Original Article

Government funded breastfeeding peer support projects: implications for practice

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Abstract

In 1999, the Government, Department of Health in England, UK established the Infant Feeding Initiative. As part of this initiative, 79 1-year infant feeding projects were selected for funding. The funded projects specifically centred upon practice innovation and evaluation in relation to promoting breastfeeding and supporting breastfeeding women in socially excluded communities. The DH recently commissioned a comprehensive evaluation of the 79 projects (DH 2003). This paper focuses upon the evaluation of the 26 DH funded projects that specifically focused upon breastfeeding peer support schemes. The evaluation illuminated many of the challenges involved in implementing community based breastfeeding peer support schemes. Lessons learnt from the most effective projects in terms of: potential to increase breastfeeding initiation and continuation rates; uptake of the service; comprehensive evaluation; and sustainability are presented here, as a series of steps required for successful operationalization of breastfeeding peer support schemes. When these steps are followed, peer support schemes offer exciting prospects for supporting breastfeeding women and increasing breastfeeding initiation and continuation rates, while respecting diversity, ensuring inclusivity and stimulating community empowerment.

Keywords: breastfeeding, peer support, government, evaluation, social exclusion, health promotion.

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Introduction

The Government, Department of Health (DH), in England, UK, as a signatory to the Innocenti Declaration, places a high priority upon the Protection, Promotion and Support of Breastfeeding (WHO

1990). The DH has particularly emphasized targeting socially excluded communities in this respect in recognition of the striking disparity in breastfeeding rates between groups of differing socio-economic status (DH 1999, 2000, 2002). In the UK in 2000, 85% of mothers in higher socio-economic occupational groups commenced breastfeeding compared with 59% in lower socio-economic occupational groups, as defined by the national statistics socio-economic classification (Hamlyn *et al*. 2002). This inequity from birth constitutes a crucial aspect of the transmitted cycle of nutritional deprivation (Barker 1994). It is now recognized that two of the government priority areas for health improvement, coronary health and cancer reduction could be positively impacted by increasing breastfeeding rates (Maternity Care Working Party 2001). Clearly, breastfeeding has become a major public health issue.

In 1999, the DH utilized Public Health development funding to establish the Infant Feeding Initiative (Carson 2001). As part of this initiative, 79 1-year infant feeding projects were selected for funding. The funded projects specifically centred upon practice innovation and evaluation in relation to supporting breastfeeding women in socially excluded communities. The projects were largely developmental in nature, focusing upon capacity building, with the aim of producing sustainable and culturally sensitive changes that would increase both initiation and duration of breastfeeding within the target communities. The projects involved a range of breastfeeding initiatives to include: peer support programmes; support centres; education in schools; education initiatives for women, health care assistants and health professionals; targeting specific groups, for example minority ethnic groups, adolescents and significant others. The author of this paper was recently funded by the DH to conduct an evaluation of the 79 projects, details of which are contained in the complete report (Dykes 2003). Twenty-six projects specifically focused upon breastfeeding peer support schemes reflecting the growing emphasis upon this form of support within the community (see Table 1). This paper focuses upon the lessons learnt from the collective review of the breastfeeding peer support projects.

Breastfeeding peer support schemes

Peer support within a health care context may be defined as:

> The provision of emotional, appraisal, and informational assistance by a created social network member who possesses experiential knowledge of a specific behavior or stressor and similar characteristics as the target population (Dennis 2003, p. 329).

The La Leche League (LLL), an international voluntary breastfeeding support organization, has taken the lead in the development and proliferation of peer support for breastfeeding mothers since 1987. LLL provides a model of peer support that includes training for both peer supporters and support scheme co-ordinators, along with ongoing support for both (La Leche League 2003a, 2003b, 2003c, 2003d). More recently, health professionals to include midwives, health visitors, lactation consultants and medical doctors, have become involved in establishing, facilitating and evaluating peer support programmes, often in collaboration with a voluntary breastfeeding organization such as La Leche League (LLL), Breastfeeding Network (BfN), National Childbirth Trust (NCT) and the Association of Breastfeeding Mothers (ABM). Peer support schemes commonly involve recruiting a group of local women, who have breast fed their babies, to undertake a short programme of training in aspects of supporting women to breastfeed. The women are then engaged in supporting breastfeeding women within their local communities in a range of ways and via a number of access points.

In England peer support schemes are generally differentiated from the one-to-one and group support offered by qualified breastfeeding counsellors (NCT) or supporters (BfN). These qualified supporters have undertaken extensive and comprehensive programmes of education lasting for 1 to 2 years. However, this distinction between peer and qualified voluntary breastfeeding supporters is not internationally recognized nor necessarily made explicit in research papers. This lack of clarity leads to some level of confusion when interpreting research findings related to impact upon breastfeeding women.

A number of peer support programmes have been established and evaluated (excluding the DH funded projects), in the UK (Wright 1996; McInnes *et al*. 2000; McInnes & Stone 2001; Timms 2002; Scott & Mostyn 2003) and internationally (Kistin *et al*. 1994; Long *et al*. 1995; Arlotti *et al*. 1998; Schafer *et al*. 1998; Morrow *et al*. 1999; Shaw & Kaczorowski 1999; Dennis 2002; Dennis *et al*. 2002; Haider *et al*. 2002). Drawing study findings together, a systematic review of support for breastfeeding women by Sikorski *et al*. (2003) concluded that:

> Lay support was effective in reducing the cessation of exclusive breastfeeding (RR 0.66 [95% CI 0.49, 0.89]; five trials, 2530 women) but its effect on any breastfeeding did not reach statistical significance (RR 0,84 [95% CI 0.69, 1.02]; five trials, 2224 women) (p. 3).

It needs to be acknowledged, however, that changing local culture through peer support is a necessarily slow process if sustainable outcomes are to be aimed at in terms of increasing the prevalence of breastfeeding. Peer support programmes are particularly important in areas in which breastfeeding is not the cultural norm, for example within socially deprived communities in the UK. Within such communities breastfeeding is commonly perceived and indeed experienced as a marginal activity, rarely seen and barely spoken about (Hoddinott & Pill 1999; Dykes 2003; Scott & Mostyn 2003). Women within such communities are particularly vulnerable to a lack of confidence in their ability to breastfeed (Dykes & Williams 1999; Hoddinott & Pill 1999; Hawkins & Heard 2001; Dykes 2002; Dykes 2003). Peer supporters within these settings provide positive role models for women with regard to breastfeeding and, in this way, are able to have a crucial impact upon individual and community attitudes towards and confidence in breastfeeding (Hoddinott & Pill 1999; Kirkham 2000; Anderson & Grant 2001; McInnes & Stone 2001; Alexander *et al*. 2003). As women are supported effectively with breastfeeding and therefore continue for longer, others will gradually start to initiate breastfeeding due to exposure to positive role models. Breastfeeding continuation rates are therefore likely to increase first, followed by initiation rates. In addition to impact upon breastfeeding the potential of peer support programmes to empower those living within socially excluded communities should not be underestimated (Dykes 2003).

DH funded peer support schemes

The 26 DH funded 'peer support' projects are not referred to individually, but a brief overview of each is provided in Table 1. This table illustrates that while most projects involved setting up and evaluating a peer support scheme, some differed in their approaches, for example in specifically targeting adolescents or providing payment to peer supporters. This paper presents issues generated through a collective review. As some of the authors have now published (Kirkham 2000; Anderson & Grant 2001; Battersby 2001a, 2001b; Battersby & Sabin 2002; Sookhoo *et al*. 2002; Alexander *et al*. 2003; Raine & Woodward 2003; Smale 2004) these papers may be referred to for illustrative purposes.

As stated, the majority of the DH funded projects were developmental and capacity building. The peer support project teams commonly referred to their ultimate aim of increasing breastfeeding initiation and duration rates within the designated communities. However, they recognized that this aim was not demonstrable within 1 year. Rather the effects would emerge slowly over several years as cultural change took place. They therefore utilized descriptive statistics and in all cases demonstrated positive trends in breastfeeding continuation rates. In addition, project teams gathered comprehensive data on uptake of, satisfaction with and the experiences of service users and providers, a much needed perspective. The project authors highlighted with impressive honesty the challenges that they faced when implementing, maintaining and evaluating peer support programmes.

Methodology for evaluating the projects

Given the practice, developmental and heterogeneous nature of the projects the approach to reviewing the reports was broad and inclusive of all the projects. The evaluation aimed to:

Table 1. Overview of breastfeeding peer support projects

Author(s)	Year	Title*	Intervention/area explored	Combined with establishment of a support group for mothers	Provided concurrent training for health professionals
Anderson T, Grant M, Alexander J, Jackson D, Sanghera J	2002	Breastfeeding Support Group	Extension and evaluation of an existing peer support programme, 'Bosom Buddies.'	✓	✓
Bachelor G, Brackstone C	2001	Peer breastfeeding support project	Establishment and evaluation of a peer support scheme.	✓	
Battersby S	2001a	'Simply the Breast' Evaluation of a Peer Support Programme	Establishment of a peer support project and linkage with a neighboring 'Wordly Wise project' with ongoing evaluation.		✓
Battersby S	2001b	The Worldly Wise Project	Appointment, training and evaluation of non-professional mature women as peer supporters.		✓
Battersby S	2002	Breastfeeding is Best Supporters (BIBS)	Amalgamation of two peer support programmes 'Simply the Breast' and the 'Worldly Wise' project to form the 'Breastfeeding is Best Supporters' (BIBS) project. Ongoing evaluation conducted.	✓	
Brown S, Draisey A	2001	Dickens Diners.	Establishment and evaluation of a peer support scheme.	✓	
Brown S, Clarke C, Tipton C, Lunn J	2001	Breastfeeding Peer Support Project	Establishment and evaluation of a peer support scheme.	✓	
Clarke C, Gibb C, King A, O'Brien A, Sookhoo M, Sen D, Dowling G	2002a	Peer Support in Breastfeeding	Action research study to establish and evaluate a postnatal breastfeeding peer support programme centring on the postnatal area of the maternity unit.	✓	
Coutts J	2002	Peer breastfeeding support for teenage mothers	Establishment of a peer support programme for adolescents.		✓
Curtis P, Stapleton H, Kirkham M, Smale M	2001	'Breastfriends'	Establishment and evaluation of peer support scheme with emphasis upon younger mothers.		
Dassut W, Ridgers I	2002	Breastfeeding Peer Support Group	Establishment and evaluation of a peer support scheme.	✓	
de Waymarn S	2002	Breastfeeding support within Sure Start project (SWISS)	Establishment and evaluation of a peer support scheme.	✓	✓

Table 1. *Continued*

Author(s)	Year	Title*	Intervention/area explored	Combined with establishment of a support group for mothers	Provided concurrent training for health professionals
Dye J	2001	La Leche League Breastfeeding Peer Counsellor Programme Evaluation Project	Expansion and evaluation of a recently established peer support programme.		
Etherington S	2001	BreastFriends Project	Establishment and evaluation of a peer support scheme.	✓	✓
Evans G	2002	Breastfeeding Advocacy Project	Establishment and evaluation of a peer support scheme.	✓	
Geaney L	2002	'One to Mum' – Peer support	Establishment and evaluation of a peer support scheme.	✓	
Hammond P	2001	Designed for Health – Breastfeeding volunteer support programme	Establishment and evaluation of a peer support scheme.	✓	✓
Hodgson E, Burns I	2001	Peer Support Groups	Establishment and evaluation of a peer support scheme.	✓	
Locke J	2001	Mum2Mum	Establishment and evaluation of a peer support scheme.	✓	
Mason B	2002	Feeding 4 Health	Implementation and evaluation of a programme of awareness raising activities related to breastfeeding to include peer support.		✓
Rosser J	2002	Breastfeeding Support Group	Establishment and evaluation of a peer support scheme.	✓	✓
Sikorski J, Cruise K, Raikes N	2002	A Study of Lay Breastfeeding Support	An experimental study to test the effectiveness of a peer support scheme in increasing breastfeeding prevalence.	✓	✓
Suppiah C	2002	Breastfeeding Supporters.	Evaluation of an existing peer support programme and extension into a neighboring area.		
Willcocks D, Carden K	2001	Bumps 'n' Babes Project	Establishment and evaluation of a peer support scheme.	✓	✓
Woodward P	2001	Breastfeeding Supporter Project	Establishment and evaluation of a peer support scheme.		✓
Woodward V	2002	Peer breastfeeding support at home. An evaluation of a peer breastfeeding support at home service (Practice)	Establishment and evaluation of a peer support scheme.	✓	

The details in this table appear, in full, in the DH evaluation report (Dykes 2003); *Place names have been removed from the project titles for ethical reasons.

- Summarize and evaluate the information generated by the individual projects.
- Synthesize common themes across projects.
- Highlight innovative ways of delivering services.
- Develop best practice pointers.
- Illustrate issues related to sustainability.
- Make recommendations for further research.

Data/information extraction forms were firstly developed enabling each study to be summarized under standard headings. Each study was then read and summarized. The individual project summaries are available in the full report (Dykes 2003). Project coordinators were contacted to request missing or follow up data, to clarify project details and to seek conclusions or information on ways in which the projects have been sustained.

The evaluations of each project were reviewed for inclusion of comprehensive baseline, process and outcome phases. The baseline and outcome data needed to relate to preproject and post implementation breastfeeding rates in addition to demographic data on those accessing (and those not accessing) the service. The process data needed to rigorously elicit peer supporters, breastfeeding mothers' and health professionals' experiences of the service through questionnaires, focus groups and/or in-depth interviews. The project evaluations that were most highly rated in the collective evaluation exercise were those that both reported on the characteristics of non-respondents and interviewed those who did not avail themselves of the service. The complex methodological challenges with regard to evaluation by individual project teams and in turn during the collective evaluation exercise are discussed in depth in the main report (Dykes 2003).

Commonalties between projects were organized primarily by grouping projects that focused on specific practice issues, for example peer support schemes. Reports were then organized, condensed and summarized accordingly and recommendations made for practice and further research. Central to these recommendations was the government target of increasing breastfeeding rates by 2% for each of the next 3 years with particular focus on women from disadvantaged groups.

The combination of descriptive data in numerical and narrative form and the reflexive accounting enabled identification, during the DH evaluation (Dykes 2003), of the most effective projects in terms of:

- Potential to increase breastfeeding initiation and continuation rates.
- Uptake of the service.
- Comprehensive evaluation to elicit views of those involved (and those preferring not to be involved), to include peer supporters, service-users and associated health professionals.
- Sustainability.

The lessons learnt are now presented as a series of steps required for the successful operationalization of peer support schemes.

(1) Cultural awareness

It is crucial to develop an in-depth understanding of the local culture before implementing innovation and change (Wright *et al*. 1997; Broome 1998; Sellen 2001). The most effective projects commenced with a local cultural assessment. This was facilitated, in part, by members of the project teams often working and in some cases living within the target area and therefore having observed local practices. In some cases, interviews or focus groups were conducted with members of the local community, to include women and men and a range of ages from childhood to the elderly. This exploratory phase enabled the project teams to elicit: cultural beliefs related to infant feeding; cultural norms to include identification of key influencers with regard to infant feeding; constraints upon women in initiating and continuing with breastfeeding. It also enabled the teams to understand how and why some of the infant feeding practices had developed. Project teams that omitted local cultural assessment tended to acknowledge that problems in implementation required them to 'go back' and address this stage later on.

(2) Building on existing infrastructure

A natural extension of local cultural assessment involved becoming aware of existing schemes and

projects in the surrounding areas. This exploratory work was crucial to learning from others' experiences and evaluations and avoided 'reinventing the wheel'. It enabled the development of interconnected projects that supported each other through shared experiences and in some cases personnel.

(3) Comprehensive planning

Involvement of key stakeholders in the strategic planning of change was crucial and effective communication lay at the heart of this process (Broome 1998). This engagement and communication involved key representatives from the local Primary Care Trusts, Sure Start, breastfeeding support organizations, local maternity services, infant feeding specialists, health visitor services, general practitioner services and health promotion units. In some cases religious leaders, council members and local businesses were involved. This multi-agency team then required co-ordination by an individual with skills in group facilitation, an understanding of the local culture and knowledge of supportive strategies for breastfeeding women. Most commonly, this person was a member of one of the national breastfeeding support organizations, an infant feeding specialist, lactation consultant, health visitor or midwife. The co-ordinator, with the support of her/his team, then took responsibility for overseeing the project and delegating and overseeing roles as appropriate. Crucial to the success of this role was the allocation of designated funding and time to conduct this role and the employment of an associate co-ordinator to ensure that the project did not collapse if the co-ordinator became unavailable. Some of the projects involved a partnership between a health professional and member of one of the voluntary breastfeeding organizations. This worked well when there was effective communication between the two individuals regarding the operationalization of their roles. Project teams that did not sufficiently involve a wide range of key stakeholders reported needing to address this at some later stage during the project. This often required them to reconfigure projects to address stakeholder concerns.

(4) Engaging peer supporters

The recruitment, selection, training and support of peer supporters formed the central aspect of the breastfeeding peer support projects. Several project teams commissioned the La Leche League to provide their peer support programme in the designated area (La Leche League 2003d). LLL then supported the project team in developing a recruitment process for potential peer supporters, assessing a suitable meeting place for the supporters and providing an ongoing support infrastructure for the supporters within the health system. They then provided training for both peer supporters and for those engaged in the administration of the programme, i.e. peer counsellor administrators.

Other project teams developed their own processes for engaging, training and supporting peer supporters, for example Kirkham (2000), Anderson & Grant (2001), Alexander *et al*. (2003). The most effective projects developed clear guidelines for these processes combined with in-built flexibility. The training programmes typically involved: exploration of personal experiences of breastfeeding; understanding breastfeeding as a bio-psychosocial process; ways in which women could be supported; basic group process skills; health and safety; record keeping; confidentiality and child protection issues. A strong emphasis was placed upon interpersonal skills, listening to and empowering women, with basic person-centred counselling skills being taught in most cases, as described by (Rogers 1961). Most courses lasted from 10–30 h and took place over several weeks. It was crucial that the times and format of the courses were flexible and that adequate provision was made for accompanying children. Follow-up sessions, to include up-dates and problem sharing exercises, were vital as part of the ongoing support. Programmes of education also needed to be organized on an ongoing 'rolling' basis to ensure that new recruits were equipped with training at the time at which they were most motivated to join the scheme.

(5) Peer – professional interface

A crucial challenge for project co-ordinators centred upon managing peer-professional relationships. With-

out attention to this, health professionals were unlikely to inform women about the peer supporters, and despite best efforts, the projects did not develop and expand. Peer-professional relationships proved to be an area of potential conflict centring upon a lack communication and understanding of each other's roles. This conflict was minimized when relevant health professionals such as health visitors and midwives were fully informed regarding the scheme and those directly involved were provided with some educational input. The La Leche League Peer counsellors administrator's course proved to be useful in providing health professionals with confidence and skills to co-ordinate and engage with aspects of the peer support programmes. For other health professionals, with more of a tangential involvement, provision of information about the scheme was required.

A number of projects provided a concurrent programme of education on breastfeeding for the health professionals, with some purchasing the three day UNICEF UK Baby Friendly Breastfeeding Management Course for this purpose (Lang & Dykes 1998; UNICEF UK 2003). Health professionals engaged with peer support programmes also identified their own need for interpersonal skills, group process awareness and conflict management. When health professionals lacked confidence in their breastfeeding support and interpersonal skills they tended to resist or avoid engagement with the peer support projects. This led to problems with health professionals not recommending the peer support scheme to women and adopting a 'gatekeeping' role that made peer supporters feel unwelcome, particularly within the hospital setting. It becomes clear therefore that health professional's educational needs must be addressed concurrently with development of peer support programmes.

(6) Marketing the programme

An ongoing, comprehensive publicity strategy was crucial to community receptivity regarding the innovation and for effective uptake of the peer support schemes. Without this publicity, project teams had difficulty both recruiting peer supporters and informing women about the availability of the scheme. Publicity needed to be targeted to key stakeholders, referred to above, and to all health professionals interacting with breastfeeding mothers. The use of a brand name for the peer supporters was key to success in marketing, for example 'Bosom Buddies' (Anderson & Grant 2001) and 'Breastfriends' (Kirkham 2000).

(7) Supportive infrastructure

In order to maintain and sustain the peer support schemes, careful planning of referral strategies and access points was required. The most successful schemes had multiple access points by which women could be referred to or directly contact the peer supporters. These extended across the hospital–community interface and included community and hospital antenatal clinics, health centres, postnatal wards and 'drop-in' centres. When peer supporters attended hospitals they needed to be welcomed by health professionals and given a designated space in which to work, and for women to be directed to them. Without this facilitation by health professionals, peer supporters felt alienated and marginalized in this setting. Working in pairs supported them in overcoming fears of the hospital environment.

Support group/'drop-in' centres were crucial as a focal point at which peer supporters, health professionals and breastfeeding women could meet. They facilitated the development and maintenance of supportive relationships within and between these groups. The most successful models of 'drop-in' center associated with peer support schemes were those that operated informally, with peer supporters taking a central role and health professionals having a background facilitative role. These drop-in centres needed to be located in a venue that was both acceptable and accessible to the target group of women and secondly needed to run at least weekly. When the drop-in venues and times linked with other activities, for example a baby clinic, they were particularly well attended. 'Drop-in' centres were most successful when they were open to both antenatal and breastfeeding women as this enabled the building of relationships before women commenced breastfeeding. A number of 'drop-in' centres were not attended due to, for

example, being situated in a place that was inaccessible to the target population or a place that was avoided due to local vandalism. In one project the center was given a name that was culturally inappropriate. This was subsequently changed and attendance at the center increased.

Other aspects that needed to be considered in providing supportive infrastructure included: developing a workable telephone and home visiting system; payment of expenses; support with childcare; ongoing support for peer supporters. Means of providing ongoing support involved, as stated, providing places and time for meeting, updating and problem sharing sessions. The peer support administrator also needed to be readily available to answer queries and for referral in situations that the peer supporters were unable or unwilling to manage. When a support infrastructure for peer supporters was not put in place, project teams reported declining motivation of peer supporters leading to difficulties in keeping the project going.

(8) Evaluating impact

Comprehensive evaluation is crucial to successful implementation of any project involving change (Broome 1998). The most effective projects implemented a clear evaluation strategy from the outset that involved a continual cycle of evaluation and subsequent implementation of improvements. As stated, the evaluations conducted during the course of the 1 year projects were not designed to make causal statements regarding changes in breastfeeding rates, although as the projects develop over time this will become increasingly possible. However, the descriptive statistics invariably illustrated a trend towards increased duration of breastfeeding. This was backed by analysis of the substantial qualitative data that illustrated the many situations in which women reported that the peer support schemes supported them with exclusive breastfeeding and in continuing to breastfeed through situations that would otherwise have contributed to them ceasing to breastfeed. This constitutes a key route through which the local cultural norms may be shifted in that positive role models for breastfeeding in the community give other women confidence to initiate and continue breastfeeding (Hoddinott & Pill 1999; Dykes *et al*. 2003)

(9) Obtaining and maintaining funding

The 1-year DH funding supported a crucial development of peer support projects in socially excluded areas. Most of these schemes have subsequently obtained further funding for sustaining and expanding the projects. Key funders include Sure Start, a government funded, community health, capacity building scheme (Department for Education and Skills 2003) and Primary Care Trusts, i.e. community National Health Service Organizations.

Conclusion

The government is committed to empowering women to initiate and continue to breastfeed. As part of its strategic policy it requires all Primary Care Trusts to increase their breastfeeding initiation rates by two percentage points per year, with particular focus on women from disadvantaged groups, as described in the recent publication Improvement, Expansion and Reform: The Next Three Years: Priority & Planning Framework 2003–06 (DH 2002). The Performance and Planning Framework (PPF) provides guidance on operationalization of this and also requires Primary Care Trusts to monitor their activities in relation to national breastfeeding targets. The development, refinement and expansion of breastfeeding peer support projects is a crucial component of this strategy. The evaluation of the DH funded projects illuminates many of the challenges involved in implementing such projects and important practice pointers for those planning to implement similar projects in the future. When the appropriate steps are followed, as outlined above, breastfeeding peer support schemes offer exciting prospects for increasing breastfeeding rates while respecting diversity, ensuring inclusivity and stimulating community empowerment.

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