceptable. This mother described seeing a peer supporter breastfeeding a toddler as 'inspiring':

...for me it was nice to see that there are people out there that do it because there's a lot of pressure to stop after a certain time...it becomes unacceptable to do it past a certain age...[BM7]

For women who continue breastfeeding through the early weeks and months the normalisation of on-going breastfeeding, through seeing and meeting mothers who are breastfeeding older babies and toddlers, is important.

Recognising that breastfeeding is about more than nutrition

Many women talked about feeling particularly supported by peer support groups through the acknowledgement that breastfeeding contributed to a way of life with a baby that was perceived to be about more than nutrition. Being with women who 'share the same ideas' is important as well as a recognition that in many ways, women who choose to breastfeed make other decisions about parenting differently too. Participants identified this as an important element in mother-to-mother support and one that was felt to be missing – or at least not overt – in support from health professionals.

...it's nice to speak to mums who have breastfed...who value the importance of it. To some people feeding the baby is just feeding the baby, it's just nutrition...whether it's a bottle or breastfeeding, if you can breastfeed all very well, it doesn't really matter. But to me breastfeeding's about a lot more than that...[BM5]

Being able to talk about co-sleeping, baby-led weaning, routines and teething in relation to breastfeeding were some of the issues named as important. One stakeholder said that it was important to tell mothers:

...they don't have to have a problem in order to come, It's a different way of parenting your baby, it's not just about feeding but it's a whole way of life with a baby, it's different...[SH9]

Cultural change

Many women identified difficulties associated with breastfeeding in a culture that is not supportive of breastfeeding. Peer support was acknowledged as playing a role in replacing the support that previous generations might have gained from family, community and from wider society:

...because we don't have society giving that support...essentially we are providing the mothers, cousins, aunts etc to society because they don't exist... So important to provide what society isn't providing... [SH2]

This is important for all women but particularly for those who have no family nearby or who come from families where generations have not breastfed. The cultural influence of the extended family was recognised as being strong in areas with currently low breastfeeding rates; the challenge for breastfeeding peer support in this context being one of:

...fighting against a culture of extended family...[SH8]

One breastfeeding mother gave a specific example of trying to breastfeed in a social milieu actively opposed to breastfeeding:

...there was lots of pressure to stop. My mother-in-law said my milk was making my son sick... Peer support showed me that other people were doing the same thing, they were saying that what I was doing was ok...[BM1]

Many women are not exposed to breastfeeding before they have a baby and have no knowledge of what is normal for a breastfed baby (in relation to feeding but also to sleep and other issues).

...we don't live in a breastfeeding culture. It's not normal and natural any more in our society. It's hard when people say in pregnancy that breastfeeding is normal and easy when for many women it's not... [BM5]

... people know what's normal for formula fed babies but there's a lack of knowledge and a lot of pressures. Lots of people are not exposed to breastfeeding before they have a baby...[BM7]

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.

3.3 The perception of peer support groups

How peer support is perceived, both by those using it (and those who do not) as well as by those responsible for commissioning and running it, is an important element of understanding whether peer support is working for those for whom it is intended. It

should be noted that this evaluation does not directly represent the views of those who do not attend groups. There were two aspects to the discussion of this theme:

- Groups are not for everyone
- Groups are for problems

Groups are not for everyone/are middle class

A number of participants talked about how some women had preconceived ideas of what might be involved in attending a breastfeeding group and that this might prevent some from attending:

‘...lots of people don’t like the whole groups thing, to be honest, do they?...women who have never been to a breastfeeding group have a very, very different picture of what a breastfeeding group is’...’Yes, everyone sits around with their boobs out being confident...’[PS1]

Many women might therefore perceive these groups as ‘*not their thing*’ [SH3]. In some areas arrangements have been made for peer support to be available over the telephone, eliminating the need to ever come to a group. The idea of attending a group was seen to be more acceptable for some groups of women than others and in some areas:

...the idea of peer support is taking off in middle classes. Groups are not part of the culture in more disadvantaged areas...[SH3]

Some stakeholders talked about the expectation that the work was in setting up groups, with the anticipation that women will then attend. For several reasons this was not always straightforward. A number of participants talked about how attendance at groups is seen as a middle class activity and that this makes thinking about attendance difficult for some women. Others talked about how some perceptions of breastfeeding women might put women off:

...I thought it would be...quite hippified mums...but it wasn’t at all...[BM6]

...a breastfeeding mum is a hippy floating on a cloud with her boobs hanging out and she’s from a well-educated background...there is a kind of

stigma...[PS2]

It's a place to go if you have a problem

A strong theme throughout the data collection was that peer support groups were generally perceived as somewhere to go with a breastfeeding problem. This was empathised by stakeholders as well as breastfeeding women and peer supporters. Others saw breastfeeding groups as a place to go with a problem which would be sorted out, and there was then no need to attend again. It was observed that this might be particularly true mothers with very young babies:

...there's some women who use it like a drop in – they come in once, get their answers and they go...[PS2]

...I felt that this was how it was marketed but once you go you realise that it is more than this. I knew people who breastfed who didn't go because they didn't have a problem and didn't see it as for them...[BM6]

...people might think that it's somewhere you go when you've got a problem
...no-one's made me feel like that. Maybe other women think that but it doesn't get communicated. Maybe if they made that point, just keep coming...[BM2]

One mother described this as a '*branding issue*' [BM4]. This was also recognised as a difficulty for poorly attended groups where, if women attended, they did not feel that they had attended a group (because no-one else was there) and did not benefit from the additional social support afforded by better attended groups:

...I think even if they've got a problem they want the social support more than they realise...[PS2]

Most breastfeeding women were clear (as discussed above) that they had benefitted as much from the social support they had gained from attending a peer support group as from specific breastfeeding advice. 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:

...the problem...is they think you go there if there's a problem, you go to the breastfeeding group if you've got a problem. So we're trying to say, it's not, it's just a group to go to, to share your feelings, share your ideas...[SH11]

Some had specifically tried to address this issue but found it difficult :

I think they view the groups as somewhere to come if they've got a problem...what we tried to do here, we tried to re-launch our group, as the attendance was so poor, as a group you can come to not only if you've got a problem, but just to come if you are a breastfeeding mum, whether you've got a problem or not. But mums view them as a group you come to if you've got a problem, rather than a social group...[SH10]

3.4 Reaching the women least likely to breastfeed

Young women

It is important to note that no young mothers were recruited for interview. The issues here were identified by the range of participants and represent their perceptions, as well as observations from those attending and being part of peer support groups and those working with young women.

Participants felt that young women perceived both breastfeeding and support groups in ways that had negative impacts. Breastfeeding was seen as something that older, middle class women did:

...they think it's the older mother, they still say it's the posh mummies that breastfeed and that doesn't seem to change...[SH11]

...its middle-aged well off mums that are breastfeeding so maybe that's putting the younger mums off...[PS2]

In addition there were felt to be issues with the perception of what might be involved with breastfeeding in a group setting:

...younger mums might think they have to sit with their tops off and they don't want anyone to see their boobs. They don't even want to see their own. Talking and seeing other women doing it might put them off...[PS2].

In interviews and focus groups both breastfeeding mothers and peer supporters noted that they had seen very few young mothers in peer support groups. Most could not remember being in a group with a young mother; some knew of young mothers who had attended briefly. This was felt to be for a number of reasons. Groups were generally not well used by young women:

Some young women don't like groups, that's my experience...often you have to take things to young women...[SH3]

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. Some of the health professionals interviewed reflected that young women might easily feel judged and see groups in this light. Others commented that young women were often keen to return to pre-pregnancy behaviour that is not recommended when breastfeeding (such as drinking coffee or alcohol) and would choose this rather than breastfeeding. Mixed feeding groups (discussed below) were felt to perhaps be an appropriate way forward with young women; this approach has been successful in other areas.

Women in areas with low breastfeeding rates/disadvantaged areas

Due to the very low numbers of women breastfeeding in some of the target areas for the evaluation as well as other recruitment issues in this project (discussed in Section 2) it was only possible to speak to one breastfeeding mother who lived in an area of particular deprivation. She had recently trained as a peer supporter, recognised that she was unusual and felt that it was important that there were more women like her. Other women were interviewed, however, who had attended groups or worked as peer supporters in these areas.

The main issue identified is that in areas where there are so few women breastfeeding it is hard to provide peer supporters from within the community. In

addition it is hard for women who come from elsewhere to come to these groups when they are so poorly attended, thus providing neither peer support for breastfeeding nor the social support identified as so important. It was felt that new mothers attending such a group were unlikely to return. Some breastfeeding mothers interviewed had this experience and sought out other, better attended groups instead – thus meeting their needs but perpetuating the poorly attended nature of the other group. Most recognised that these were difficult issues and that it was hard to see solutions:

...how do you change a culture without putting someone else in, but that doesn't work, you need them to be from within the community to make a difference...[SH3]

Several mentioned groups where the peer supporter would sit on their own and no-one would come:

...she's really great and she's passionate and she's really keen. She'll come here week in, week out, even if she's on her own and I think that shows her dedication to it...[SH10]

...demoralising to be sat in a support group week after week and nobody turns up – these aren't paid people – they turn up with their child and nobody comes...[SH2]

Conversely, breastfeeding mothers who attended such groups sometimes felt that they were unwelcome, with support reluctantly given:

...the peer supporter said *'I want to see some new mums'*...[BM1]

This issue was also related to the retention of peer supporters once trained:

...we probably do need to rethink, in some of our more deprived areas, how we can support peer supporters. They are really keen...and they are being disillusioned by not having sufficient mothers walking through the door to support and I think we are going to lose them very quickly...[SH8]

Solutions to some of these issues were suggested, including better promotion of groups, developing a one-to-one model, providing drop-in sessions, visiting breastfeeding women at home and increasing antenatal contact. Some Centres had tried solutions such as having a peer supporter available on the telephone to speak to anyone who arrived wanting support, with some success (whilst recognising that this only provides one aspect of what women need). It was generally felt that the proposed ante- and post-natal texting service would help, particularly in reducing isolation for women who had no-one to attend a group with. However, one stakeholder felt that:

...in some areas it won't work at all...[SH3]

Most stakeholders felt that it was important that peer supporters came from within their communities:

...peer support is best with someone from within the community because they can identify with the issues faced by that community. They can understand the influences that are on other people, what issues and challenges they are faced with...people are likely to receive information from someone who comes from the same place...[SH4]

although the difficulties with this were recognised:

...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...[SH2]

It was also recognised that, in some areas, community beliefs about breastfeeding are long-standing and entrenched, resulting in the potential for change being very slow:

...fighting against a culture of extended family..it's a deprived area, so you've got that cyclical 'you don't need to breastfeed' and it's fighting that wider extended family culture as well as the culture of the individual...we've got some real challenges in those areas...I think to see and encourage that peer

support network will produce benefits...it's going to take slightly longer and it's more challenging...[SH8]

...it's a long term strategy that's needed, it isn't short term...[SH7]

Other important issues that were identified were in relation to the location and perception of groups. Disadvantaged women were noted to attend Children's Centres for other reasons but not to attend breastfeeding groups, and in part this was felt to be about the perception of the group as somewhere to go if you have a problem. In the most disadvantaged areas encouraging women to attend Children's Centres for any reason was felt to be challenging.

3.5 The provision of peer support

The provision of peer support was discussed by participants in seven main ways:

- The location and timing of groups
- Leadership issues
- The peer supporters
- Retention of peer supporters
- Should peer supporters be paid?
- The role of health professionals
- 'Mixed' groups?

Location and timing

The location and timing of groups was a theme raised by many participants. Groups have been established in Children's Centres and this was seen as having both advantages and disadvantages. Peer supporters like the infrastructure provided by Children's Centres, including support with setting up and preparing for groups – this was contrasted with a few groups which are run in church halls where the peer supporters felt that they had to do much more than just providing breastfeeding support. 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.

...women are confused about what contact from the Children's Centre means.

In the most deprived areas women won't go to Children's Centres...[SH4]

When the groups were being established there was some expectation that women would go to their nearest Children's Centre. This was often not the case – women in some areas, for example, might choose to go to a group which was near other facilities such as shops or cafés, so that they could combine activities on one day. Women living in some deprived areas choose to go out of their area, perhaps because of other associations with the Children's Centre; other women would not go to some Children's Centres:

...some women won't touch it with a bargepole because they won't go to that geographical area...[SH3]

Overall it was felt important to have peer support in places where women want it and to give them choice.

Whilst some Children's Centres were felt to be physically suitable and welcoming places in which to hold a group, others were less so. Paradoxically, some of the most well-attended groups were held in Children's Centres with the most limited facilities (small rooms, nowhere to store buggies, limited facilities for older toddlers).

The timing of groups was felt to be as important as location. In some areas they are able to have groups at a number of Children's Centres on different days of the week so that a woman with breastfeeding difficulties could be seen in a group on one day and followed up in a different group elsewhere on another day:

...if it's awful you don't have to wait, you can go and find another group...[SH6]

This did not seem to have been considered in all areas (and is only possible in areas where there are several groups geographically close to each other).

The co-location of the groups with places/times of baby clinics (run by health visitors) was felt to be important by some as these clinics are often attended by large numbers of women, who also use them for social support:

...women tend to hang around before, they hang around after...[SH3]

In some areas the breastfeeding groups is planned to follow on from a 'bumps and babes' group, in recognition of the importance of both social and breastfeeding support. During the evaluation, peer support was also being offered in a limited way in some hospital maternity units (with one peer supporter volunteering in Salisbury hospital, for example). Some participants felt that it would be particularly beneficial to increase the availability of this, recognising that breastfeeding support is crucial in the early days and that many find out about peer support after some time. Follow-up conversations with stakeholders suggest that the importance of this has been recognised – peer supporters are being trained specifically to work in hospitals, with 15 volunteering at the Royal United Hospital in Bath since January 2013 and 5 at the Great Western Hospital in Swindon. Early feedback from mothers and staff was reported to be good.

Leadership issues

During data collection a number of specific issues relating to leadership were raised. Leadership at a strategic level was clearly apparent, with a strongly articulated commitment to making peer support in Wiltshire work. At the community level, groups appeared to be most successful, to run most smoothly and to support the most breastfeeding mothers in Children's Centres where the manager was actively involved. Some Children's Centre managers were also overtly pro-breastfeeding and related this to their own experience as breastfeeding mothers. Peer supporters recognised this as an issue:

...some Children's Centres are not as supportive as they'd like – they felt that some managers paid lip service to breastfeeding support but unless they were passionate about it the support wasn't there. They named the manager from [...] Children's Centre as one who is passionate...[notes following PS1]

One, who had worked as a peer supporter in more than one Children's Centre, talked about the difference:

...the groups are poorly attended and the children's centre staff are nowhere near as good at promoting the group....[Children's Centre manager] is so pro-breastfeeding that she promotes the group wherever possible. Other places it feels like they have 'to tick the breastfeeding box' but are not going to actually support...[PS2]

Whether or not a Children's Centre manager had breastfed was felt to be an important element in the support that was offered:

...it makes a big difference whether the Children's Centre manager has breastfed...often the Children's Centre managers haven't got children and they are more like business women who are running a centre...different expectations...[PS2]

...in some places you always have to fight your corner – here starting from the same place...[PS2]

This was also recognised by stakeholders, one describing it as '*hugely important*' [SH11], another seeing her role in the continuation of peer support groups as '*crucial*', adding:

...our peer supporters have gone to other centres to deliver their groups and they say...the difference here is that I'm always available, we do the meetings, I'm pro what they're doing and will help to work things out with them. They say that they are almost taken for granted in other centres. So they'll go and people will say 'oh, it's in there' and they go and they set it up themselves and they feel that no-one really values what they are doing. Maybe because I breastfed my children and I was a peer supporter. If I hadn't breastfed my babies I wouldn't be doing this job...[SH9]

In some Children's Centres, managers offered individual and group supervision to peer supporters, and sometimes stepped in to help in groups when peer supporters were unwell or not available. This was recognised as a difficulty in Children's Centres where there may not be anyone with this expertise:

...if the peer supporters don't come every week and somebody does turn up to get help – we're not really trained or in a place where we can offer help on breastfeeding – if people turn up and we can't offer help then they are not going to come back. And if I'm honest, that's happened in the past...[SH10].

In follow-up conversations with a small number of stakeholders the issue of support from Children's Centre managers was raised, with their experience recognised as very important in the management and continuation of groups. One stakeholder felt that on-going leadership was a missing element, that the peer support coordinators were working at a different level, and that what was needed was immediate on-the-ground reactive support.

The peer supporters

The peer supporters who took part in focus groups and the breastfeeding mothers who had recently completed peer support training were overwhelmingly positive about the training and about their work. Many used the word 'passionate' to describe how they felt about breastfeeding, talking about the value of the support that they had themselves received, and about wanting to 'give a bit back' [BM6]

...the training? – inspired by the group and by other people being inspired, passionate about breastfeeding...[BM7]

...I found the groups totally...without it I would have given up, really supportive, I can't stress that enough which is why I want to go on and be a peer supporter myself...it's really important, really...[BM6]

...they talked about how they were passionate about breastfeeding and that's what made them good peer supporters...[notes following PS1]

One group of peer supporters talked about how becoming a peer supporter was a way of being able to keep coming to the group, even after stopping breastfeeding. All the peer supporters said that they had enjoyed the training and had learnt from it. In particular the opportunity to debrief from their own experiences was valued, in addition to learning more about breastfeeding:

...finding out about the mechanics of breastfeeding, the science, more about how the breast works and all that, you can get a better understanding. And about the potential problems you can have – before that you've only known about your own problems. Listening to other people's experiences...myself I've never suffered from mastitis but speaking to someone who's had mastitis you are just that little bit more aware...[PS2]

Those who were still breastfeeding when they undertook the training found it helpful to be able to learn more about it whilst it was still so much part of their lives. For others, who had stopped breastfeeding, it was sometimes difficult to look back on and reflect on their breastfeeding experience, whilst learning how to support others. Being taught more about communication skills, including active listening, was identified as valuable. All peer supporters recognised that the training and their peer support experience had given them transferable skills that they might be able to take into employment in the future.

Most felt that the commitment they had made to peer support was manageable, for the majority this was one or two groups a week plus occasional input to antenatal breastfeeding workshops, run by local midwives. None had yet been involved in the texting/telephone intervention but were concerned about how much work this might involve. Several women talked about the conflict they felt when being at a peer support group took them away from spending this time with their own children:

...we are mums first...it's not just our time it's our children's time...[PS2]

Difficulties in being in a group as a peer supporter if you had a child who was a toddler were discussed by all peer supporters. How this was managed varied from group to group and depended to a certain extent on the facilities and space provided:

...I've found it very difficult...it's been really difficult...sometimes he gets really bored...[PS2]

One woman talked about being made to feel unwelcome (by the Children's Centre) as she had a very active 2 year old. It was suggested to her that she might be better off going to another group elsewhere, and she found this hard. One stakeholder also

talked about this, acknowledging that it was difficult to ask women to move on, particularly if they had formed friendships, but that some Children's Centres did not have space for mothers, babies, buggies and toddlers. She felt that it was better that mothers with toddlers were signposted to groups in Children's Centres that had more space and more appropriate facilities.

Although some peer supporters lived close to the group at which they volunteered many travelled, usually by car, to the groups. They acknowledged that they did not always come from the same socio-economic background as the women they were supporting, but felt that it was more important that they were welcoming and able to listen and support in a non-judgemental manner.

Retention issues

The retention of peer supporters was primarily discussed by stakeholders, for whom it was a concern. Most participants felt that there was no ideal point at which someone would make a good peer supporter, that this was very individual. However it was recognised that, as their children grew older, most women moved on to other activities and occupations. Although women were not required to be breastfeeding, it was acknowledged that:

...once you've stopped breastfeeding yourself the temptation to be a peer supporter might wane a little...[BM4]

Peer supporters tended to be recruited from groups of women who were less likely to need to return to work:

...we do tend to find...that they are the women who don't need to go back to work, we...lose the mums who go back to work...[SH1]

In some areas the retention of peer supporters was a particular issue, although in some of the more long-standing and successful groups peer supporters had worked for several years (one, unusually, for 15 years). In areas of particular need both recruiting and retaining peer supporters is difficult:

...in the areas of more need...we've recruited some mums who were local to

the area, and because it's an area of need we've found that the peer supporters had their own needs. For instance some of them were in abusive relationships or they had depression, financial problems, those kinds of things so we've found it much more difficult to retain...because of the other things that were going on in their lives. Their lives are quite chaotic and so it's difficult to retain them as peer supporters...[SH1]

This is a particular difficulty, recognised as important in the context of trying to recruit peer supporters from within the communities in which they are most needed (discussed above):

...the mothers who tend to want to be peer supporters tend to be from higher socio-economic groups...we've got people who are teachers, and...more professional. And the idea was that we would recruit mothers from the community who would be able to relate to other mothers from the community but that feels like one of the things that's not working...[SH1]

More generally, it appears to be the case that women are keen to train to be peer supporters, but by the time training is complete have moved on in their lives and are less able to commit to working as peer supporters. In follow-up conversations with stakeholders this issue was discussed and has been addressed through the implementation of a more rigorous recruitment process, along with the requirement that peer supporters attend groups for at least six months after their training. The idea of a minimum commitment was suggested during data collection although some saw this as '*fraught with difficulty*' [SH3]

Should peer supporters be paid?

In Wiltshire peer support is offered on a voluntary basis; only the peer support coordinators are in paid posts. In some other areas in the UK peer supporters are paid, sometimes through a tiered system where some, with additional responsibilities, are paid and others are volunteers.

The issue of paying peer supporters was discussed with participants. Some felt that the voluntary nature of the role meant that they could be taken for granted:

...sometimes I think we are treated as if we are paid and we are expected to do more than we really should...[PS2]

whereas others felt that being a volunteer made it easier, particularly if there are a number of peer supporters who can share the work:

...not being paid makes it easier not to come if a child is ill or something...[PS2]

One woman talked about ringing a Children's Centre to say she that she was unable to come, and feeling that they were critical, not acknowledging that she was a volunteer.

Most peer supporters said that they would volunteer for the role whether it was paid or not, although acknowledging:

...it would be a bonus – getting money for something you love to do anyway...[BM1]

...I wouldn't say no to being paid but I don't think it would make me want to do it more...[PS2]

Others felt strongly that paying peer supporters would change the nature of the contact:

...it's important that it's voluntary, if it was paid it would be more professional rather than just voluntary, mum to mum...[BM7]

...it becomes a job, less about the experience of breastfeeding...[BM6]

Some stakeholders felt that it was important to consider paying peer supporters, particularly as the commitment that was asked was becoming greater:

...once a week for two hours is ok but they are being asked to volunteer for other groups, make phone calls, take part in parent craft sessions – a lot of other roles have been added...[SH6]

...the best way is to pay peer supporters. You lose them as soon as they're trained. Don't have control if they are not paid. But there is no money for this. This happens in other areas...Not paying them is a missed opportunity...[SH3]

This was acknowledged as a difficult issue – some felt that whilst people were prepared to undertake the role on a voluntary basis it was important to keep it this way. Others felt that payment might assist with both recruitment and retention but that there were complexities involved in managing this. Suggestions were offered:

...the commitment needed has increased, it's more of a job. Could have a 'senior' peer supporter who is paid and then others who are volunteers. Could have supervision on site from Children's Centres, be clearer re boundaries, safe-guarding etc. They are not professionals but they are expected to behave as if they are. Senior one doesn't have to be in each centre – could oversee a few...[SH5]

The role of health professionals

As noted in Section 2, it was not possible to speak to any midwives in collecting data for this report.

There was general acknowledgement from other participants that whilst some health visitors and midwives were very knowledgeable, both about peer support and about breastfeeding, that there was a lack of consistency. Peer supporters reported examples of poor advice given to breastfeeding mothers by both health visitors and GPs. The majority of mothers who participated in this evaluation had been signposted to peer support by health visitors, although felt that this had often come rather late. Although one stakeholder said '*ours are all for it*' [SH12], when GPs were discussed there was almost universal agreement that they were neither interested nor knowledgeable about breastfeeding.

...as part of the training package we asked GPs, midwives, Children's Centre managers etc to come along to a meeting – no GPs turned up...They don't see it as a priority. I don't think they get the whole breastfeeding thing. It's

unlikely that GPs will be pointing women in the direction of peer support groups. Would be nice to happen but unrealistic that it'll happen in the near future...[SH1]

...we've had GPs who've said recently 'don't worry about breastfeeding, just give your baby a bottle'...all the time, to be honest...very depressing...[SH11]

...[we get] referrals from GPs but their advice is variable and very odd sometimes...[SH4]

It was generally felt that GPs were either not aware of the peer support groups, or if they were it was unlikely that they would ever make a referral:

...information has been sent to them but I don't remember a time when a GP referred or suggested to someone that they come down here...GPs often work in isolation...they never come to child protection conferences...[SH9]

Working with GPs was felt to be an issue that would not be easily resolved:

...GPs are such a challenge for any of us to engage with...[SH8]

One group of peer supporters felt that the low breastfeeding rates in their area impacted on health professionals' knowledge and skills:

...not many breastfeeders in the area so the health professionals know more about formula feeding – this is the norm. Breastfeeding is different – grow differently, feed differently...[PS2]

Lack of breastfeeding knowledge and awareness was also discussed in relation to midwives and examples were given, including inappropriate advice (regarding formula feed preparation), given at an antenatal breastfeeding workshop. Most referred to the advice given by midwives and health visitors as 'variable', with some very good. There was sometimes a tension between how roles were perceived:

...they are not really trained properly...they are sick of it...they've had this lengthy training, they don't want to refer people to us because they think they should know more than we do...they don't want to say 'go to the peer

supporters'. Maybe they feel threatened. We're mums and we haven't done all their years of training and got all their experience. But for some of them I think it's relief to refer to the breastfeeding group...[PS2]

One group of peer supporters felt that although there was '*support from on high*' [PS1], health visitors and others who should know about the groups were not making referrals.

Most breastfeeding mothers and peer supporters distinguished clearly between quality of the support available from health professionals and that from peer supporters. Issues that were identified included feeling judged:

...some of the midwives and health visitors are brilliant but a lot of the time you...feel judged and you feel like you're doing it wrong...whereas the peer supporters, rather than say 'this is how you do it' they say 'how are you doing it now...have you tried?'. They are more open...[BM3]

Health professionals were felt to have time pressures that limited their ability to be involved with breastfeeding:

...because we've got the time, where the health professionals...they have a time slot...your appointments finished, off you go...[PS2]

Contact with health professionals was described as:

...more formal, on the spot a bit more...when you're talking to other breastfeeding mums it's more relaxed... quite reassuring too, a good balance of factual information and just having a chat with other mums... when you've been through it yourself you've got a lot more empathy than someone who's maybe well versed in the research...but not done it themselves...[BM4]

Many of these participants talked about the crucial difference being the knowledge that a peer supporter has breastfed:

...somebody who just understands the mechanics of it...they might have all the knowledge in the world about breastfeeding but if they've never actually done it...they just don't get that connection...[BM5]

...some health professionals, you don't even know if they've had children. You think, do you know what I mean on a factual basis or, emotionally do you know what I mean and do you know how that feels?... [BM3]

For many women this was a very important element of the support that they received.

'Mixed' groups?

Although this was not raised by all participants, a small number expressed the opinion that offering support for breastfeeding in groups that were also open to mothers who were formula feeding might be advantageous. This was felt to be particularly pertinent in areas with few breastfeeding mothers and to perhaps be more attractive to younger mothers:

...I would be in favour of a mixed feeding group in areas like this – we have to be all inclusive anyway - this would be better with young mums in deprived areas just to see mums breastfeeding and you not criticising their bottle feeding – it would be slow change without the pressure, knock on effect for subsequent babies....[SH5]

Some felt that this was about acknowledging the realities of women's lives:

...could tie it in with the baby weighing clinics – have peer supporters at those? But then it wouldn't be a sole breastfeeding group, I think we need to come away from the idea that we need a sole breastfeeding group, it needs to be more holistic, I think we need to see it as a whole...[SH10]

Others related their opinions to experience they had of seeing mixed feeding groups operating successfully:

...I understand the reasons why UNICEF want us to have a breastfeeding only

group, but at the moment when we have a bottle feeding culture I think there would be a place to do post-natal groups with breastfeeding support.....if you are going to be wavering, seeing someone bottle feed isn't going to make you decide to bottle-feed...[SH2]

although others felt that a group of this nature would undermine breastfeeding.

Most participants felt strongly that generic support was available elsewhere for mothers but that specific breastfeeding support was also needed:

...there are other groups where you can meet other mums, the important thing about this was the breastfeeding focus – I did go to other groups but I did come to the breastfeeding ones specifically to pick people's brains or talk about or share experiences about breastfeeding...[BM4]

This was felt to be particularly important in areas with few breastfeeders:

...I do think it's important to have groups for breastfeeding women because if you find yourself the only breastfeeding woman in that feeding group you then don't get the support you need and you feel more isolated...[SH9]

3.7 Ante- and post-natal contact

Has the intervention been implemented?

In most of the areas visited for this evaluation the planned ante- and post-natal contact/intervention was not yet taking place. At the time of meeting participants it had only just started on a very small scale, in Salisbury only. Towards the end of the data collection period (described in Section 2), when the intervention might have been expected to be now taking place, recently trained peer supporters were unaware of it. A follow-up conversation with one stakeholder revealed the intervention was only just starting, in June 2013 – far later than originally envisaged – and that this was at this stage only a pilot in one postcode area.

In all areas implementation was delayed by information technology (IT) issues and the need for information sharing agreements between different agencies (in order for

information about live births and consent for contact to be sent from Maternity Units to Children's Centres). The compatibility of IT systems was one problem identified. Another issue raised during the main data collection period was the high rates of opt-out to consent to contact from the Children's Centre – this was acknowledged as needing further investigation and discussion with midwives (as they are responsible for obtaining this consent from pregnant women).

The interviewees who were able to talk about the intervention in detail were the stakeholders who had been involved in setting it up and/or those who were working in Salisbury. Others knew less but had been at meetings where it was discussed. One stakeholder was not aware of what was planned and felt that it was not appropriate:

...haven't heard about it. Too many visits and calls. They don't need visiting at home or calling – home situations are really hard, lots of things going on...[SH12]

Even where the intervention was taking place, there was some confusion about what was happening and whose role it was.

Most stakeholders felt that women were already being given information about peer support during pregnancy and that they should also be encouraged to attend groups antenatally. Both peer supporters and breastfeeding mothers were vague about the details of the intervention, even if they were aware of it. This theme is discussed here in four main ways:

- How do breastfeeding mothers find out about peer support?
- Why is antenatal contact important in relation to breastfeeding support?
- Is the proposed texting/telephone contact a good idea?
- How do peer supporters feel about making this contact?

How do breastfeeding mothers found out about peer support?

The breastfeeding mothers who participated in this evaluation had not received the ante- and post-natal contact intervention. It was, however, felt useful to ask them how they had been introduced to peer support. Some women found out for themselves, often when pregnant by seeing notices in Children's Centres or by word

of mouth. Several said that their health visitor had told them about peer support in the first few weeks after birth, or had suggested that they sign up with a Children's Centre. One woman had first heard about peer support during an antenatal class run by midwives, but no-one else mentioned midwives as a source of information.

Why is antenatal contact important in relation to breastfeeding support?

Most participants felt that contacting women about breastfeeding peer support early on was important, and that it might help to reach some of the women who were not attending groups. Having a name or a face to identify when walking into a new situation was felt to be particularly important for new mothers:

...women need to know somebody, anybody, before they can walk in...[SH3]

...some women like to go in with another person – you feel vulnerable as a new mum – texting, phone calls etc will help...[BM1]

...it might be easier if you have had some contact and then it's not so daunting...[BM7]

It was thought that texting/telephone calling could play an important role in helping women to see breastfeeding support groups as welcoming places where support could be gained and friends made, even if there was no specific breastfeeding problem.

...that would be really good...really good idea...lots of random leaflets when you're pregnant but it's probably a bit hit or miss...something more focused or targeted could help...[BM4]

It was also recognised that the intervention might make a difference in areas where there were few breastfeeders, and where women were reluctant to attend groups as they had no-one to go with. Targeting invitations was felt to be valuable:

...far more labour intensive but potentially more significant than doing a blanket invitation to a group...[SH2]

Most felt that antenatal contact was particularly important in making attending groups easier. Having an introduction from someone beforehand was felt to facilitate attendance. In some groups women already attending know each other well, and so:

...for a newcomer to come in you felt a bit on the side lines rather than immediately gelling into a group...[BM4]

Some talked about going to a group like this being '*completely alien*' [BM6], '*daunting*' [BM7] or '*nerve-wracking*' [PS2] and that contact with someone beforehand would really help. For some this was not so important:

...I didn't know anybody and it didn't matter but it does to some people...[BM5]

Many talked about the value of increased information about breastfeeding before birth and of contact with peer supporters helping to reinforce this:

...maybe people are frightened to put some people off – they don't talk about the realities before you have a baby. So many things – how time consuming it is, breastfeeding in public etc. Not so much a part of life in our culture...[BM6]

...we have found when women go along antenatally they are much more likely to go along for support once they've had their babies because they are so vulnerable when they've just had a baby and...antenatally women often can't focus on anything beyond the birth, so the amount of information they retain about what happens post-natally is limited...if they could go along to the group and experience it, that would be something that they would remember...[SH1]

How do peer supporters feel about making this contact?

Most of the peer supporters who attended focus groups or who were newly trained had not yet been involved in this contact. They had some misgivings about what was expected, some were particularly anxious about making contact with someone they had never met and said it would be different if this was a follow up contact after meeting someone at a group. They felt that it might be inconvenient for them and

time consuming, but recognised that it was hard for them to judge this before embarking on it.

Some were worried about what might be involved:

...I wouldn't want to be some kind of helpline!...[BM6]

Notes following one focus group reflect some anxieties:

...some concern because they thought that they were supposed to ask about feeding intentions when they rang, and not specifically about breastfeeding and they found that hard. If a woman asked them a question about formula feeding they would find it hard to answer. They were concerned that it might be a bit onerous – they thought it was something they'd do at groups when the groups were quiet...[PS1]

Stakeholders recognised that peer supporters might be '*uncomfortable about making unsolicited phone calls*' [SH6] but that until the intervention had properly begun it was difficult to know more.

Part 4: Discussion

4.1 Introduction

In this section of the report we discuss the findings from the evaluation in relation to the original objectives, other findings from the evaluation, and existing knowledge about peer support.

In order to address the objectives of the evaluation key questions included: Are peer supporters being drawn from appropriately diverse sections of the community, particularly from the more disadvantaged communities the intervention specifically seeks to target? If not, why not? What are the factors that may impede more disadvantaged women getting involved? Are women being offered contact prior to birth as planned? If not, why not? If so, are they taking up the offer? If not, why not?

This section discusses these questions but also other issues which arose, and which may affect the provision of peer support in Wiltshire.

4.2 Are peer supporters being drawn from disadvantaged communities?

In carrying out this evaluation attention was paid both to women from disadvantaged communities, as identified in the Wiltshire Breastfeeding Strategy and in the Breastfeeding: Agreed Data Set but also to young women, another group identified as least likely to breastfeed in Wiltshire. As noted in the previous sections, it did not prove possible to speak to many women from identified disadvantaged communities or to any young women. Nevertheless important points about peer support in relation to these two groups were made by participants.

The importance of breastfeeding peer support in socially deprived communities is well recognised (Dykes, 2005). Although peer support is successful provided in some areas of deprivation in Wiltshire (one very successful group runs in one of these areas), peer supporters are currently being drawn from disadvantaged communities in very small numbers and attendees at groups are often women from

outside the immediate community. In the main this is because very few women are breastfeeding in these communities, and subsequently coming forward to train as peer supporters. The present model of the provision of peer support via groups is not felt to be working well in these areas, both for this reason and because of the perception of groups as middle-class. Negative associations with Children's Centres also appear to potentially be an issue for some women. Given the acknowledgment of the importance of Children's Centres in promoting and supporting breastfeeding, both in the literature (Condon and Ingram, 2011) and through policy and guidance, this is an issue which needs to be addressed. Other models of peer support may prove to be more successful with this group, such as one-to-one buddying systems, providing telephone contact or home visits or linking peer support with other activities (as noted by Dykes, 2005).

Cultural norms are recognised as powerful factors in influencing a woman's decision to breastfeed. Social support, recognised by many participants in this evaluation as a very important factor in the success of peer support groups contributes to self-confidence in both breastfeeding and mothering and acts to normalise breastfeeding behaviour and experiences (Alexander *et al*, 2003; Thomson *et al*, 2012). In areas where few women breastfeed, these aspects of peer support are very difficult to provide and yet are crucial elements in countering long-held community beliefs about infant feeding. As suggested by Dykes (2005), further work may be necessary before deciding how best to approach work with these communities. This might include increasing understanding of local culture and beliefs about breastfeeding and considering how best to make the peer support programme acceptable to the community.

Young women are also influenced by cultural norms and peer pressure. Although the findings in relation to this group are limited in this evaluation (and this was not specifically addressed in the literature review), they suggest that there are problems in relation to the perception both of groups and of breastfeeding. The barriers to young women breastfeeding in city environments have been explored elsewhere (Condon *et al*, 2013) with significant social and cultural obstacles influencing the breastfeeding behaviour of young women. More work is needed to understand the experiences of young women breastfeeding in rural areas and to understand how

best to offer them support. Some participants in this evaluation felt that mixed feeding groups, a buddy system or other alternative methods of provision might be more successful with young women.

4.3 Are women being offered contact prior to birth?

During the evaluation

As noted in the previous section, during the evaluation women in Wiltshire were being offered information about peer support groups in routine antenatal discussions via antenatal breastfeeding workshops. Few women who participated in this evaluation felt that they were directed to peer support by midwives. The planned ante-natal contact was only just beginning in one area, in this and the others it was hampered by information sharing agreements and IT difficulties. Stakeholders were well informed about what the intervention would entail, breastfeeding peer supporters had little information and no experience of undertaking it. There were some anxieties about the amount of work that the intervention would generate for peer supporters and some confusion about the responsibility for the texting and telephone calling.

Since the evaluation

In the time since the majority of the data collection took place the texting and telephone calling intervention has started as a pilot in a small area in another of the evaluation areas. It is obviously not possible to comment on the success of this, or whether it will impact on breastfeeding rates. Stakeholders expressed frustration that factors such as IT difficulties had resulted in the implementation of this intervention becoming so protracted.

4.4 What other issues are affecting the provision of peer support in Wiltshire?

A number of specific factors were identified that are affecting the provision (and take-up) of peer support in Wiltshire. The idea that groups were perceived as being for those with specific breastfeeding problems was strongly expressed, and this

appeared to persist despite attempts to counter this belief. Follow-up conversations with stakeholders suggest that work is underway to change this, with work on branding and a new name for groups across Wiltshire, along with an associated logo and posters.

Groups were also perceived as being more attractive to 'middle-class' women; this was believed to deter other women from attending, along with ideas about breastfeeding women and what might happen in groups. Women from more advantaged socio-economic and educational backgrounds may be more likely to seek out support and to attend groups without additional input, and are more likely to breastfeed (for a range of reasons, highlighted by McAndrew *et al*, 2012). These factors may support the findings of Ingram *et al* (2010) who, in relation to antenatal support, suggested that targeted peer support may be more appropriate than universal support. This may also hold true for post-natal support of the type examined here but more research is needed in this area.

Social support was experienced by group attendees as extremely important, this was also recognised by the majority of stakeholders. Breastfeeding groups provide much more for women than advice on breastfeeding, normalising the experience and providing models for breastfeeding behaviour and mothering a breastfed infant at different stages. It is important to acknowledge the role that this plays in replacing cultural understanding and support for breastfeeding. This is important for all women but particularly for isolated breastfeeders and those living in areas hostile to breastfeeding (Condon and Ingram, 2011).

This evaluation also identified a number of specific factors in relation to the location and running of groups in Wiltshire. Groups which were perceived to be successful and supportive of both breastfeeding mothers and peer supporters were those with strong local leadership. Peer support is clearly endorsed at a high level in Wiltshire and the continuation of provision seen as desirable. A commitment to breastfeeding more locally, usually overtly identified with personal experience of breastfeeding, was recognised as a crucial factor in the maintenance of well-attended groups. This leadership enabled peer supporters to feel valued and supported, provided practical back-up when needed and generated a culture of breastfeeding awareness and support in which the peer support groups were held. The best of these people were

also able to help peer supporters think creatively about the running of their groups, supported them in trying new approaches and offered supervision on both group and individual bases.

Children's Centres, whilst recognised as appropriate places within which to hold groups were also felt to be problematic in some ways. Not all were suitable physical spaces for groups, particularly well-attended ones, and this was sometimes difficult to manage. Children's Centres are not seen as welcoming places for all (despite some excellent practice and welcoming staff and buildings) and some have negative associations both for communities and for individuals. The recent work on branding is seen as going some way towards addressing this, with the common name for groups removing the association with individual Children's Centres. There was an acknowledgement amongst participants that women would choose to go to different locations for personal reasons, and not always to attend the group held nearest to their home. Very poorly attended groups were considered problematic – their continued provision was felt to be important whilst at the same time recognising that either attending or peer supporting at a group with few or no members was difficult. Social support and building up community breastfeeding awareness was not possible in these situations. One of the most poorly attended groups in the evaluation area has recently stopped running.

Examples of good practice in the provision of groups were possible in areas with more than one group in a relatively small area. This gave women the choice of whether to attend a group close to home or to combine attendance with other social or daily living activities. Groups in a range of settings enabled women with older children to choose to go somewhere with more space and facilities and allowed for more than one visit per week for women with on-going difficulties. In rural areas this is, of course, not always possible, and in some cases women were travelling some distance to attend a group. In some areas groups were offered on the same day as others that women might choose to attend, enabling both the social contact with other mothers (formula and breastfeeding) and specific breastfeeding support and advice. Dykes (2005) identified peer support as most successful when linked to other activities, such as baby clinics.

Whilst the provision of breastfeeding peer support might be considered primarily in relation to the well-recognised public health benefits it contributes to, it is important to acknowledge that there are other important effects also. Social support, strongly identified in this work, has been discussed above. The benefits to peer supporters, in relation to self-confidence, self-esteem, skills and knowledge are also important factors, found here but also recognised in the literature (Kempenaar and Darwent, 2013; Ingram *et al*, 2004; Dennis, 2002). These factors are important in contributing to increase community and culture awareness of breastfeeding in addition to the personal benefits to the individuals concerned.

4.5 Summary of enablers and barriers

Factors which have been identified as enabling the provision of peer support in Wiltshire include:

- Strategic leadership. There is clear enthusiasm for breastfeeding peer support at a high level, both within the Council and in provider Trusts, coupled with a real understanding of why it is important.
- Dedicated and enthusiastic peer support coordinators and peer supporters.
- Children's Centre managers with enthusiasm for and experience of breastfeeding.
- Careful consideration of the timing and location of groups in some areas, with a recognition that this can increase the likelihood of attendance at peer support.

Factors which have been identified as barriers to the provision of peer support in Wiltshire include:

- Inconsistency in leadership at a local level, leading to the poor support of groups and peer supporters and impacting on the provision of peer support groups.
- The perception of groups as for middle class women, preventing some of the women least likely to breastfeed from accessing support, or from seeing this as a possibility for them antenatally.
- Cultural beliefs about breastfeeding and family and community experiences of infant feeding are barriers to improving breastfeeding rates in some areas.

- Inter-professional working is not seamless across the areas. All health professionals are not offering consistent advice or signposting women to breastfeeding peer support groups. The support of midwives for breastfeeding peer support was not clear. In particular the attitude and knowledge of the majority of GPs was identified as a barrier.

Part 5: Conclusions and recommendations

5.1 Conclusions

Breastfeeding peer support in Wiltshire faces a number of specific challenges. Breastfeeding initiation rates in the County remain high whilst drop-off rates are higher and 6-8 week rates lower than elsewhere, both in the South-West and in England as a whole. Strategic leadership to address these issues is clear and there is institutional acknowledgement of the public health importance of this work.

Whilst leadership at a higher stakeholder level is apparent and commitment to peer support high, this is not so obvious at a local level. There are examples of excellent leadership and clear links between this and successful peer support groups, but in other areas leadership is lacking and groups have floundered or closed down. The peer support coordinators are committed and enthusiastic but day-to-day and reactive support for peer supporters is not always apparent. This is also observed in relation to the ante- and post-natal contact intervention where senior leadership was not apparently able to anticipate or prevent IT and information sharing difficulties, significantly slowing down implementation.

The influence of good partnership working is not clear throughout the County. There are examples of good practice but the experience of peer supporters and breastfeeding women is of a lack of consistency, mixed messages and sometimes poor advice. Health visitors appear to be signposting women to groups but the involvement and enthusiasm of midwives was difficult to assess. GPs were singled out as being particularly uninvolved. This is an issue which needs addressing as GPs have multiple points of contact with women and babies and opportunities for breastfeeding promotion, support and the provision of accurate and up-to-date advice.

The effectiveness of the planned ante- and post-natal contact intervention was impossible to assess as it had not yet commenced in most of the areas covered by the evaluation or had only just commenced in one. Stakeholders were

knowledgeable about the intervention plans, peer supporters knew less and were anxious about the implications for their work. Breastfeeding mothers and peer supporters could clearly identify advantages to this contact and felt that it would be beneficial in introducing mothers to groups and to breastfeeding support.

Women from areas where breastfeeding rates are very low are accessing peer support in very small numbers. This appears to be both because there are very few breastfeeders to involve, in addition to cultural influences and beliefs about support groups. Young women are also not accessing peer support and this is felt to be both in relation to perceptions of breastfeeding and of groups. A number of different approaches to peer support were suggested by participants that might be more appropriate for these groups of women.

Peer support groups are clearly valued and important and this evaluation provides evidence that they work on a number of levels, offering social support and breastfeeding advice and support. Peer supporters also gain skills, confidence and knowledge and recognise the transferability of these.

5.2 Limitations to the work

A range of circumstances led to this work being carried out over a much longer time-frame than was originally envisaged. This means that it is not possible to draw any, even tentative, associations between the provision of peer support and breastfeeding rates in these areas of Wiltshire. In addition, the ante- and post-natal texting and telephone service is not being universally implemented. It is therefore not possible to draw any conclusions about the impact of this, either on attendance at groups or on breastfeeding rates and this would need to be the focus of a future project.

Factors outside the investigators control led to difficulties in recruiting breastfeeding women and midwives for interview and in setting up one focus group with peer supporters. Resolving these resulted in some compromise and women were interviewed who had received peer support outside the evaluation area. No midwives were interviewed and so their perspective is missing from this analysis. As the final breastfeeding women were also drawn from a pool of newly-trained peer supporters they were also able to contribute insights about peer support from this

perspective. There may be differences between women who train as peer supporters and other breastfeeding women, which may relate to their breastfeeding experience and/or their commitment to breastfeeding and to breastfeeding peer support. As the sample was skewed in favour of women who had both breastfed and trained as peer supporters this may have impacted on the data collected. Recruiting participants who had not accessed peer support or who had negative experiences of peer support may have added richness to the findings, although recruitment and sampling from this group would have been challenging.

5.3 Recommendations

- Peer support groups are important and valued and there is some evidence that they work. This evaluation suggests, however that a ‘one size fits all’ approach is not working, particularly for women in disadvantaged groups and for young women. These women may need more flexible options – 1:1 support, home visits, buddies or telephone support. The women least likely to breastfeed are likely to be the most challenging and will need enhanced ante-natal input, community input and imaginative solutions.
- Continued provision of peer support groups will enhance breastfeeding experience for some women, providing both breastfeeding advice and social support. The importance of social support for breastfeeding women should be overtly recognised. The importance of peer support groups in normalising breastfeeding and in providing some elements of lost cultural/societal support should not be underestimated and recognised as an important factor when assessing groups for continuing support and funding.
- In rural areas there are particular challenges; a rural area with pockets of severe deprivation will be particularly challenging. It is suggested that contact is made with other peer support projects working in similar areas nationally to share ideas and learn from good practice. Similar contact with those in other areas successfully working with young women would be beneficial.
- The texting/telephone contact ante- and post-natally is a good idea which appears supported by stakeholders, peer supporters and breastfeeding mothers,

with clearly identifiable benefits. It is too early to assess whether texting/telephone contact will improve breastfeeding drop-off rates in the targeted areas. This should be evaluated when it is properly established in all three areas and drop-off rates can be clearly compared pre- and post-intervention.

- Leadership issues are very important. Sign-up at a strategic level does not appear to lead to consistency at a local level. The background and commitment of those closest to peer supporters and breastfeeding women is very important; a lack of belief in the importance and value of peer support impacts on the provision of support and this issue, although challenging, needs to be addressed. Breastfeeding 'champions' are needed in each locality to enhance the work of the peer supporters and to contribute to a supportive infrastructure. In addition, further strategic work is needed to fully engage both GPs and midwives.
- The association of groups with 'breastfeeding problems' is preventing some women from accessing on-going support and social support and, in some areas, inhibiting the development of a group identity. The 'marketing' or 'branding' of groups is important in this respect (and might also help to change the perceptions of the small number of women who have negative associations with Children's Centres).
- In her evaluation of peer support projects for the DH, Dykes (2005) identified a series of important steps necessary to implement successful peer support schemes. It is suggested that, although peer support is already established in Wiltshire, it might be beneficial to compare existing practice against these steps in order to identify specific areas for targeted work. Suggestions include re-examining the interface between peer supporters and health professionals, avoiding reliance on a key coordinator, establishing a supportive infrastructure and developing an in-depth understanding of local cultures.
- Further evaluation and research priorities have been identified through undertaking this work. Examples include:

- A further evaluation to fully assess of the impact of the ante- and post-natal contact intervention. This would require the project to be fully implemented across at least one identifiable area.

An action research project to focus on enhanced GP involvement in breastfeeding promotion and support. Action research is a process which involves actively participating in organisation change whilst conducting research.

- A participatory research project involving the women least likely to breastfeed in identifying barriers and enablers and in setting up pilot support projects.

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Sally Dowling and David Evans, October 2013